STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395309	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York South Skilled Nursing and Rehabilitation Ctr	200 Pauline Drive York, PA 17402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document review, and staff interview, it was determined that the facility failed to provide care and services consistent with the resident comprehensive plan of care, which resulted in harm as evidenced by a decline in health status for one of three residents reviewed (Resident 1). Findings include: Review of Resident 1's clinical record revealed diagnoses that included diabetes mellitus type II (decreased ability of the body to utilize insulin) and atrial fibrillation (irregular heart rate). Review of Resident 1's Pennsylvania Orders for Life-Sustaining Treatment (POLST - document identifying a resident's basic wishes if they become critically ill and/or enter cardiopulmonary arrest), revealed that section B: Medical interventions for a resident who has a pulse and/or is breathing, was marked as, Limited Additional Interventions, which the document defined as, .Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care if possible. Further, section C, Antibiotics, of Resident 1's POLST was marked as, Use antibiotics if life can be prolonged. Review of the POLST revealed it was signed and dated by Resident 1's Representative on [DATE]. Review of Resident 1's clinical interdisciplinary progress notes revealed that on [DATE], at 12:46 PM, staff documented that Resident 1 had experienced a temperature of 101.5 f (Fahrenheit [F]). Resident was provided acetaminophen, which decreased Resident 1's temperature to 98.7 F. Review of a change in condition note dated [DATE], at 8:31 AM, entered by Employee 1 (Registered Nurse) revealed that nursing staff noted Resident 1 had been experiencing a low-grade fever for 24 hours, and that nursing staff had reported foul smelling urine. Symptoms that could indicate possible urinary tract infection (UTI). Review of facility documentation revealed that a contracted on-call provider, CRNP 1 (Certified Registered Nurse Practitioner), was contacted and updated with Resident 1's status as identified in Employee 1's progress note. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the progress note dated [DATE], at 8:26 AM, by CRNP 1 stated, CC Patient is currently under comfort care measures only. No escalation of care per plan. HPI Initial temperature recorded at 101.7 F. Tylenol administered per protocol. Temperatures rechecked post-medication and noted to be 98.9f. Patient appears more comfortable following intervention. Assessment: Febrile episode managed effectively with antipyretic. Patient remains under comfort-focused care with no signs of acute distress at this time. Plan: Continue Tylenol administrations as needed to maintain patient comfort. Monitor temperature and overall comfort level. Continue with comfort care measures; no escalation of medical interventions per care directive. A request was made to the facility to obtain a statement from CRNP 1 as to the circumstances of documenting that Resident 1 was comfort measures; however, as of [DATE], at 12:00 PM, the facility was unable to procure a statement from CRNP 1. Review of Resident 1's physician orders and comprehensive plan of care revealed no indication that Resident 1 was comfort care measures as of [DATE]. Review of Resident 1's progress note revealed that the next day [DATE], at 12:23 PM, Employee 1 documented that Resident 1 continued with foul smelling urine and lethargy. Employee 1 documented that an on-call provider (CRNP 2) was contacted and at that time, orders for a urinary analysis (laboratory study of the urine to determine if a urinary tract infection is present), and a culture and sensitivity test (microbiological study of the urine to determine the type of bacteria present and effectiveness of antibiotics towards the bacteria) were provided. Review of CRNP 2's progress note from [DATE], stated, Chief complaint: foul smelling urine[.] Assessment: Patient is incontinent, family/nurse noticed foul smelling urine when changing patient today. He is on comfort care . However, review of Resident 1's clinical record revealed no indication that Resident 1 was on comfort care measures as of [DATE]. Review of a progress note from 2:39 PM on [DATE], stated, Resident continues to decline. Resident total feed this shift and coughing with thin liquids. Resident downgraded to [nectar thick liquids] per nursing judgement, which resident did well. Dietician [sic] made aware, requested [speech therapy] to [evaluate] . On the morning of [DATE], at 3:45 AM, facility staff documented that the results of Resident 1's urinary analysis confirmed the presence of a urinary tract infection. The progress note also stated, .Obtained lab orders from provider. complete a CBC [complete blood count] and CMP [comprehensive metabolic panel] on Tuesday [[DATE]]. Awaiting sensitivity and culture results before any antibiotic treatment is initiated. On Tuesday, [DATE], at 12:51 PM, Speech Therapist 1 documented a note which stated, Worse overall status compared to yesterday. Shallow respiratory cycles noted. Mouth breathing. Does not respond to tactile, auditory, or visual stimulation - eyes partially opened but does not appear to [be] receiving visual information. Still has occasional reflexive responses to pain with guttural utterances. Not deemed safe for [by mouth consumption] at this present time except for occasional 1/3 [teaspoon] of water. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	At 2:03 PM, on [DATE], Employee 6 (Nurse Manager) documented the following progress note, [Intramuscular] Cefazolin administered in bilateral upper extremities for UTI. [Unit manager] started IV and IV fluids started at this time at 100 [milliliters per hour] for 1 Liter then to have 75 [milliliters per hour] x2 liters . Review of a progress note entered on [DATE], at 5:25 PM, CRNP 3 documented, Patient seen at the request of staff for reports of lethargy and abnormal lab work today. On-call service was notified over the weekend with reports of fever and lethargy, on-call service ordered UA C&S on 5/25 a CBC and CMP for today. Over the last 2 days nursing documentation shows [Resident 1] has been lethargic with poor [by-mouth] intake. Patient was seen by speech therapy today speech therapy reports patient with mouth hanging open and fluids draining out of the side. Family at bedside reports they ran on Saturday patient was sitting up in a wheelchair talking and playing cards. Patient seen today lying in his bed nonresponsive. [No fever] today with a temp at 97.7. No [nausea or vomiting] or [difficulty breathing] .[Blood work] shows patient in [acute kidney injury] . Review of the interventions/plan section of the note revealed that CRNP 3 documented that Resident 1 was to have Cefazolin (an antibiotic) 2 grams intramuscular injection, then 500 milligrams via IV every 12 hours for two days, then review, as well as, If little to no improvement plan to discuss comfort measures with family. Resident 1 did not improve and on [DATE], Resident 1 expired at 11:25 AM. Based on Resident 1's clinical record review, the facility's contracted on-call provider incorrectly identified Resident 1's plan of care as comfort measures, which was identified as the basis not to provide further intervention after Resident 1 had experienced fever and foul smelling, mucousy presentation of urine. During a staff interview on [DATE], at approximately 12:00 PM, Director of Nursing (DON) confirmed that there was no indication that Resident 1 was on comfort care measures on [DATE]. During the interview, the DON confirmed that it is the facility's expectation that care and interventions are implemented that are consistent with the residents' advanced directives, or stated wishes as outlined by the POLST. 28 Pa code 201.18(b)(1) Management 28 Pa code 211.2(d)(7) Medical director 28 Pa code 211.12(d)(1)(3)(5) Nursing services