STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395058	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REST HAVEN-YORK STATE LICENSE NUMBER: **440902**	**1050 S GEORGE STREET** **YORK, PA 17403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights survey and Complaint survey completed on January 30, 2025, it was determined that Rest Haven-York was not in compliance with the following requirements of 42 CFR Part 483 Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0583 SS=E		F 0583		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0583 SS=E	Continued from page 1 483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in	F 0583	All video monitoring devices have been removed from resident rooms. All residents that had video monitoring removed, will have their fall care plans reviewed and updated by IDT as needed. All staff will be educated on resident rights to privacy and confidentiality of their personal and medical records including accommodations, medical treatment, written and verbal communications, personal care, visits and meetings of family and resident groups. Video monitoring will no longer be used in facility- all staff have been notified, and all cameras have been removed. A QA tool has been developed to review 10% of residents weekly to ensure privacy and confidentiality of their personal and medical records including accommodations, medical treatment, written and verbal communications, personal care, visits and meetings of family and resident groups. The Quality	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/12/2025**

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F 0583 SS=E	Continued from page 2 accordance with State law. This REQUIREMENT is not met as evidenced by:	F 0583	Assurance (QA) Coordinator or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator will review the completed QA tool monthly and will report any trends or patterns at the quarterly Interdisciplinary Quality Assurance and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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F 0583 SS=E	Continued from page 3 Based on policy review, observations, clinical record reviews, facility document review, and staff interviews, it was determined that the facility failed to protect the residents' right to privacy for three of three residents reviewed for the use of video/audio monitoring (Residents 16, 27, and 65). Findings include: Review of facility policy, titled "Resident Rights," not dated, revealed it stated: "1. The Resident has the right to be informed of their rights and of all rules and regulations governing resident conduct and responsibilities both orally and in writing prior to or upon their admission or as appropriate during their stay." "2. The Resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility."	F 0583		

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F 0583 SS=E	Continued from page 4 "3. The Resident has the right to exercise their rights as a Resident of Rest Haven - York and as a citizen of the United States." "4. If the Resident is not capable of exercising their rights, a court-appointed person or Power of Attorney may exercise their rights. A Resident who has not been adjudged incompetent has the right to designate a representative and the representative may exercise the Resident's rights to the extent provided by the law ..." "11. The Resident has the right to choose a personal attending physician and to be fulling informed by the physician or other professional in advance about the risks and benefits of proposed care and treatment, alternatives to proposed care and treatment, and to participate in planning care and treatment ..." "24. The Resident has the right to privacy and confidentiality with their written, electronic, and telephone communication and personal visits ..."	F 0583		

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F 0583 SS=E	Continued from page 5 "31. The Resident has the right to an environment that promotes maintenance or enhancement of quality of life including respect, dignity, and privacy during personal care ..." Review of Resident 27's clinical record on January 29, 2025, revealed diagnoses that included chronic kidney disease stage three (moderately decreased ability of the kidneys to filter toxins from the blood) and history of cerebral infarction (stroke - sudden loss of blood, or bleeding in the brain that causes damage to the brain cells, which can result in physical and mental deficits and/or death). During observations on January 29, 2025, at approximately 9:30 AM, it was observed that a device resembling a camera was observed on the bedside dresser of Resident 27. During a staff interview at approximately 9:36 AM, Employee 9 stated that it was a monitor for Resident 27 to monitor Resident 27 at night due to Resident	F 0583		

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F 0583 SS=E	Continued from page 6 27 having a history of attempting to get out of bed and falling. At the time of the observation Resident 27 was not in bed, nor in the room. Observation of the nurses' station adjacent to the unit Resident 27 resided, revealed two small monitor screens. Both screens were in direct line of sight from the hallway. During the observation, no staff were sitting at the nurses' station. It was observed that both monitors were on at that time. Review of Resident 27's physician's orders revealed an order dated January 13, 2025, for, "Safety measures: encourage grip socks in bed, offer [out of bed] to nurses station in restless, camera monitor at bedside, low BED." Review of Resident 27's comprehensive plan of care revealed that it did not include the use of a video/audio monitoring system. Observation of the second monitor revealed it displayed Resident 16 who was laying in bed, facing	F 0583		

