STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395442	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York North Skilled Nursing and Rehabilitation Ctr	1770 Barley Road York, PA 17408

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 33879 Based on resident and staff interviews, policy review, clinical record record review, and facility document review, it was determined that the facility failed to ensure the resident right to receive mail, including packages, in a timely manner for one of one resident reviewed for personal property (Resident 19). Findings include: Review of the facility policy, titled OPS206 Resident Rights Under Federal Law, last reviewed December, 2024, revealed subsection 7.2.8 stated, The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service . Further, subsection 8.2 stated, The facility must respect the residents' right to personal privacy .including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident . Review of Resident 19's clinical record revealed diagnoses that included anxiety disorder (mental health disorder characterized by excessive fear or worry) and congestive heart failure (decreased ability of the heart to pump blood through the body resulting in poor circulation and fluid overload). During an interview with Resident 19 on February 11, 2025, the Resident expressed concern that a package that was not provided to her timely. During the interview, Resident 19 stated that she had been expecting a package, approximately two to three months prior. Once Resident 19 had not receive the package on the expected date, Resident 19 asked Employee 12 about the package being delivered. Resident 19 stated that Employee 12 stated Employee 12 had no knowledge of the package being delivered. Resident 19 then stated she called and confirmed with the post office that the package was delivered. At which time, Resident 19 reapproached Employee 12. Resident 19 stated that Employee 12 then told her that the package was given to the Director of Nursing (DON) due to concerns that the package may have contained items that aren't appropriate for the facility. Resident 19 stated that the package was eventually provided by the Nursing Home Administrator (NHA), but had been delayed approximately one week. During an interview with Employee 12, confirmed that she had received a package for Resident 19 in November 2024. Employee 12 revealed that the package sounded like it contained pills. Upon hearing the package, Employee 12 gave it to the DON. Employee 12 could not recall the date that the package was received by the facility. (continued on next page)

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

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 19's clinical record revealed no documentation regarding Resident 19's package. Review of handwritten document written by Employee 12 revealed a documented entry on November 14, 2024, which stated, [Resident 19] came to my office about her missing package and accused me of lying to her about the package. I explained that when I spoke to her - I didn't remember the package that came in last week and was given to [Director of Nursing] due to it feeling and sounded like pills/supplements . During a staff interview on February 13, 2025, at approximately 10:50 AM, the DON confirmed that she was given the package by Employee 12, however, could not remember when it was provided. During the interview, the DON stated that she was subsequently out sick which contributed to Resident 19 not receiving her package timely. During the staff interview, the NHA confirmed that Resident 19's package was not provided timely, and that the NHA provided education to Resident 19 upon identifying the package contents (pills) regarding the safety concerns regarding having medications shipped to the facility. The NHA was unable to provide a length in time that Resident 19's package was delayed. Review of Resident 19's clinical record revealed no documentation regarding concerns with Resident 19's package, nor the education provided. During the staff interview, the NHA confirmed that Resident 19's package was delayed and that there was no documentation regarding Resident 19's package being delayed. Review of available information revealed the facility had no policy developed regarding process or procedure to follow when a package, addressed to a resident and delivered to the facility, is identified as possibly containing items that could pose a safety concern. As of February 13, 2025, at 1:00 PM, the facility did not provide a policy regarding the facility procedure for concerns with resident packages being delivered at the facility. 28 Pa code 201.18(b)(2) Management

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 34631 Based on clinical record review, policy review, and staff interview, it was determined that the facility failed to ensure each resident and/or representative the right to formulate an Advance Directive for one of two residents reviewed for Advance Directives (Resident 57). Findings Include: An Advance Directive is defined as a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. A review of the facility's policy, titled Health Care Decision Making, revised January 8, 2024, read, It is the right of all patients/residents to participate in their own health care decision making .including the right to formulate or not formulate an advance directive. The policy continued, Approach a capable patient who does not have an advance directive upon admission; the patient will be approached by the Social Worker or another designated staff person on admission, quarterly, and with change in condition to discuss whether he/she wishes to consider developing an advance directive. Also, Establish mechanisms for documenting and communicating the patient's choices to the interprofessional team and staff responsible for the patient's care. A review of Resident 57's clinical record revealed diagnoses that included chronic kidney disease (CKD-a condition in which the kidneys gradually lose their ability to filter waste products from the blood. This leads to a buildup of toxins in the body, which can damage other organs and affect overall health.) and chronic pain syndrome (a condition characterized by persistent or recurring pain that lasts for more than 3 months. It is not a specific disease but rather a symptom that can result from various underlying causes). A review of Resident 57's Quarterly Minimum Data Set (MDS- a tool used to assess all care areas specific to the resident) revealed under Section C- Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 15/15. This score denotes intact cognitive status. A review of Resident 57's interdisciplinary progress notes revealed documentation of an interdisciplinary plan of care meeting held on January 30, 2025. The progress notes revealed under the heading Advance Directives Reviewed: No. A continued review of Resident 57's clinical record revealed no documentation of the facility offering the Resident and/or Representative information regarding the right to formulate an advance directive. An interview with the Social Services Director (Employee 1) on February 12, 2025, at 2:34 PM, revealed he does not discuss Advance Directives with any residents and/or representatives. 28 Pa. Code 201.14 (a) Responsibility of licensee (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d) (5) Nursing services

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 33879 Based on clinical record review, facility document and policy reivew, and staff interviews, it was determined that the facility failed to ensure residents were free from chemical restraints for one of five residents reviewed for unnecessary medication (Resident 143). Findings include: Review of facility policy, titled NSG233 Restraints: Use of, last reviewed December, 2024, revealed it stated it was the facility's policy that, Patients have the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the patient's medical symptoms. Review of facility document, titled Un[n]ecessary Psychotropic Medications, not dated, revealed subsection titled, Chemical Restraints, stated, Facilities are responsible for knowing the effects medications have on their patients. If a medication has a sedating or subduing effect, and is not administered to treat a medical symptom, the medication acts as a chemical restraint. The sedating/subduing effects to the patient may have been caused intentionally or unintentionally by staff and would indicate an action of discipline or convenience .When any medication restricts the patient's movement or cognition, or sedates or subdues the patient, and is not an acceptable standard of practice for a patient's medical or psychiatric condition, the medication may be a chemical restraint. Even if use of the medication follows accepted standards of practice, it may be a chemical restraint if there was a less restrictive alternative treatment that could have been given that would meet the patient's needs and preferences or if the medical symptom justifying its use as subsided. Review