

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/21/2024
NAME OF PROVIDER OR SUPPLIER  York North Skilled Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  1770 Barley Road York, PA 17408	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34631</p> <p>Based on policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure all residents receive treatment and care in accordance with professional standards of practice for one of three residents reviewed (Resident 2).</p> <p>Findings Include:</p> <p>A review of the facility's policy, titled Medication Regimen Review, recently reviewed June 1, 2024, read, in part, The consultant pharmacist will conduct MRR's [Medication Regimen Reviews] .and will make recommendations based on the information made available in the resident's health record. The policy continued, Facility should independently review each resident's medication regimen directly from the resident's medical chart and with interdisciplinary care team member, resident, or responsible party, as needed.</p> <p>A review of Resident 2's clinical record revealed diagnoses that included Diabetes Mellitus Type II (A long-term condition in which the body has trouble controlling blood sugar and using it for energy) and hypercholesterolemia (High amounts of cholesterol in the blood).</p> <p>A review of Resident 2's hospital discharge information revealed a discharge from the hospital, admission to the facility on [DATE], and discharge home on May 17, 2024.</p> <p>A review of the hospital discharge summary revealed Resident 2's allergies included spider venom, honey-bee venom, and Atorvastatin (also known as Lipitor - a medication to lower cholesterol).</p> <p>A continued review of the hospital discharge summary revealed Resident 2 had received the medication Metformin 500 mg tablet. The medication order read Take 1 tablet (500 mg total) by mouth every evening.</p> <p>Metformin is a medication used to treat high blood sugar levels that are caused by a type of diabetes mellitus or sugar diabetes called type 2 diabetes.</p> <p>A review of Resident 2's facility's clinical record revealed the Resident's allergens information dated April 29, 2024, to include Atorvastatin and Reaction Manifestation listed as Rash.</p> <p>Review Resident 2's facility medication order audit report, revealed Metformin .500 mg. Give 500 mg by mouth two times a day for DM [Diabetes Mellitus], dated April 30, 2024.</p> <p>(continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Employee 6 (Registered Nurse/Unit Manager) on June 18, 2024, at 1:37 PM, revealed Resident 2 was prescribed and administered the Atorvastatin despite having an allergy to the medication, documented to produce a rash. The interview also revealed Resident 2 was prescribed and administered the Metformin two times per day instead of once per day as documented on the hospital discharge summary. Further, Employee 6 revealed that neither the facility's pharmacy representative nor the facility's interdisciplinary team caught the medication errors for Resident 2.</p> <p>Electronic mail correspondence with the Nursing Home Administrator on June 20, 2024, at 11:31 AM, revealed an understanding of the concerns regarding the medications ordered and administered to Resident 2 during her stay.</p> <p>28 Pa. Code 201.18 ( b ) (1) Management</p> <p>28 Pa. Code 211.9 (a) (1) Pharmacy Services</p> <p>28 Pa. Code 211.12 (d) (1) (2) (5) Nursing services</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>34631</p> <p>Based on observation, facility-provided documentation, and resident and staff interviews, it was determined that the facility failed to provide meals at regular times and in accordance with resident needs, preferences, and requests for five of 10 resident areas reviewed for mealtimes and one of three residents reviewed (Resident 1).</p> <p>Findings Include:</p> <p>A review of the facility's document, titled Time Sheet for Cart Services to Stations, dated June 4, 2024, revealed the posted arrival time for the dinner meal on Medbridge #2 at 5:20 PM. A review of the document also revealed the cart left the kitchen at 6:05 PM.</p> <p>The document also revealed the posted arrival time on the C-1 Station at 5:30 PM, and the cart arrival at 6:15 PM; the posted arrival time on the C-2 Station at 5:40 PM, and the cart arrival time at 6:22 PM; and the posted arrival time on the A Station-1 at 5:55 PM, and the cart arrival time at 6:34 PM.</p> <p>An interview and observation with Resident 1 on June 18, 2024, at 1:20 PM, revealed the arrival of the lunch meal cart on the Heritage -1 hall. According to the facility's posted lunch arrival time, Resident 1's hall should have received its meal cart at 12:35 PM. Resident 1 was served his lunch meal at 1:23 PM; therefore, making the lunch meal for Resident 1 approximately 48 minutes late.</p> <p>An interview with the Employee 3 (Food Services Director) on June 18, 2024, at 1:45 PM, revealed the facility has hired seven new staff members and is aware of residents not receiving meals as posted from the kitchen.</p> <p>Electronic mail correspondence with the Nursing Home Administrator on June 20, 2024, at 11:31 AM, revealed an understanding of the concerns regarding the delay in the resident meals arriving in resident areas and being served to residents.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p>		