STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395774	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Nursing and Rehabilitation Center	900 East King Street Lancaster, PA 17602

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41765 Based on observations, clinical records review, and staff interview, it was determined that the facility failed to ensure dignity was maintained during meals for one of the 35 residents reviewed (Resident 51). Findings include: A review of Resident 51's Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated March 11, 2025, revealed that Resident 51 had a moderate cognitive impairment. The same MDS revealed that the resident had a diagnosis of Traumatic Brain Injury (A brain dysfunction caused by an outside force, usually a violent blow to the head). An observation conducted on April 9, 2025, at 9:16 a.m., revealed Resident 51 was sitting on a recliner in the hallway outside of his/her room. The resident was alert to themself with difficulty finishing words. When the resident was asked by the surveyor if they could talk inside his room, non-licensed Employee E5 who was passing another resident's breakfast meal tray suddenly interrupted and stated No, he's going to have breakfast. Instead of placing the meal tray and setting up the resident for breakfast, Employee E5 opened the top lid of the resident's breakfast plate that was still in the tray on the food cart, and with bare hands picked up half of a peice of French toast and handed it to the resident's right hand. The resident started eating the French toast placed by the staff in his/her hands. Employee E5 proceeded to pass the breakfast trays of the other residents. The above was conveyed to the NHA (Nursing Home Administrator) on April 11, 2025, at 10:00 a.m. The facility failed to ensure dignity was maintained during breakfast for Resident 51. 28 Pa. Code: 211.12(d)(1)(5) Nursing services

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46166 Based on housekeeping routine schedule, observations, and resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, and home-like environment for one of 40 sampled residents (Resident R197). Findings include: The facility's ISH Health Services, Job Routine H4 states that housekeeping is scheduled to clean Resident R197's room between 8:00 a.m. and 9:00 a.m. An interview with Resident R197 on April 8, 2025, at 9:45 a.m. revealed that housekeeping had not cleaned his room for several days. Observations of Resident R197's room revealed a dried, light brown substance under the resident's urinary drainage bag. Resident R197 reported that the substance had been there for over four days. Further observations on April 9, 2025, at 9:16 a.m. and 12:43 p.m. confirmed that housekeeping had not cleaned the room, as the dried light brown substance remained under the urinary drainage bag. Additional observations on April 10, 2025, at 9:59 a.m. showed the same dried light brown substance under the urinary drainage bag. A review of Resident R197's clinical record found no documentation indicating that Resident R197 had refused housekeeping services. An interview with the Nursing Home Administrator (NHA) on April 11, 2025, at 1:15 p.m. confirmed these findings. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913 Based upon clinical record review, and staff interview it was determined the facility failed to ensure Minimum Data Set Assessments (MDS) were completed accurately for two of two residents reviewed (Resident 193 and Resident 244). Findings include: Review of Resident 193's diagnosis list revealed diagnoses including traumatic brain injury, diabetes mellitus (DM - failure of the body to produce insulin to enable sugar to pass from the blood stream to cells for nourishment), protein calorie malnutrition, gastrostomy (feeding tube) and tracheostomy (breathing tube). Review of Resident 193's Quarterly Minimum Data Set (MDS - periodic assessment of resident needs) dated January 25, 2025, revealed Resident 193 had a significant weight loss. Review of Resident 193's Weight Summary failed to reveal evidence of a significant weight loss. Interview with Licensed Employee E11 on April 10, 2025, at 12:15 p.m. revealed that Resident 193's Quarterly MDS was completed in error regarding the significant weight loss and Resident 193 did not have a significant weight loss. Review of Resident 244's MDS (Minimum Data Assessment - periodic assessment of resident needs) assessment dated [DATE], section O0110 - Special Treatments, Procedures, and Programs revealed Resident 244 was not receiving hospice care. Review of Resident 224's physician's orders revealed Resident 244 was receiving hospice care since December 11, 2024. Interview on April 11, 2025, at 9:40 a.m. with Licensed Employee E11 confirmed Resident 244's MDS assessment was marked incorrectly. 28 Pa. Code 211.5(f) Clinical Records Previously cited 5/22/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41765 Based on observations, clinical record review, and staff interview, it was determined that the facility failed to develop a comprehensive care plan for two of the 35 residents reviewed (Resident 23 and 111). Findings include: A review of Resident 23's Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated February 16, 2025, revealed that the resident had severe cognitive impairment. The same MDS revealed that the resident utilizes a wheelchair for mobilization. A review of the nursing progress notes dated March 19, 2025, at 4:00 p.m., revealed Resident 23 was found on the ground floor of the building with clothes stating she/he was leaving. An Alpha Watch (device that triggers alarms if they approach restricted areas or attempt to leave) was applied to the resident's wheelchair. A review of Resident 23's Elopement Evaluation dated March 19, 2025, revealed a Yes check mark for the following questions: Resident with a history of elopement or attempted leaving the facility without informing the staff; Resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door; Resident wander; and Resident's wandering behavior a pattern, goal-directed. The evaluation revealed Resident 23 was at risk for elopement. A review of Resident 23's care plan failed to reveal a care plan for the resident's exit-seeking behavior was developed. An interview with the NHA (Nursing Home Administrator) on April 11, 2025, at 1:00 p.m., confirmed a care plan for Resident 23's exit-seeking behavior was not developed. An observation conducted on April 8, 2025, at 10:15 a.m., revealed Resident 111 was lying on the bed with a wound vac machine (A medical device that uses negative pressure to help heal wounds) on the bedside table. A review of Resident 111's physician order dated March 12, 2025, revealed an order for a wound vac to the sacrum continuously setting 125 mm/Hg every shift. Check placement and function every shift, and change canister as needed. A review of Resident 111's care plan failed to reveal that a comprehensive plan of care was developed for Resident 111's use of a continuous wound vac. An interview with the NHA on April 11, 2025, at 10:00 a.m., confirmed that a comprehensive care plan for Resident 111's continuous use of a wound vac was not developed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure a comprehensive care plan was developed for Resident 23's exit-seeking behaviors and Resident 111's continuous use of a wound vac. 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.12(d)(1)(5) Nursing services