of Resident 143's clinical record revealed diagnoses that included Alzheimer's disease (irreversible, progressive degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension (elevated/high blood pressure). Review of Resident 143's comprehensive plan of care revealed a care plan for behaviors, which included being physically aggressive towards staff with care, resistant to care, refusals to eat related to cognitive loss/dementia. Review of the interventions of the care plan revealed staff were to attempt non-pharmacological interventions and document effectiveness; utilize diversional techniques such as snacks, hydration, toileting, magazines, and television. Review of Resident 143's physician orders revealed an order for Ativan (psychotropic medication used to treat anxiety - excessive worry or fear) 0.5 milligrams (mg - metric unit of measure) one, by mouth, as-needed every four hours. Review of Resident 143's physician orders revealed Resident 143's as needed Ativan order was revised on January 21, 2025. The revised order was for Ativan 0.5 mg to give 0.5 mg very four hours as-needed for dementia with behaviors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 143's January 2025, medication administration record (MAR - documentation tool utilized to record when physician orders for medications or treatments are provided) and interdisciplinary progress notes, revealed multiple administrations that: did not contain an indication as to why the as needed Ativan was administered, provided indications that were not associated with stated behaviors, was administered in response to Resident 143 not remaining in his chair or bed, and/or administered due to Resident 143 experiencing insomnia (inability to sleep). Review of Resident 143's MAR and progress notes revealed the following, but not limited to: January 3, 2025, at 11:49 PM, administration with no indication documented; however, approximately 2 hours later at 1:31 AM, staff noted that the as-needed administration was ineffective due to, Resident still claiming out of bed and needing continuous redirection. January 4, 2025, at 4:03 AM, with documented indication as, Resident is restless. January 9, 2025, at 2:47 AM, documented indication was, Patient awake, trying to get out of bed several times despite snack given. Ativan 0.5 mg administered. As-needed medication effectiveness documented at 5:51 AM, as Ineffective, due to patient still awake. January 10, 2025, at 12:28 AM, noted indication for as-needed Ativan was that Resident 143 was noted awake, trying to get out of bed. February 1, 2025, at 8:27 PM, administration of the as-needed Ativan had no documented indication for the time of administration; however, approximately three hours later, staff documented that the Ativan administration was ineffective as evidenced by, resident by nursing station, attempting to stand up out of [wheelchair]. February 6, 2025, at 5:31 AM, staff behaviors as, Resident restless overnight-up for most of 11-7 shift. [As-needed] [A]tivan effective in calming resident to stay at nurses station[in] his chair. February 13, 2025, at 3:30 AM, staff administered the as-needed Ativan with the documented indication of, Very restless. Still awake. Difficult to re-direct at times. Will re-attempt to lay resident down again. During a staff interview on February 13, 2025, at approximately 10:50 AM, Director of Nursing (DON) stated that Resident 143 was as risk for physical harm when attempting to get out of his chair and/or bed and ambulate on the unit (e.g., falling); however, review of Resident 143's clinical record revealed Resident 143 had no falls identified for the three month period prior to admission to the facility and had no falls while a resident at the facility. Review of Resident 143's physical therapy discharge notes, dated December 26, 2024, revealed the Resident was able to ambulate with hand-held assistance. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview on February 13, 2025 at approximately 12:25 PM, the Rehabilitation Director (RD) revealed that as a result of working with Resident 143, she felt that Resident 143 did not pose a risk of falls with ambulation. Further, that Resident 143 required hand-held assistance due to cognitive decline, needing cueing as to where to go, or to achieve was Resident 143 was attempting to achieve. When RD was asked if she felt Resident 143 was physically safe when ambulating, RD responded, Yes, [Resident 143] did well for us walking. He walked for 200 feet. [Hand-held assistance] just more for direction. As of February 13, 2025, at 1:00 PM, the facility had no further information to provide regarding staff administering as needed Ativan to Resident 143 for reasons outside the indicated behaviors. 28 Pa code 211.12(d)(1)(5) Nursing services

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 33305 Based on clinical record review and staff interviews, it was determined that the facility failed to notify the resident/resident representative and the representative of the Office of the State Long-Term Care Ombudsman of resident transfers in writing to include the following: the reason for the transfer or discharge, date of transfer, location of transfer, statement of the resident's appeal rights, and name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman for three of four resident records reviewed regarding hospitalization s (Residents 37, 66, and 121). Findings include: Review of the clinical record for Resident 37 on February 11, 2025, revealed clinical diagnoses that included obstructive uropathy (a condition that causes a retention of urine), diabetes mellitus (the body has trouble controlling blood sugar). Further review of Resident 37's clinical record revealed transfers to the hospital on June 20, 2024, and October 24, 2024. The surveyor requested copies of the transfer, bed hold, and Ombudsman notification. The Ombudsman notification and bed hold notices were provided, however, the transfer notice provided failed to include a statement of the resident's appeal rights and the name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman. During an interview on February 13, 2025, at 11:00 AM, with the NHA, the NHA revealed that the facility changed transfer forms and failed to include all of the required information on the current form being used for transfer notice. Review of Resident 66's clinical record revealed diagnoses that included congestive heart failure (the heart doesn't pump blood as well as it should). Further review of Resident 66's clinical record revealed a transfer to the hospital on May 27, 2024. Surveyor requested a copy of the transfer notice on February 11th and 12th, 2025, it wasn't provided. During an interview on February 13, 2025, at 11:00 AM, with the NHA, it was revealed that the facility didn't have the transfer form for Resident 66 transfer. Review of Resident 121's clinical record revealed diagnoses that included type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment) and hypertension (elevated/high blood pressure). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 121's clinical record revealed that on September 18, 2024, and February 7, 2025, Resident 121 was transferred to the hospital due to acute medical changes. Review of Resident 121's clinical record revealed no evidence that the Resident and/or Resident's Representative was provided with a written notice of transfer for the hospital transfers on September 18, 2024, and February 7, 2025. Review of an electronic communication from the NHA on February 12, 2025, at 1:26 PM, revealed that NHA confirmed the facility staff did not provide Resident 121 nor Resident 21's Representative with a written notice of transfer. During a staff interview on February 13, 2025, at approximately 12:50 PM, the NHA revealed it was the facility's expectation to provide a written notice of transfer when they are transferred to the hospital. Review of submitted example of the facility's written transfer notice revealed that the transfer notice did not include the following required elements: A statement of the resident's appeal rights, nor the required contact information for the entity responsible for receiving such requests. Information on how to obtain an appeal form, assistance with completing the form and assistance with submitting the appeal hearing request. The required contact information for the Office of the State Long-Term Care Ombudsman. The required contact information for the agency responsible for the protection and advocacy of individuals with developmental disabilities. The required contact information for the agency responsible for the protection and advocacy of individuals with mental disorder(s). During a staff interview on February 13, 2025, at approximately 12:50 PM, the NHA confirmed that the written transfer notice should include information that is required. 28 Pa. Code 201.14(a) Responsibility of Licensee