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F 0583 SS=E	Continued from page 7 the camera. It was also observed that audio from Resident 16's room was audible from the monitor, which also included light indicators of the audio transmission. Review of Resident 16's clinical record, revealed diagnoses that included peripheral vascular disease (disease of the cardiovascular system that results in decreased blood flow to the extremities) and 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). Review of Resident 16's physician orders revealed they did not include an order for the video/audio monitoring device. Review of Resident 16's comprehensive plan of care revealed that the use of a video/audio monitor was not included in the comprehensive plan of care. Review of Resident 65's clinical record on January 30, 2025, revealed diagnoses that included epilepsy	F 0583		

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F 0583 SS=E	Continued from page 8 (neurological condition characterized by seizures caused by abnormal brain activity) and dementia (irreversible, progressive degenerative brain disease that results in decreased ability to perform activities of daily living and decreased contact with reality). Review of Resident 65's physician orders revealed an order dated November 27, 2024, for "Safety measures: redirect/reorient/reassure [as-needed] if resident is seeking to get up to go home, camera monitor, [bilateral] crash mat." Review of Resident 65's comprehensive plan of care revealed it did not include the use of a video/audio monitor. During a staff interview on January 30, 2025, Nursing Home Administrator (NHA) provided a list that revealed seven total residents had video/audio monitoring. Review of the resident list revealed the start date of the monitors were as follows:	F 0583		

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F 0583 SS=E	Continued from page 9 Resident 16's monitoring device was started on October 1, 2024. Resident 27's monitoring device was started on January 13, 2025. Resident 65's monitoring device was started on November 27, 2024. During a staff interview on January 30, 2025, at approximately 10:15 AM, NHA characterized the video/audio devices as "baby monitors." The NHA stated that the use of the monitors is decided during a residents' care plan meeting and that the monitors should be included in the care plan. The NHA further revealed that the facility did not have a policy or procedure for to the protection of Resident(s) privacy with the use of a video/audio monitor. When asked if the facility obtained consent from the resident/resident representative, or the consent of the resident/resident representative of the roommate, the NHA stated that there was no consent obtained. During the staff interview, the NHA revealed that she was not aware that Resident 16's video/audio monitor was transmitting both video and audio.	F 0583		

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F 0583 SS=E	Continued from page 10 28 Pa code 201.18(b)(1)(2)(3)(d) Management 28 Pa code 201.29(a) Resident rights 28 Pa code 211.12(d)(1)(3)(5) Nursing services	F 0583		
F 0584 SS=D		F 0584		

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F 0584 SS=D	Continued from page 11 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	Resident 106's bedside table and mat have been cleaned. Tray tables in all resident rooms have been checked for cleanliness and cleaned as needed. All staff have been educated on resident rights to a safe, clean, comfortable and homelike environment; including cleanliness of bedside tables by nursing staff with care each day. Dirty mats will be discarded and replaced as needed. A QA tool has been developed to review 10% of resident environments weekly to ensure resident rights to a safe, clean, comfortable and homelike environment The Quality Assurance (QA) Coordinator or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator will review the completed QA tool monthly and will report any trends or patterns at the quarterly Interdisciplinary Quality Assurance	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/12/2025**

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F 0584 SS=D	Continued from page 12 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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F 0584 SS=D	Continued from page 13 Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, and home-like environment for one of 30 resident's reviewed (Resident 106). Findings include: Review of facility policy, titled "Resident Rights", not dated, read, in part, "The Resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely." Observation in Resident 106's room on January 27, 2025, at 10:01 AM, revealed her tray table was dirty, and the mat overtop was stained with a red substance. Observation in Resident 106's room on January 28, 2025, at 10:48 AM, revealed her tray table was dirty, and the mat overtop was stained with a red substance, same as the day prior.	F 0584		

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F 0584 SS=D	Continued from page 14 Observation in Resident 106's room on January 29, 2025, at 10:51 AM, revealed her tray table was dirty, and the mat overtop was stained with a red substance, same as the days prior. During an interview with the Nursing Home Administrator (NHA) on January 29, 2025, at 11:12 AM, the surveyor revealed the concern with the observations of Resident 106's tray table. Follow-up interview with the NHA on January 30, 2025, at 10:11 AM, she revealed house keeping staff does weekly rounds to clean rooms, and it is the responsibility of nursing staff to wipe down tray tables daily and clean them as needed. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(3) Nursing services	F 0584		
F 0637 SS=D		F 0637		

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F 0637 SS=D	Continued from page 15 483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 0637	Resident R 70's MDS has been corrected to reflect significant change. All residents receiving hospice services have had their last MDS reviewed to ensure any determination of significant change is reflected on MDS. Corrections will be made as needed. RNAC has been educated on the need for significant change MDS completion within 14 days after determination of resident significant change in status and in relation to hospice services. A QA tool has been developed to review 10% of hospice residents weekly to ensure significant change MDS completion within 14 days after determination of resident significant change in status. The Quality Assurance (QA) Coordinator or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/12/2025**