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 30934 Based on observation, interview with residents and staff, it was determined that the facility failed to ensure resident call bells were answered and addressed in an appropriate amount of time for one of one resident (Resident R197). Finds include: Review of Resident R197's clinical record revealed the following diagnoses: unspecified injury at an unspecified level of the cervical spinal cord (spinal cord injury), quadriplegia (a symptom of paralysis that affects all of a person's limbs and body from the neck down), and muscle wasting and atrophy (thinning of muscle tissue). Review of Resident R197's care plan revealed the following interventions: TRANSFER: Resident is dependent on the assistance of two staff members using a mechanical lift (Hoyer lift) for all transfers; non-ambulatory. This care plan had a start date of March 4, 2019. An interview conducted with Resident R197 on April 8, 2025, at 9:45 a.m. revealed that when he activates his call bell (a system used to notify staff that assistance is required), staff will enter his room, turn off the call bell, and then leave without providing further assistance. Review of Resident R197's clinical record revealed a progress note dated April 1, 2025, at 3:01 p.m., which stated: Resident rang for assistance to get out of bed (OOB) four times, all within approximately 15-minute intervals. Resident was informed each time that the CNA assigned to provide care was also training a new CNA that day, so it would take her longer to complete her duties in order to ensure proper training. Resident was unhappy with this explanation. We will continue to communicate with the resident regarding their assignments and any changes to them. An interview conducted with the Nursing Home Administrator (NHA) on April 11, 2025, at 1:15 p.m. confirmed the above. 28 Pa. Code 211.12(d)(1(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35913 Based upon clinical record review and interview, it was determined the facility failed to follow physician orders for medication administration and fluid restrictions for 3 of 3 residents reviewed (Resident 1, Resident 27 and Resident 371). Findings include: Review of Resident 1's diagnosis list includes Congestive Heart Failure (CHF-A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs) and Acute Respiratory Failure. Review of Resident 1's physician order dated October 21, 2024, revealed an order for 2000 ml fluid restriction every 24 hours. 1020 ml- dietary, and 980 ml - nursing. Review of April 2025 Medication Administration Record (MAR) revealed no documentation that the fluid restriction was followed. Review of Resident 27's care plan revealed resident had a diagnosis of hyponatremia (low blood sodium level) with a need for fluid restriction. Review of physician's orders included an order for 1000 milliliter (mL) fluid restriction (Nursing total=280 ml in 24 hours; Dining total=720 ml in 24 hours). Review of the March 2025 and April 2025 Medication Administration Record (MAR) revealed no documentation that the fluid restriction was followed. Interview with the Nursing Home Administrator on April 11, 2025, at 10:57 a.m. confirmed that there was no documentation indicating that the fluid restriction was followed for Resident 27. Review of Resident 371's diagnosis list revealed diagnoses including coronary artery disease (narrowing of the blood vessels which supply the heart with blood and oxygen), hypertension (high blood pressure) and carotid artery stenosis (narrowing of the carotid artery). Review of Resident 371's physician orders revealed an order for Amlodipine (high blood pressure medication) 2.5 milligrams (mg) to be administered daily for hypertension and to give the medication if the systolic blood pressure (measure of blood pressure while heart is beating; amount of force that blood exerts on the walls of the blood vessels) is greater than 140 mm Hg (millimeters of mercury). Review of Resident 371's February 2025 Medication Administration Record (MAR) revealed Resident 371 received Amlodipine 2.5 mg 19 times from February 1, 2025, through February 28, 2025, when Resident 371's systolic blood pressure was less than 140 mm Hg. Review of Resident 371's March 2025 MAR revealed Resident 371 received Amlodipine 2.5 mg 16 times from March 1, 2025, through March 31, 2025, when Resident 371's systolic blood pressure was less than 140 mm Hg. (continued on next page)