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 33305 Based on review of the Resident Assessment Instrument (RAI- a standardized approach for applying a problem identification process in nursing homes, adopted to examine nursing home quality and to improve nursing home regulation), clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that each resident received an accurate assessment, reflective of the resident's status at the time of the assessment, by staff who are qualified to assess relevant care areas for two of 37 residents reviewed (Residents 10 and 118). Findings include: Review of the RAI Version 3.0 v1.20.1 dated October 1, 2024, section O - special treatments, Coding Instructions for Column b. While a Resident Check all treatments, procedures, and programs that the resident received or performed after admission/entry or reentry to the facility and within the last 14 days. If no treatments, procedures or programs were received by, performed on, or participated in by the resident within the last 14 days or since admission/entry or reentry, check Z, None of the above. Review of the clinical record for Resident 10 on February 11, 2025, revealed clinical diagnoses that included diabetes mellitus (the body has trouble controlling blood sugar), pneumonia (lung infection), and three Stage 4 chronic pressure ulcers (wounds that extend deep in the tissue, exposing muscle, tendon, or bone and a high risk of infection). Review of the clinical record for Resident 10 revealed the presence of three Stage 4 pressure ulcers. Review of Resident 10's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) dated February 7, 2025, revealed Section M, Skin Conditions, marked with two Stage 4 pressure ulcers instead of three Stage 4 pressure ulcers. On February 13, 2025, Employee 9 (Registered Nurse Assessment Coordinator) provided a modified MDS for Section M that accurately reflected Resident 10's thee Stage 4 pressure ulcers. During an interview with the Nursing Home Administrator (NHA) on February 13, 2025, at 11:00 AM , the NHA confirmed that section M of the MDS should accurately reflect the number of pressure ulcers. Review of Resident 118's clinical record revealed diagnoses that included chronic kidney disease (the kidneys are damaged and can't filter blood properly). Review of Resident 118's discharge-return anticipated MDS with the assessment reference date of October 14, 2024, revealed in section O - special treatments, procedures, and programs, K1- hospice care was documented as no. During an interview with the NHA on February 13, 2025, at 1:00 PM, revealed that Resident 118 was discharged from hospice services on October 3, 2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Employee 9 on February 13, 2025, at 1:20 PM, it was revealed the Resident 118's discharge MDS should've been documented as yes for hospice services while a resident and that an amendment would be completed. 28 Pa. Code 211.5 Medical records

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to develop and implement a baseline care plan for one of one resident reviewed for baseline care plans (Resident 252). Findings include: Review of facility policy, titled OPS416 Person-Center Care Plan, last reviewed December 2024, revealed, it stated, The [Facility] must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/resident [sic] that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care . Further review of the aforementioned policy revealed subsection Practice Standards, stated, 1. A baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient including, but not limited to: 1.1 Initial goals based on admission orders; 1.2 Physician orders; 1.3 Dietary orders; 1.4 therapy services; 1.5 Social services; 1.6 PASRR recommendations, if applicable .3. The [Facility] must provide the patient and his/her resident representative with a summary of the baseline care plan that includes, but is not limited to: 3.1 Initial goals of the patient; 3.2 Medications and dietary instruction; 3.3 Any services and treatments to be administered by the [Facility] and personnel acting on behalf of the [Facility]; and 3.4 Any updated information based on the details of the comprehensive care plan, as necessary, if the comprehensive care plan is developed within 48 hours . Review of Resident 252's clinical record revealed diagnoses that included type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood into the cells for nourishment) and chronic pain syndrome (condition that is characterized by persistent pain that last more than three to six months). Review of Resident 252's clinical record revealed that Resident 252 was admitted to the facility on [DATE]. Review of Resident 252's clinical record revealed that the baseline care plan, initiated on January 31, 2025, only identified and included two Focus areas, including: Resident 252's code status (identification of resident/representative preference for intervention if the resident stops breathing or is assessed as pulseless) and Resident 252's needs for completing activities of daily living (hygiene, bathing, oral care, etc.). Review of Resident 252's baseline care plan revealed it did not include focus areas and interventions to address concerns, including but not limited to, falls, cardiovascular health condition which Resident 252 was receiving medications to treat, dietary needs including the use of insulin, incontinence, nor the use and monitoring of psychotropic medications as identified on the physician orders upon Resident 252's admission to the facility. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 252's comprehensive plan of care revealed it was created and initiated on February 3, 2025, after the 48 hour requirement of the baseline care plan. During a staff interview on February 12, 2025, at approximately 12:10 PM, Director of Nursing confirmed that Resident 252's baseline care plan did not include items that the facility would expect to be included. 28 Pa code 211.12(d)(1)(3)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 33305 Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for three of 37 residents reviewed (Residents 10, 14, and 57). Findings Include: Review of the facility's policy, titled Person-Centered Care Plan, revised October 24, 2022, read, A comprehensive person-centered care plan must be developed for each patient. Review of the clinical record for Resident 10, revealed clinical diagnoses that included neurogenic bladder (a condition that occurs when the nervous system's connection to the bladder is disrupted), diabetes mellitus (the body has trouble controlling blood sugar), pneumonia (lung infection), and three Stage 4 chronic pressure ulcers (wounds that extend deep in the tissue, exposing muscle, tendon, or bone and a high risk of infection). Further review of Resident 10's clinical record revealed Resident 10 was required to have enhanced barrier precautions (EBP-infection control precaution measures) due to his internal devices supra pubic catheter (external bladder catheter), ostomy (abdominal site for excretion of waste), and chronic wounds. On February 11, 2025, there was no care plan to indicate EBP for Resident 10. An interview with the Director of Nursing (DON) on February 12, 2025, at 11:58 AM, confirmed that Resident 10 should have a care plan for EBP. Review of the clinical record for Resident 14 on February 11, 2025, revealed diagnoses that included hospice status (end of life) and chronic diastolic congestive heart failure (a condition where the heart muscle becomes stiff, preventing it from properly filling with blood during the resting phase [diastole]). Review of Resident 14's interdisciplinary plan of care revealed no hospice care plan was developed for hospice care and services when services were implemented on January 17, 2025. During an interview with the DON on February 12, 2025, at 11:58 AM, the DON agreed that a care plan for hospice should have been developed. A review of Resident 57's clinical record revealed diagnoses that included chronic kidney disease (CKD-a condition in which the kidneys gradually lose their ability to filter waste products from the blood. This leads to a buildup of toxins in the body, which can damage other organs and affect overall health.) and chronic pain syndrome (a condition characterized by persistent or recurring pain that lasts for more than 3 months. It is not a specific disease but rather a symptom that can result from various underlying causes). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 57's physician orders revealed an order for hospice services dated August 26, 2024. Review of Resident 57's interdisciplinary plan of care revealed none developed or implemented regarding Resident 57's hospice care and services. An interview with the DON on February 12, 2025, at 11:58 AM, revealed Resident 57's interdisciplinary plan of care was fixed and a hospice care plan was developed and added to the plan of care. 28 Pa. Code 211.12(d)(1)(3)Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37817 Based on observation, clinical record review, and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for two of 37 residents reviewed (Residents 59 and 118). Findings Include: Review of Resident 59's clinical record revealed diagnoses that included malignant neoplasm of colon (a cancerous tumor in the colon) and congestive heart failure (a serious condition that occurs when the heart can't pump blood efficiently enough to meet the body's needs). Review of Resident 59's care plan revealed a focus area of, Resident 59 requires indwelling catheter due to terminal illness/comfort measures, with a revision date of December 15, 2024. Observation of Resident 59 on February 10, 2025, at 10:30 AM, revealed Resident 59 lying in bed and no catheter was present. Review of Resident 59's clinical admission assessment (readmission assessment completed at the facility after Resident 59's hospital stay), dated January 6, 2025, revealed that Resident 59's catheter was removed during Resident 59's hospital stay from January 2-6, 2025. Interview with the Director of Nursing (DON) on February 13, 2025, at 11:30 AM, revealed that her expectation would be that the catheter focus area would have been removed from Resident 59's care plan. Review of Resident 118's clinical record revealed diagnoses that included chronic kidney disease (the kidneys are damaged and can't filter blood properly). During an interview with the Nursing Home Administrator (NHA) on February 13, 2025, at 1:00 PM, revealed that Resident 118 was discharged from hospice services on October 3, 2024. Review of Resident 118's care plan documented hospice as a position responsible for interventions listed on care plan for the following focus areas: pain, requires assistance/potential to restore function for transferring from one position to another; urinary incontinence; and activities of daily living self-care deficit. During an interview with the NHA and DON on February 13, 2025, at 11:00 AM, they were informed the care plan included hospice services responsible for interventions. During an interview with the NHA and DON on February 13, 2025, at 1:00 PM, it was revealed that the care plan would be updated to remove hospice. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 47966 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to maintain adequate personal hygiene and grooming of residents' dependent on staff for assistance with these activities of daily living for two of two residents reviewed for activities of daily living (Residents 112 and 117). Findings include: Review of Resident 112's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and chronic heart failure (when the heart muscle does not pump blood as well as it should). During an interview with Resident 112 on February 10, 2025, at 9:51 AM, revealed the Resident does not always receive showers on their shower days. Resident 112 revealed her shower days are on Wednesdays and Saturdays, but due to short staff, Saturday showers often get missed. Resident 112 revealed she did not receive a shower as scheduled for this previous Saturday (February 8, 2025). Review of the facility's grievance log revealed Resident 112 filed a grievance on January 6, 2025, relating to not receiving showers. Further review of the grievance revealed the full concern was that Resident 112 was not receiving showers, especially on Saturdays. The grievance was marked as confirmed, and the correction action included staff education. The grievance was resolved on January 21, 2025, with the Resident being satisfied with the corrective action taken and included a statement that Resident 112 has seen an improvement with receiving showers. Review of Resident 112's comprehensive care plan revealed an ADL (Activities of Daily Living) focus area with an intervention to assist to bathe/shower as needed, initiated on March 14, 2024, and an intervention that she prefers early AM shower, initiated on March 14, 2024. Review of Resident 112's Kardex (a tool for organizing and providing a readily accessible summary of patient information) revealed a bathing section that included Resident 112's tub/shower schedule is on Saturday and Wednesdays during the day, she prefers early AM showers, and she requires setup assistance. Review of Resident 112's tub/shower task for the past 30 days revealed she did not receive a shower on January 18 and 22, 2025; and February 8, 2025. Review of Resident 117's clinical record revealed diagnoses that included syncope (fainting) and cardiomyopathy (a disease of the heart muscle). During an interview with Resident 117 on February 10, at 10:10 AM, revealed she does not always receive showers on their scheduled shower day. Resident 117 revealed that she prefers to take showers, and that staff do not ask what her preference is. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 117's comprehensive care plan revealed an ADL focus area with an intervention to assist to bathe/shower as needed, with an initiation date of August 25, 2023, and an intervention that it is important to the resident to choose between a tub bath, shower, bed bath, or sponge bath and to please ask her, with an initiation date of December 31, 2024. Review of Resident 117's tub/shower task revealed her shower schedule is on Mondays and Thursdays. Further review of Resident 117's tub/shower task for the past 30 days revealed she did not receive a shower on February 3, 6, and 10, 2025. Review of Resident 117's GG-bathing task for the past 30 days revealed she received a bed bath on February 3, 6, and 10, 2025. During an interview with the Director of Nursing on February 13, 2025, at 10:40 AM, revealed she would have expected Resident 112 and Resident 117 to have received showers to their preference, as scheduled. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 33305 Based on observations, review of the clinical record, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for three of 33 residents reviewed (Residents 14, 90, and 252). Findings include: Review of the clinical record for Resident 14 revealed diagnoses that included hospice status (end of life) and chronic diastolic congestive heart failure (a condition where the heart muscle becomes stiff, preventing it from properly filling during the resting phase [diastole]). Further review of the clinical record for Resident 14 revealed hospice status was initiated January 17, 2025, and the physician orders dated February 2025, failed to reveal a physician order for hospice status. During an interview with the Director of Nursing (DON) on February 12, 2025, 10:00 AM, the DON was informed there was no physician order for hospice status upon review of all orders for January 2025 and February 2025. The DON stated the Resident contacted hospice herself to enroll. The DON was questioned about the requirement for the physician to write an order for hospice status, but the DON was unable to provide that information. During an interview on February 12, 2025, at approximately 1:00 PM, the DON was able to provide a fax, dated February 11, 2025, and timed 10:27 AM, that was obtained from the hospice service that provided an order for hospice and certification of hospice status. The DON confirmed that the order and certification was sent to hospice from the Attending physician but the facility never received a copy. The DON agreed that the hospice orders should have been entered on January 17, 2025, when hospice status was effective. Review of Resident 90's clinical record revealed diagnoses that included hypertension (high blood pressure) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Review of Resident 90's comprehensive care plan revealed a focus area that she is at risk for alteration in skin integrity and potential for skin tears, bruises, abrasions, excoriation, and pressure ulcers, with a revision date of June 27, 2023; and the following interventions: Geri-leg to left lower extremity, revised on June 10, 2024, and Geri-sleeve to right arm, revised on June 10, 2024. Review of Resident 90's Kardex (a tool for organizing and providing a readily accessible summary of patient information) revealed a skin care section that included Geri-leg to left lower extremity and Geri-sleeve to right arm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident 90 on February 11, 2025, at 12:58 AM, revealed her sitting in the Activities Dining Hall on the 200's hall, sitting in her wheelchair, not wearing a Geri-leg on their left lower extremity or a Geri-sleeve on their right arm. Observation of Resident 90 on February 12, 2025, at 11:13 AM, revealed her sitting in the Activities Dining Hall on the 200's hall, sitting in her wheelchair, not wearing a Geri-leg on her left lower extremity or a Geri-sleeve on her right arm. During an interview with the DON on February 13, 2025, at 10:32 AM, revealed Resident 90's Geri-sleeves were in the wash and new ones were obtained. DON revealed she would have expected Geri-leg and Geri-sleeve to have been worn on Resident 90 as care planned. Review of Resident 252's clinical record revealed diagnoses that included type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood into the cells for nourishment) and chronic pain syndrome (condition that is characterized by persistent pain that last more than three