

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Hanover		STREET ADDRESS, CITY, STATE, ZIP CODE 3370 High Pointe Boulevard Bethlehem, PA 18017	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>09315</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide a copy of a discharged resident's clinical record within two days as requested by the legal representative for one of four resident's sampled. (Resident CR1)</p> <p>Resident CR1 was discharged from the facility on May 29, 2024. A request was made for a copy of Resident CR1's clinical record to be copied and sent to the legal representative on August 29, 2024.</p> <p>In an interview on March 4, 2025, at 11:00 a.m., the Nursing Home Administrator confirmed the the requested information was not faxed until December 10, 2024.</p> <p>28 PA. Code 201.29(a) Resident rights.</p>

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

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