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	395774	A. Building B. Wing	04/11/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 371's April 2025 MAR revealed Resident 371 received Amlodipine 2.5 mg four times from April 1, 2025, through April 11, 2025, when Resident 371's systolic blood pressure was less than 140 mm Hg. The above information was conveyed to the Nursing Home Administrator on April 11, 2025, at 1:00 p.m. 28 Pa. Code 211.12(d)(1)(5) Nursing Services Previously cited 5/22/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 ased on observations, clinical records review, and staff interviews, it was determined that the facility failed to follow a wound treatment order for one of the four residents reviewed (Resident 111). Findings include: Clinical records review revealed Resident 111 was admitted to the facility on [DATE], with a Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss) to the sacrum (The triangular bone just below the lumbar vertebrae). Admission skin assessment revealed that the sacral wound measured 12 x 9.0 x 1.0 cm. with 10% slough (A non-viable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). Further review revealed that the resident has Osteomyelitis (bone infection) and was receiving Intravenous (Medication administered through a vein) Antibiotics (medication used to fight infections). A review of resident 111's physician's order dated March 12, 2025, revealed an order for a wound vac (A medical device that uses negative pressure to help heal wounds) to the sacrum continuously setting 125 mm/Hg every shift. Check placement and function every shift, and change canister as needed. An observation conducted on April 8, 2025, at 10:15 a.m., revealed Resident 111 was lying in bed, a wound vac machine was observed on the bedside table. Further observation revealed that the machine was off. The canister was observed filled with a light red gel-like substance. An observation conducted on April 8, 2025, at 12:41 p.m., and 2:15 p.m., revealed that the machine was off/not working. An interview with licensed nurse Employee E3 on April 8, 2025, at 2:20 p.m., revealed that she/he was Resident 111's nurse for the day. When asked when the last time she/he checked on the resident's wound vac, Employee E3 stated, I did not see it the whole day. Employee E3 checked the machine and found that the cord that was plugged into the wall socket was not connected to the machine's adaptor. After Employee E3 connected the cord, she/he turned the machine's power on button, but the machine did not start and started beeping. Employee E3 reported that the canister might be full which could be the reason why it was beeping. Employee E3 reported that the wound dressing/canister was changed on April 7, 2025. An interview with licensed nurse Employee E4 on April 8, 2025, at 2:25 p.m., revealed that she/he was one of the nurses on the unit and did observe Resident 111's wound vac working at around 9:44 a.m., and documented on the TAR (Treatment Administration Record) that the machine was working for the day shift. Clinical records review failed to reveal that Resident 111's wound vac machine was monitored from 10:15 a.m., until 2:10 p.m., to ensure the functioning of the machine. The above was conveyed to the Nursing Home Administrator on April 11, 2025, at 10:00 a.m. (continued on next page)

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	395774	A. Building B. Wing	04/11/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure Resident 111's order for a continuous wound vac to the sacral wound was followed. 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.12(d)(1)(5) Nursing services

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	395774	A. Building B. Wing	04/11/2025