to six months). Review of Resident 252's physician orders revealed that upon admission Resident 252, an order for Percocet (combination drug that contains oxycodone and acetaminophen) 5-325 mg (five milligrams of oxycodone and 325 milligrams of acetaminophen) one tablet as-needed every four hours as needed for pain for one day (until January 31, 2025). Starting on January 31, 2025, Resident 252's as-needed Percocet 5-325 mg order was one tablet by mouth every 12 hours as-needed for pain. Review of Resident 252's Medication Administration Record (MAR - documentation tool utilized to record when physician orders were performed and by whom) revealed that staff documented the following: January 30, 2025, at 6:51 PM, staff documented administration of the as needed Percocet 5-325 mg for a documented pain level of 0 (no pain). February 1, 2025, at 7:53 PM, staff documented administration of the as needed Percocet 5-325 mg for a documented pain level of 0 (no pain). February 2, 2025, at 9:25 PM, staff documented administration of the as needed Percocet 5-325 mg for a documented pain level of 0 (no pain). February 4, 2025, at 5:15 PM, staff documented administration of the as needed Percocet 5-325 mg for a documented pain level of 0 (no pain). February 8, 2025, at 4:00 PM, staff documented administration of the as needed Percocet 5-325 mg for a documented pain level of 0 (no pain). Review of Resident 252's clinical record for the administrations failed to reveal documented rationale(s) for administering the as-needed Percocet when it was documented that Resident 252 was not experiencing pain at the time of administration. During a staff interview on February 13, 2025, at approximately 10:50 AM, the DON revealed that it was the facility's expectation that staff administer as needed medications in accordance with the physician's order and physician ordered indication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47966 Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to monitor the resident's nutritional status for four of seven residents reviewed for nutrition (Residents 90, 117, 131, and 252). Findings include: Review of the facility policy, titled NSG244 Weights and Heights last reviewed December 2024, revealed that patients are weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Review of Resident 90's clinical record revealed diagnoses that included hypertension (high blood pressure) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Review of Resident 90's weights summary task revealed the Resident was not weighed in September 2024, October 2024, November 2024, and January 2025. Review of Resident 90's September 2024 MAR (Medication Administration Record) revealed the monthly weights order was marked as completed, however, no weight was recorded. Review of Resident 90's October 2024 MAR revealed the monthly weights order was marked as refused. Review of Resident 90's November 2024 MAR revealed the monthly weights order was marked as completed, however, no weight was recorded. Review of Resident 90's December 2024 MAR revealed there were no weights obtained as ordered for monthly weights starting on the 1st for 7 days, with an active date of December 1, 2024. Review of Resident 90's January 2025 MAR revealed there were no weights obtained as ordered for monthly weights starting on the 1st for 7 days, with an active date of December 1, 2024. Review of Resident 117's clinical record revealed diagnoses that included syncope (fainting) and cardiomyopathy (a disease of the heart muscle). Review of Resident 117's clinical record revealed a discontinued physician's order to weigh every day shift every 1 month starting on the 1st for 7 days, with a start date of November 1, 2024, and discontinued date of December 8, 2024. Review of Resident 117's clinical record revealed a current physician's order to weigh every day shift every 1 month starting on the 1st for 7 days and every day shift every Monday for 4 weeks, with an active date of December 9, 2024. Review of Resident 117's December 2024 MAR revealed Resident 117 was not weighed on December 1, 2, 3, 4, 5, or 7th, 2024, per physician's order. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 117's December 2024 MAR revealed Resident 117 was not weighed on December 9, December 16 or 23, 2024, per physician's order. Review of Resident 117's weight summary task revealed there was not a weight obtained for Resident 117 in January 2025 or February 2025. Review of Resident 117's clinical record revealed a Progress note written by the Dietitian on January 2, 2025, at 3:23 PM, that stated, in part, Resident 117 had a significant weight gain noted of 10% in the past 6 months. No weight comparison available for the past 3 months. Review of Resident 131's clinical record revealed diagnoses that included hypertension (high blood pressure) and type 2 diabetes (occurs when your blood sugar is too high). Review of Resident 131's clinical record revealed the Resident was admitted to the facility on [DATE]. Review of Resident 131's clinical record revealed a current physician's order to be weighed every evening shift every Saturday for 4 weeks and every evening shift every 1 month starting on the 1st for 1 day, with an active date of January 4, 2025. Review of Resident 131's January 2025 MAR revealed the Resident was not weighed on January 4, 2025, and was marked as a refusal on January 11, 2025. Review of Resident 131's February 2025 MAR revealed no weight has been obtained. Review of Resident 131's comprehensive care plan revealed a focus area that the Resident is at nutritional risk, with an intervention to weigh per facility policy/orders and alert dietitian and physician to any significant loss or gain, with an initiated date of January 3, 2025. During an interview with the Director of Nursing (DON) on February 13, 2025, at 10:40 AM, she revealed she would have expected Residents 90, 117, and 131 to have been weighed as ordered per the physician's orders. Review of Resident 252's clinical record revealed diagnoses that included type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood into the cells for nourishment) and chronic pain syndrome (condition that is characterized by persistent pain that last more than three to six months). Review of Resident 252's clinical record revealed that Resident 252 was admitted to the facility from the hospital on January 30, 2025. Review of Resident 252's physician orders revealed an order dated January 30, 2025, for staff to, Weigh every evening shift every [Monday] for 4 weeks. Review of Resident 252's clinical record revealed that the only documented weight that was obtained by facility staff was on January 30, 2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 252's Medication Administration Record (MAR - documentation tool utilized to record when physician orders were performed and by whom) revealed there was no documentation by facility staff that Resident 252's weight was obtained for Monday, February 3, 2025, nor Monday, February 10, 2025, as provided in the MAR. During a staff interview on February 13, 2025, at approximately 10:50 AM, the DON revealed staff should have been completing and documenting a weight assessment for Resident 252 as ordered by the physician. 28 Pa code 211.12(d)(1)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37817 Based on review of facility policy, observations, record reviews, and resident and staff interviews, it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for two of 37 residents reviewed (Residents 48 and 77). Findings include: Review of facility policy, Nebulizer: Small Volume, revised November 1, 2023, read, in part, rinse mouthpiece and T piece with sterile water and dry. Place in treatment bag, labeled with patient name and date. Review of Resident 48's clinical record contained diagnoses that included congestive heart failure (the heart doesn't pump blood as well as it should) and chronic obstructive pulmonary disease (COPD-a group of lung disease that block airflow and make it difficult to breathe) Resident 48's physician orders included: Ipratropium-Albuterol (medication used to control symptoms of lung disease) Solution 0.5-2.5 (3) MG/3ML 1 dose inhale orally three times a day for COPD, with a start date January 13, 2025; and Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 dose inhale orally every 6 hours as needed for shortness of breath, with a start date January 13, 2025. Observation on February 10, 2025, at 11:07 AM, in Resident 48's room, revealed a nebulizer mask was uncovered on the seat of his wheelchair. Observation on February 12, 2025, at 12:17 PM, in Resident 48's room, revealed the nebulizer machine was running and the tubing with the medication canister was laying on top of the corner of the trash can and the mask was on top of Resident 48's mattress. During an interview with Resident 48 on February 12, 2025, at 12:17 PM, it was revealed he just took the mask off. Observation with Employee 10 (Licensed Practical Nurse) on February 12, 2025, at 12:29 PM, Employee 10 turned off the nebulizer machine, removed the mask from Resident 48's mattress and medication canister off the trash can, rinsed mask with tap water from the bathroom sink and placed the mask and canister in the plastic bag and placed it on the Resident's nightstand. It was also revealed that the mask became separated from the medication canister and, therefore, the Resident's treatment lasted longer than it normally does, and she went on break and forgot to check the Resident prior to leaving. She stated the Resident is able to remove the mask and turn off the machine himself. Surveyor mentioned previous observation of the mask not being securely stored. It was revealed that weekly an employee working in central supply distributes a new bag, required nebulizer/oxygen equipment, and dates the new supplies. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident 77's clinical record revealed diagnoses that included: hemiplegia left non-dominant side (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and facial muscles), dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking), congestive heart failure (the heart doesn't pump blood the way it should), and chronic obstructive pulmonary disease (a lung condition characterized by inflammation and narrowing of the airways, leading to difficult breathing). Resident 77's physician orders documented: Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML - 1 vial inhale orally every 4 hours for worsening cough with a start date 1/30/2025, and discontinued date 2/07/2025; and Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML - 1 vial inhale orally every 4 hours as needed for worsening cough with a start date 1/30/2025, and discontinued date 2/07/2025. Observations in Resident 77's room on February 10, 2025, at 11:23 AM, and February 11, 2025, at 11:27 AM, a nebulizer mask and medication canister were on the nightstand not covered, and a plastic bag wasn't observed. Additional observation in Resident 77's room on February 12, 2025, at 12:21 PM, revealed the nebulizer mask and medication canister were in a bag on the nightstand. During an interview with the Director of Nursing (DON) on February 13, 2025, at 11:00 AM, it was revealed that central supply distributes bags, nebulizer supplies, and retrieves equipment that is no longer required/discontinued on a weekly basis. It was also revealed that the facility has distilled water, and it should be utilized to clean the equipment. Surveyor informed the DON of the concern regarding the mask being stored uncovered. No further information provided. 28 Pa code 211.12(d)(1)(2)-Nursing Services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 47966 Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of two residents reviewed for dialysis (Resident 88). Findings include: Review of the facility policy, titled Dialysis Guidelines with a last review date of December 2024, revealed, in part, that collaborative communication forms must be used and include the following information regarding: nutritional/fluid management including documentation of weights, patient compliance with food/fluid restrictions or the provision of meals before, during, and after dialysis, and monitoring intake and output measurements as ordered. Review of Resident 88's clinical record revealed diagnoses that included discitis (an inflammation of the intervertebral discs) and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). Review of Resident 88's comprehensive care plan revealed a focus area that Resident 88 is at risk for impaired renal function and is at risk for complications related to hemodialysis, with an intervention to request pre and post weights from dialysis center, with an initiation date of August 13, 2024. Review of Resident 88's Hemodialysis Communication Record forms from January 2, 2025, through February 6, 2025, revealed there were no communication forms completed for Resident 88 on January 4, 7, 11, and 16, 2025, or February 4, 2025. Further Review of Resident 88's Hemodialysis Communication Record forms that were completed between January 2, 2025, through February 6, 2025, revealed on January 14, 18, 23, 25, and 28, 2025, there was no post-dialysis weight recorded. On January 21, 2025, and February 6, 2025, there was no pre-dialysis weight or post-dialysis weight recorded. During an interview with the Director of Nursing on February 12, 2025, at 1:54 PM, revealed she would have expected Resident 88's Hemodialysis Communication Record forms to have been completed and would have expected pre and post weights to have been recorded. 28 Pa Code 211.5(f) Clinical records 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 33879 Based on clinical record review, facility document review, pharmacy statement review, and staff interviews, it was determined that the facility failed to ensure pharmaceutical services that assured the accurate acquiring and administration of medications were provided that met the needs of each resident for one of 33 resident records reviewed (Resident 252). Findings include: Review of Resident 252's clinical record revealed diagnoses that included type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood into the cells for nourishment) and chronic pain syndrome (condition that is characterized by persistent pain that last more than three to six months). Review of Resident 252's admission medication orders revealed an order for benazepril (medication used to treat high/elevated blood pressure) 20 mg (milligrams - metric unit of measure), once a day, which was dated January 30, 2025, with a start date of January 31, 2025. Review of the facility pharmacy medication delivery manifest revealed that on January 31, 2025 (no time recorded) the pharmacy delivered a total of five tablets of the benazepril 20 mg; however, review of Resident 252's Medication Administration Record (MAR - documentation tool utilized to record when medications are administered) revealed that staff documented administration of the benazpril 20 mg, as ordered, between January 31, 2025, and February 5, 2025 for a total of six administrations (January 31, 2025; February 1, 2, 3, 4, and 5, 2025). As of February 13, 2025, at approximately 1:30 PM, Director of Nursing (DON) was unable to provide an explanation as to how the facility staff were able to administer six tablets of medication when the pharmacy documentation showed only five tablets were delivered. According to Resident 252's clinical record, including the MAR, on the morning of February 6, 2025, the facility did not have the benazepril 20 mg to administer Resident 252. Review of a communication form to the physician from facility staff, dated February 6, 2025, revealed staff notified the physician that the medication was unavailable and that it was reordered from the pharmacy. No changes to Resident 252's plan of care were ordered as a result. Review of documentation provided to the facility by the consultative pharmacy revealed the pharmacy received an electronic refill request for Resident 252's medication on February 6, 2025, at 8:23 AM. According to the statement from the pharmacy, the order was filled with only five tablets on February 7, 2025, and was sent out for delivery at 5:00 PM. The delay between the submitted a medication refill request by facility staff on February 6, 2025, at 8:23 AM, and filling the medication on the following day to be sent for delivery at 5:00 PM by the pharmacy (approximately 31 and a half hours) resulted in Resident 252 missing a second dose of the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview on February 13, 2025, at approximately 12:50 PM, the DON confirmed it was the facility's expectation that the facility have medications ready for administration for the residents. As of February 13, 2025, at approximately 1:30 PM, the facility was unable to provide a justification as to why the medication was not reordered when the supplied amount was depleted. Due to a discrepancy between the initial amount delivered by pharmacy (five) and the documented medication tablets administered (six), the date that the medication supply was depleted prior to the administration time on February 6, 2025, was unable to be determined. In an electronic communication from the DON, it was confirmed that the facility had an alternative pharmacy to secure medication from in the case the contracted pharmacy did not have the ordered medications or could not provide adequate delivery times. 28 Pa code 211.9(k) Pharmacy services 28 Pa code 211.12(d)(1)(3)(5) Nursing services

