

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>395309                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                         | (X3) DATE SURVEY<br>COMPLETED<br><br>06/18/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>York South Skilled Nursing and Rehabilitation Ctr                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>200 Pauline Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                  |                                                 |
| F 0804<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on review of select food service committee meeting minutes, resident and staff interviews, observation, and completion of one meal test tray, it was determined that the facility failed to provide foods that are palatable and at appetizing temperatures. Findings include: Review of Facility Test Tray Evaluation form, dated May 1, 2023, read, in part, hot entree, vegetable, and starch should be served at 140 degrees Fahrenheit (F). Review of Resident council meeting minutes dated April 20, 2026, documented breakfast was cold. Interview with Resident 3 on June 15, 2026, at 11:25 AM, revealed the temperature of the food is often poor. Interview with Resident 7 on June 15, 2026, at 12:21PM, revealed the temperature of the food is not good. A test tray completed on June 16, 2026, revealed adequate portions size, and the food was palatable for taste and texture for a regular diet; however, the temperature of the Turkey, brussels sprouts, and baked potato weren't palatable for temperature. The test tray was placed on a meal cart and delivered to 700 unit with other trays being delivered at that time; 10 minutes had elapsed between the time the test tray was prepared from the service line and presented for evaluation. Employee 12 (Dining Services Director) took temperatures of the food items at the time the test tray was served for evaluation. The following were the recorded highest temperatures: Roast Turkey- 130 degrees F Brussels sprouts - 112 degrees F Baked potato - 122 degrees F Peach cobbler - 45 degrees F Coffee - 130 degrees F Milk - 48 degrees F Apple juice - 48 degrees F At that time, interview with Employee 12 revealed that several months prior residents had concerns with food temperatures and the facility replaced the pellet warmer (equipment which warms a base placed under the plate helps keep the food warm). The surveyor felt the plate was slightly warm, and the heated base was barely warm and looked like it was worn (faded in color and coating). During an interview with the Nursing Home Administrator on June 18, 2026, at 1:30 PM, the surveyor revealed concern regarding food temperature of the turkey, brussels sprouts and baked potato. It was confirmed that the machine that heats the pellets was replaced but not the pellets. 28 Pa. Code 201.14 (a) - Responsibility of licensee 28 Pa code 211.6 - Dietary Services</p> |                                                                                  |                                                 |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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