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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. 46166 Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure weights were monitored and a significant weight change was promptly addressed for five out of 15 residents reviewed (Residents 27, 74, 158, 202, and 338). Findings include: A review of the facility's policy titled Weight Assessment and Interventions, last revised in March 2022, states Resident weights are monitored for undesireable or unintended weight loss or gain. Any weight change of 5% or more since the last weight assessment must be retaken the next day for confirmation. A. If the weight is verified, nursing will notify the dietitian. Review of Resident 27's physician's orders included an order to weigh monthly every day shift every four weeks. Review of the clinical record revealed a weight of 153.9 pounds on September 16, 2024, and a weight of 139.4 pounds on September 30, 2024, indicating a loss of 14.5 pounds (9.4%). Further review of the clinical record indicated that a weight was not obtained until October 9, 2024 (9 days after the identified weight loss). Further review of Resident 27's clinical record revealed no weight was obtained in November 2024 or January 2025. Review of Resident 74's clinical record revealed that on February 14, 2025, the resident weighed 152.0 lbs. On March 11, 2025, Resident 74's weight was recorded at 137.8 lbs., indicating a 9.34% decrease in weight. Further review of Resident 74's clinical record on April 11, 2025, revealed that nursing staff did not retake the resident's weight the following day, as required by the facility's policy. An interview conducted with the Nursing Home Administrator (NHA) on March 11, 2025, at 1:15 p.m. confirmed the above. Review of Resident 158's physician's orders included an order to weigh monthly every day shift every four weeks on Friday. Review of the resident's clinical record revealed the last recorded weight was on February 21, 2024. Review of Resident 202's clinical record revealed a weight was obtained on November 27, 2024. No weight was documented for December 2024 or January 2025. A weight was obtained on February 23, 2025, with no further documentation of weights for March 2025. Interview with Employee E12 on April 11, 2024, at 10:54 a.m. revealed that the standard is for residents to be weighed monthly and reweights should be obtained within 72 hours. Review of Resident 338's clinical record revealed an order that stated, 'weigh monthly every evening shift every 4 weeks on Sun for wt (weight)'. (continued on next page)

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	395774	A. Building B. Wing	04/11/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 338's clinical record revealed of monthly weights of 114.6 pounds on October 15, 2024 ;112 pounds on October 27, 2024; and 107.5 pounds on December 4, 2024. Further review of the weights revealed facility failed to weigh and record resident weight for the month of November 2024. Interview with the Nursing Home Administrator on April 11, 2025, at 1:15p.m. confirmed the above 28 Pa Code 211.10(c) Patient care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 35913 Based upon review of consultant pharmacist's Medication Review, it was determined the facility failed to provide a pain scale as recommended by the pharmacist and agreed to by the nurse practitioner for the use of a narcotic and failed to provide Non-pharmaceutical Interventions prior to the administration of narcotic pain medication for one of five residents reviewed (Resident 371). Findings include: Review of Resident 371's diagnosis list revealed diagnoses including encephalopathy (swelling in brain), osteoarthritis of the left shoulder, and chronic tension headaches. Review of Resident 371's physician's orders dated January 22, 2025, revealed an order for Hydromorphone (narcotic pain medication) HCl 2 milligrams (mg) give one half tablet (1 mg) by mouth every 2 hours as needed (PRN) for pain. Review of Resident 371's consultant pharmacist's Medication Regimen Review (MRR) dated February 27, 2025, revealed the need to add a pain scale for the administration of Hydromorphone. Review of Resident 371's March 2025 and April 2025 Medication Administration Record (MAR) failed to reveal evidence that a pain scale was implemented in the physician's order as agreed to in the consultant pharmacist's recommendation. Review of Resident 371's March 2025 MAR revealed Resident 371 received Hydromorphone sixty-three times for pain levels ranging from 3 to 10. Further review of Resident 371's April 2025 MAR revealed Resident 371 received Hydromorphone twenty-one times for pain levels ranging from 0 to 8. Further review of Resident 371's March and April 2025 MAR and review of clinical documentation failed to reveal evidence that non-pharmaceutical interventions were implemented prior to the administration of the PRN Hydromorphone. 28 Pa. Code 211.12(d)(1)(5) Nursing Services Previously cited 5/22/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41765 Based on a review of the facility policy, review of the medication manufacturer's guidelines, observations, and staff interviews, it was determined that the facility failed to properly store and label medication on four of four medication carts reviewed (7th Floor South Side Cart, 7th Floor North Side Cart, 8th Floor North/South Cart and 8th Floor Southeast/Northeast Cart) Findings include: A review of the facility's policy titled Medication Labeling and Storage, revision date of February 2023, revealed that medications and biologicals are stored in the packaging, containers, or other dispensing systems they are received. Only the issuing pharmacy is authorized to transfer medications between containers. Medications may not be transferred between containers. Multi-dose vials opened and accessed are dated and discarded within 28 days unless the manufacturers specify a shorter or longer time for the open vial. A review of manufacturers' storage guidelines for Lantus Insulin Pen (long-acting insulin) revealed that the medication may be stored at room temperature and must be discarded within 28 days after opening. A review of the manufacturer's storage guidelines for Insulin Lispro (Humalog-fast-acting insulin), revealed that the medication must be stored at room temperature and must be discarded within 28 days after opening. A review of the manufacturer's storage guidelines for Novolog Insulin (fast-acting insulin), revealed that the medication must be stored at room temperature and must be discarded within 28 days after opening. A review of the manufacturer's storage guidelines for Insulin Aspart (Novolog-fast-acting insulin), revealed that the medication must be stored at room temperature and must be discarded within 28 days after opening. A review of manufacturers' storage guidelines for Insulin Gargline (long-acting insulin) revealed that the medication may be stored at room temperature and must be discarded within 28 days after opening. An observation on the south side medication cart was conducted on April 8, 2025, at 10:00 a.m., in the presence of licensed nurse Employee E6. The observation revealed two Lantus Insulin pens used and undated and one Lispro Insulin pen used and undated. An interview conducted with Employee E6 on April 8, 2025, at 10:05 a.m., confirmed that the Insulin pens should have been dated when opened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395774	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Nursing and Rehabilitation Center	900 East King Street Lancaster, PA 17602