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REST HAVEN-YORK STATE LICENSE NUMBER: **440902**	**1050 S GEORGE STREET YORK, PA 17403**

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F 0637 SS=D	Continued from page 16	F 0637	will review the completed QA tool monthly and will report any trends or patterns at the quarterly Interdisciplinary Quality Assurance and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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F 0637 SS=D	Continued from page 17 Based on clinical record review and staff interview, it was determined that the facility failed to conduct a Significant Change Minimum Data Set (MDS - standardized assessment tool utilized to identify a resident's physical, mental, and psychosocial needs) for one of four residents reviewed for hospice status (Resident 70). Findings include: Review of Centers for Medicare and Medicaid Services' Resident Assessment Instrument Version 3.0 Manual provides instructions for completing the resident Minimum Data Set assessment. The manual revealed instructions that a Significant Change Minimum Data Set is required to be performed when a terminally ill resident enrolls into a hospice program (end of life program). Review of Resident 70's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes that causes memory loss in older adults) and hypertension	F 0637		

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F 0637 SS=D	Continued from page 18 (elevated blood pressure caused by the force of blood against the artery walls being too high). Review of Resident 70's MDS assessments revealed Resident 70 had an annual MDS completed with an assessment reference date of April 4, 2024. Review of Resident 70's clinical record revealed that Resident 70 was admitted to Hospice services on March 29, 2024. Review of Resident 70's MDS assessments revealed the facility did not conduct a Significant Change MDS after Resident 70 was admitted to Hospice. Instead, the facility conducted an Annual MDS assessment that had an assessment reference date of April 4, 2024. During a staff interview on January 29, 2025, at approximately 11:00 AM, the Nursing Home Administrator revealed that the facility should have conducted a Significant Change MDS because of	F 0637		

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F 0637 SS=D	Continued from page 19 Resident 70 entering Hospice services. A copy of the modified MDS dated April 4, 2024, changed to a significant change in status assessment was provided on January 29, 2025. 28 Pa Code 211.12(d)(1)(5) Nursing services	F 0637		
F 0677 SS=D		F 0677		

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F 0677 SS=D	Continued from page 20 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Resident 7 has had facial hair removed. All residents have been observed and facial hair removed as needed per policy. Education provided to nursing staff, residents who are unable to carry out activities of daily living have the right to necessary services to maintain good nutrition, grooming, and personal and oral hygiene; including removal of facial hair. A QA tool has been developed to review 10% of residents weekly to ensure residents who are unable to carry out activities of daily living, maintain good nutrition, grooming, and personal and oral hygiene; including removal of facial hair. The Quality Assurance (QA) Coordinator or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator will review the completed QA tool monthly and will report any trends or	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0677 SS=D	Continued from page 21	F 0677	patterns at the quarterly Interdisciplinary Quality Assurance and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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F 0677 SS=D	Continued from page 22 Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming for one of 30 residents reviewed (Resident 7). Findings include: Review of facility policy, titled "Shaving Residents-Preparation, Completion", last revised May 23, 2017, read, in part, "Policy: It is the policy of this facility to prepare for and shave residents as needed. Purpose: To provide a uniform process, through which staff prepare for and shave residents. Document in electronic health record." Review of Resident 7's clinical record revealed diagnoses that included hypertension (high blood pressure), anxiety disorder (a persistent a feeling of worry, nervousness, or unease), and neuromuscular dysfunction of bladder (occurs when the nerves that	F 0677		

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F 0677 SS=D	Continued from page 23 control the bladder are damaged or not functioning properly). Observation of Resident 7 on January 27, 2025, at 11:57 AM, revealed a quarter inch of facial hair over her upper lip and on her chin. Interview with Resident 7 on January 27, 2025, at 11:57 AM, revealed she had a shower that morning and she prefers assistance with shaving on shower days. Observation of Resident 7 on January 28, 2025, at 10:53 AM, revealed a quarter inch of facial hair over her upper lip and on her chin. Observation of Resident 7 on January 29, 2025, at 10:47 AM, revealed a quarter inch of facial hair over her upper lip and on her chin. Review of Resident 7's care plan revealed a focus area of "ADLs (Activities of Daily Living) Functional Status," last edited December 23, 2024, with an	F 0677		