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 37817 Based on observation, policy review, review of facility documentation, and resident and staff interviews, it was determined that the facility failed to provide sufficient dining services staff to ensure that resident meals and nourishments were served timely during two of three meals observed (February 11 and 12, 2025). Findings include: Review of facility policy Snacks, Nourishments, Supplements, and Pantry Stock, effective May 1, 2023, read, in part, Food and Nutrition Services delivers snacks to nursing stations at specified times. Resident interviews during the initial pool process revealed resident concerns with meals being served late. Review of Food Committee meeting minutes for October 2024 and November 2024, revealed concerns for meals being served late especially on the weekends, and that the food cart may sit in the hallway for 20 minutes before trays are being passed out. There were concerns with snacks not being offered at the November 2024 meeting. Documented meal service times are as follows: breakfast 7:10 AM - 8:20, lunch 11:35 AM - 12:45 PM, dinner 5:00 PM - 6:15PM. Observation of lunch meal service on February 11, 2025, the A nursing unit first food cart was delivered 45 minutes late, scheduled 12:25 PM and delivered at 1:13 PM, tray pass started at 1:18 PM. Employee 5 went to Heritage unit to request nursing staff from that unit pass trays on A nursing unit. During an interview with Employee 5 on February 11, 2025, at 12:00 PM, it was revealed that three employees called off for day shift in Dietary. Review of cart delivery time records revealed the following dates the last meal cart was delivered late to the unit 55 minutes or more: February 1, 2025, breakfast; February 2, 2025, breakfast and lunch; February 5, 2025, dinner; February 6, 2025, dinner; and February 11, 2025, lunch and dinner. Observation on February 12, 2025, the 10:00 AM, snacks/nutritional supplements were delivered as followed: C nursing station 12:35 PM - nutritional supplements for the following residents: 17, 60, 80, 83, 96, 109 , and 128. B nursing station 12:37 PM - nutritional shakes for the following residents: 22, 29, 78, 116, 119, and 132, resident 57 an oatmeal cookie. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing station 12:43 PM - nutritional shake for resident 27, and milk and fruits for Resident 8. During an interview with Employee 7 (Licensed Practical Nurse) on February 12, 2025, at 12:43 PM, it was revealed that Dietary was notified that the 10:00 AM snacks/nourishments weren't delivered, and they were just delivered to the units. During an interview with the Nursing Home Administrator (NHA) on February 13, 2025, at 1:00PM, it was revealed that the number of staff scheduled to work in Dietary daily depends on the number of staff available. It also was revealed that in previous months there were multiple open Dietary positions, and within the past several weeks many positions have been filled. Surveyor informed the NHA that 10:00 AM snacks/nourishments were delivered to the nursing stations late on February 12, 2025. 28 Pa code 201.18(b)(3)(e)(6) Management

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety in the kitchen. Findings include: Review of facility policy, Food and Nutrition Services Use By Dating Guidelines, dated [DATE], read, in part, frozen shakes use by date of 14 days once thawed - use labels for individual items when removed from the carton. Bulk items in large quantities such as flour, sugar and food thickener - use by date six months when opened and transferred to a storage bin. Review of facility policy, Food and Nutritional Services Personal Hygiene, effective date [DATE], read, in part, facial hair coverings are used to cover all facial hair. Observations at the three-compartment sink on February 10, 2025, at 9:30 AM, the test strips expired [DATE]. Upon testing sanitizer solution in the third sink, which was in use, it registered 0. The temperature log at the three-compartment sink was documentation of dish machine temperatures for wash and rinse water, and didn't contain documentation of pH levels for sanitizer. During an interview with Employee 6 on February 10, 2025, at 9:30 AM, it was revealed that the test strip was the incorrect type of strip, and that the facility had ordered the correct test strips. Observation at the three-compartment sing on February 11, 2025, at 12:00 PM, revealed a new container of test strips. The sanitizer solution in the third sink was tested and registered 0. The temperature log at the three-compartment sinks documented dish machine temperatures. During an interview with Employee 5 on February 11, 2025, at 12:00 PM, it was revealed there should be a log for the three-compartment sink. Observation in the dry storeroom on February 10, 2025, at 9:18 AM, the following cereal was stored in bulk containers and wasn't date marked: corn flakes, raisin bran, cheerios, and rice Krispies. During an interview with Employee 6 on February 10, 2025, at 9:18 AM, it was revealed the containers of cereal should be date marked. Observation in the reach-in refrigerator near the receiving area on February 10, 2025, at 9:26 AM, the following nutritional shakes were thawed and not date marked with a thaw or pulled date: 20 vanilla, 43 strawberry. The nutritional shake product is delivered frozen and are to be used within 14 days of thawing. During an interview with Employee 6 on February 10, 2025, at 9:26 AM, it was revealed that the aforementioned nutritional shakes were delivered Thursday (February 6th, 2025), the case was put in the refrigerator when they are delivered, and the facility goes through them by the next delivery. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on February 11, 2025, at 11:58 AM, in the reach-in refrigerator near the receiving area, 3 vanilla nutritional shakes not date marked. Observation on February 10, 2025, at 9:21 AM, the ceiling and vent over the prep area and tray line, grate on the front of the vent hood over the grill, and the wall fan on the clean side of the dish room contained a black fuzzy substance. During an interview with Employee 6 on February 10, 2025, at 9:22 AM, it was revealed that maintenance is responsible for cleaning the aforementioned areas. Observation in the prep area on February 10, 2025, at 9:32 AM, there were three plastic bags that contained the ends of white sliced bread that were not date marked. During an interview with Employee 6 on February 10, 2025, at 9:32 AM, it was revealed that the bags of bread should be date marked. Observation in the prep area on February 11, 2025, at 12:03 PM, the bulk container of sugar was not date marked, had a scoop stored inside the bin and the lid to the bin was not securely closed; the bulk container of flour was not date marked and the lid wasn't securely closed; and the bag of thickener inside the cardboard box was not securely closed. During an interview with Employee 5 on February 11, 2025, at 12:07 PM, it was revealed that the scoop shouldn't be stored in the sugar, the flour and sugar should be date marked, and the aforementioned containers should be securely closed. Observation on tray line February 11, 2025, at 11:50 AM, three male employees had a beard and mustache that were working on tray line without a facial hair restraint. During an interview with Employee 5 on February 11, 2025, at 11:50 AM, it was revealed he was unsure of the facial hair restraint policy at the facility. Interview with the Nursing Home Administrator on February 12, 2025, at 1:51 PM, revealed the aforementioned items should be date marked, the scoop not stored in the container of sugar, a log of the three-compartment sink is required to include use of the correct test strips, staff should wear correct hair restraints, and the ceiling and vents and fan should be clean. 28 Pa code 211.6(f) - Dietary Services

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 37817 Based on observation, record review, and resident and staff interviews, the facility failed provide therapy services to ensure residents receive specialized rehabilitative services to assist them to attain, maintain, or restore their highest practical level of physical, mental, functional, and psycho-social well-being for one of 37 residents reviewed (Resident 23). Findings include: Review of Resident 23's clinical record documented diagnoses that included artificial right shoulder joint. Interview with Resident 23 on February 10, 2025, at 10:48 AM, revealed she had right shoulder surgery and was in a sling, but was released from using the sling last Monday (February 3rd, 2025) and was to start therapy to increase range of motion to her right arm and shoulder, and that she is restricted to 1 pound weight limit. She stated that she would like to receive therapy services because she was unsure what stretching exercises were appropriate, however, she wasn't on therapy case load. She also noted that she has had muscle atrophy and wanted to prevent it from getting worse. Review of Resident 23's physician orders included: weight bearing as tolerated right arm, with a start date of February 3, 2025; Physical Therapy for gentle stretching only, no directions specified for order, with a start date of February 3, 2025; activity as tolerated to right arm, with a start date of February 3, 2025; 1 pound lifting restriction-right arm/no shoulder extension, with a start date of January 7, 2025, Physical Therapy (PT)- Evaluation & treatment as recommended & as needed, with a start date of December 20, 2024. Review of Orthopedic follow-up visit for after care following joint replacement surgery, dated February 3, 2025, read, in part, okay to discontinue sling, activity as tolerated right arm, weight bearing as tolerated right arm, Physical Therapy for gentle stretching only. The consult was initialed by the facility Doctor on February 4, 2025. Review of Resident 23's Physical Therapy discharge summary read, in part, services December 21, 2024, to January 17, 2025, for ambulation functional mobility, transfers, and to reassess when non-weight bearing to upper extremity is lifted. Review of Resident 23's Occupational Therapy discharge summary read, in part, services December 24, 2024, to January 17, 2025, for sit at edge of bed, ambulate to bathroom, left shoulder active range of motion, bath/dress/toilet, recommended functional maintenance program for passive range of motion to right shoulder, active range of motion to right elbow/wrist/hand. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Employee 8 (Occupational Therapist) on February 13, 2025, at 9:28 AM, it was revealed that he spoke with the Resident shortly after her follow-up appointment and discussed with her about doing gentle stretching on her own. It was explained that the Resident can stretch her arm at least to a 90 degree angle, which is sufficient to accomplish the majority of activities of daily living (basic tasks such as bathing, dressing, toileting, eating) and that is why a restorative nursing program (RNP- a structured plan designed to help residents maintain or regain their independence by providing nursing interventions that focus on improving fictional abilities) wasn't initiated. It was also revealed that therapy will follow-up with the Resident after her next orthopedic follow-up and would pick her up once she can tolerate resistance exercise. Surveyor informed the Nursing Home Administrator (NHA) and Director of Nursing on February 13, 2025, at 11:00 AM, regarding lack of therapy services or an RNP program for Resident 23. During an interview with the NHA on February 13, 2025, at 12:49 PM, it was revealed that Employee 8 had completed a therapy screen and felt Resident 23 could complete stretching exercises independently and didn't require therapy services or an RNP program, however, he didn't document the official therapy screen. 28 Pa Code 210.27 Advertisement of special services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 33305 Based on observation, policy review, and staff interviews, it was determined that the facility failed to maintain a safe environment that supports infection prevention and control for five of 33 residents reviewed (Residents 10, 37, 108, 113, and 119). Findings include: Review of the facility's infection control policy required residents colonized or infected with multi-resistant drug organisms (MDRO), have chronic wounds, or an internal device require enhanced barrier precautions (EBP). EBP is an infection control intervention designed to reduce the transmission of novel or multi-drug resistant organisms. The facility requires EBP signage be placed that directs staff to wear personal protective equipment (PPE) during high contact resident activities. Review of the clinical record for Resident 10 on February 11, 2025, revealed clinical diagnoses that included neurogenic bladder (a condition that occurs when the nervous system's connection to the bladder is disrupted), diabetes mellitus (the body has trouble controlling blood sugar), pneumonia (lung infection), and three Stage 4 chronic pressure ulcers (wounds that extend deep in the tissue, exposing muscle, tendon, or bone and a high risk of infection). Further review of Resident 10's clinical record revealed he had internal devices that include an ostomy (prosthetic device that collects waste from a surgically created opening in the abdomen, called a stoma) and a supra pubic catheter (medical device that drains urine from the bladder through the abdominal wall. Observation on February 11, 2025, failed to reveal any PPE cart or signage to indicate the Resident was required to have EBP. There was one PPE cart sitting in a small alcove in the hall where Resident 10 resides with a droplet precautions sign laying on the top of the cart. There was no droplet precautions signage posted. During interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on February 12, 2025, at 12:30 PM, both agreed that both EBP and droplet precautions signage should be posted and PPE should be immediately available. When this surveyor ask about the cart location and droplet signage, the DON responded that Resident 10 was on droplet precautions due to a diagnoses of pneumonia (lung infection). A review of Resident 10's clinical record revealed he was receiving an antibiotic for the pneumonia until February 12, 2025. Review of the clinical record for Resident 37 on February 11, 2025, revealed clinical diagnoses that included obstructive uropathy (a condition that causes a retention of urine) and diabetes mellitus (the body has trouble controlling blood sugar). Further review of Resident 37's clinical record and observation revealed presence of a supra pubic catheter (an internal medical device that drains urine from the bladder through the abdominal wall). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on February 11, 2025, at 10:30 AM, failed to reveal any PPE cart or signage to indicate the Resident was required to have EBP. There was one PPE cart sitting in a small alcove in the hall where Resident 37 resides, with a droplet precautions sign laying on the top of the cart. This cart was 4 rooms away from Resident 37's room. During interview with the NHA and DON on February 12, 2025, at 12:30 PM, both agreed that both EBP signage should be posted and PPE should be immediately available. Review of Resident 108's clinical record revealed diagnoses that included discitis (inflammation of the of the soft tissue between vertebrae of the back typically caused by a bacterial infection) and hypertension (elevated/high blood pressure). Review of Resident 108's clinical record revealed that Resident 108 had the following health related concerns, which indicated the need for enhanced barrier precautions: A non-healing pressure ulcer (wound of the skin) of the left ischium (part of the bone that makes up the hip). Placement of a PICC line (peripherally inserted central catheter - tube inserted into a large vein of the upper arm that travels and terminates in the large vein above the heart). Indwelling internal urinary catheter (tube inserted into the body and to the bladder to facilitate the evacuation of urine). Observations of Resident 108's room on February 10, 11, and 12, 2025, revealed Resident 108's rooom had no indication that Resident 108 was on enhanced barrier precautions, nor was PPE made available at Resident 108's room. During a staff interview on February 13, 2025, at approximately 10:50 AM, the DON revealed that Resident 108 should have been placed on enhanced barrier precautions. Review of Resident 113's clinical record revealed diagnoses that included hypertension and history of VRE (Vancomycin-resistant enterococci) in urine (a type of bacteria called enterococci that have developed resistance to many antibiotic). Review of Resident 113's comprehensive care plan revealed a focus area relating to history of VRE in urine, initiated on April 12, 2024, with an intervention for Infection precautions: enhanced barrier precautions (contact/gloves), initiated on April 12, 2024. Observation on February 10, 2025, at 10;35 AM, and February 11, 2025, at 9:54 AM, failed to reveal an PPE signage to indicate Resident 113 was required to have EBP. During an interview with the DON on February 11, 2025, at 1:50 PM, revealed that Resident 113 should have a sign posted outside of their door to indicate the Resident was on EBP. Review of Resident 119's clinical record revealed diagnoses that included type II diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment) and atrial fibrillation (irregular heart beat). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395442	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York North Skilled Nursing and Rehabilitation Ctr	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 119's clinical record revealed that Resident 119 had the following health related concerns, which indicated the need for enhanced barrier precautions: Suprapubic urinary catheter (tube surgically inserted through an opening of the abdomen that is placed into the bladder to facilitate the removal of urine). Multiple wounds to Resident 119's left great toe and left second toe. Observations of Resident 119's room on February 10, 11, and 12, 2025, revealed Resident 119's room had no indication that Resident 108 was on enhanced barrier precautions, nor was PPE made available at Resident 119's room. During a staff interview on February 13, 2025, at approximately 10:50 AM, the DON revealed that Resident 119 should have been placed on enhanced barrier precautions. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa code 211.12(d)(1)(3)(5) Nursing services