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on north side medication cart was conducted on April 8, 2025, at 10:12 a.m., in the presence of licensed nurse Employee E8. The observation revealed one Lispro insulin vial used with an open date of February 9, 2025. The same observation revealed a two Lantus insulin pen used and undated, and a Lidocaine vial (A medication that prevents pain by blocking the signals at the nerve ending in the skin) used and undated. An interview conducted with Employee E8 on April 8, 2025, at 10:15 a.m., confirmed that the above medications should have been dated when opened. An observation on the north/south side medication cart was conducted on April 8, 2025, at 12:15 p.m., in the presence of licensed nurse Employee E9. The observation revealed the following insulins were all opened, used, and undated: three Novolog pens, one Lantus pen, one Insulin Aspart pen, and two Insulin Gargline pens. An interview conducted with Employee E9 on April 8, 2025, at 12:28 p.m., confirmed that the above insulin pens should have been dated when opened. An observation conducted on the southeast/northeast side medication cart was conducted on April 8, 2025, at 12:40 p.m., in the presence of licensed nurse Employee E10. The observation revealed the following: Two Insulin Aspart vials and one Insulin Gargline pen were all opened, used, and undated. Further observation revealed 16 white long tablets in a medication cup in the top drawer. An interview conducted with Employee E10 on April 8, 2025, at 12:45 p.m., confirmed that the insulin medications should have been dated when opened. Furthermore, Employee E10 was unable to verify the name of the white medications observed on the top drawer of the medication cart. The above findings were discussed with the Nursing Home Administrator on April 11, 2025, at 11:00 a.m. The facility failed to ensure correct storage and labeling were maintained on the 7th and 8th Floor medication carts. 28 Pa. Code 201.18(b)(1) Management Previously cited 5/22/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 5/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395774	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Few	Provide and implement an infection prevention and control program. 41765 Based on observations and staff interviews, it was determined that the facility failed to ensure infection control prevention and management was practiced during medication administration and meal set up for two 35 residents reviewed (Resident 1 and 51). Findings include: An observation of the medication administration was conducted with licensed Employee E6 on April 8, 2025, at 9:55 a.m. The observation revealed that after preparing Resident 1's medication, Employee E6 approached Resident 1 who was lying in bed to give the medication. While the resident was trying to pick up the medications in the cup, one of the pills fell on the resident's tray table. Further observations revealed Employee E6 picked up the pill that fell with bare hands without performing hand hygiene and then gave it to the resident to swallow. An observation conducted on April 9, 2025, at 9:16 a.m., revealed Resident 51 was sitting on a recliner in the hallway outside of his/her room holding a puzzle book. While talking to the resident, non-licensed Employee E5 who was observed passing another resident's breakfast meal tray said that it was time for Resident 51's breakfast. Without performing hand hygiene, and without cleaning the resident's hands, Employee E5 opened the top lid of the resident's breakfast plate that was still in the tray on the food cart, and with bare hands picked up half of a bread and handed it to the resident's right hand. The resident started eating the French toast placed by the staff in his/her hands. Employee E5 proceeded to pass the breakfast trays of the other residents without performing hand hygiene. The above was conveyed to the NHA (Nursing Home Director) on April 11, 2025, at 10:00 a.m. The facility failed to ensure infection control prevention and management were practiced during medication administration and meal set-up. 28 Pa. Code: 211.12(d)(1)(5) Nursing services