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F 0677 SS=D	Continued from page 24 intervention for "I need staff to follow my care profile for specific ADL information," last edited January 29, 2024. Review of Resident 7's clinical record revealed documentation on January 27, 2025, at 7:14 AM, that she received a shower and required "Physical help in part of bathing" with "1 person physical assist," and documentation that stated "How did the resident maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands," and was documented that Resident 7 required "Partial/Moderate Assistance." Email correspondence with the Nursing Home Administrator (NHA) on January 29, 2025, at 2:29 PM, revealed she did not have any information to provide regarding Resident 7's facial hair. During a follow-up interview with the NHA on January 30, 2025, at 10:13 AM, she revealed her expectation that staff should offer shaving with	F 0677		

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F 0677 SS=D	Continued from page 25 showers and as desired. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0677		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 26 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident 240 has been assessed by a RN and CRNP. Physician has been notified of alterations in skin integrity and all documentation has been updated to include characteristics and type of alteration in skin. All residents' current skin wound records have been reviewed for appropriate documentation of character and/or type of alterations in skin. Residents with wound infections, diabetic ulcers, venous ulcers, arterial ulcers, pressure ulcers, open lesions, surgical wounds, and stage 2 and greater burns will be assessed by an RN, referral to wound CRNP will be completed, and physician will be notified if not done previously. Admission policy and skin wound policies will be updated to include residents with wound infections, diabetic ulcers, venous ulcers, arterial ulcers, pressure ulcers, open lesions, surgical wounds, and stage 2 and greater burns will be assessed	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/19/2025**

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F 0684 SS=D	Continued from page 27	F 0684	by a RN, referral to wound CRNP will be completed, and physician will be notified. All licensed nursing staff will be educated on updated policies and requirements for wound documentation to include character and type of wound. A QA tool has been developed to review 10% of admissions weekly to ensure residents with wound infections, diabetic ulcers, venous ulcers, arterial ulcers, pressure ulcers, open lesions, surgical wounds, and stage 2 and greater burns are assessed by a RN, referral to wound CRNP is completed, and physician is notified. 10% of wound documentation forms will be reviewed weekly to ensure new alterations in skin integrity include documentation of character and type of wound. The Quality Assurance (QA) Coordinator or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator will review the completed QA tool monthly and will	

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F 0684 SS=D	Continued from page 28	F 0684	report any trends or patterns at the quarterly Interdisciplinary Quality Assurance and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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F 0684 SS=D	Continued from page 29 Based on clinical record review, hospital record review, and staff interviews, it was determined that the facility failed to provide care and services that met professional standards for one of 30 residents reviewed (Resident 240). Findings include: Review of Resident 240's clinical record on January 29, 2025, revealed diagnoses that included stage three chronic kidney disease (moderate impairment of the kidneys to filter toxins from the blood) and anxiety disorder (mental health disorder characterized by excessive worry and fear). Review of Resident 240's clinical record revealed that Resident 240 was admitted to the facility from the hospital on January 27, 2025, at 1:40 PM. Review of hospital discharge records for Resident 240 revealed that the discharge information did not include any wounds identified on Resident 240.	F 0684		

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F 0684 SS=D	Continued from page 30 Review of Resident 240's electronic health record revealed that on January 27, 2025, Employee 15 (Licensed Practical Nurse) completed the admission document titled, "Other Ulcers, Wounds and Skin Problems," provided the descriptive categories for staff to check that included "Infection of the foot (e.g., cellulitis, purulent drainage); Diabetic foot ulcer(s); Other open lesion(s) on the foot; Open lesions(s) other than ulcers, rashes, cuts (e.g., cancer lesion); Surgical wound(s); Burn(s) (second or third degree); Skin tear(s); Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage); None of the above were present." Review of the aforementioned subsection revealed it was marked as, "None of the above were present," by Employee 15. Review of the subsection, titled "Referrals" revealed it provided areas to identify needed referrals to "Wound Team [sic]," and "Wound Clinic" and it was marked "No Referrals Necessary."	F 0684		

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F 0684 SS=D	Continued from page 31 Review of paper document, titled "Skin Wound Documentation Form," revealed that on January 27, 2025, Employee 15 documented multiple areas, including: wound 1 - wound at the tip of the left great toe that measured 1 centimeters (cm - metric unit of measure) by 0.5 cm; wound 2 - a wound at the top of the right great toe that measured 0.7 cm by 0.7 cm; wound 3 - a wound to the side of the right fifth digit (toe) that measured 0.5 cm by 0.5 cm; and wound 9 - an area at the right chest that measured 0.1 cm by 0.1 cm with the description of "open area." Review of the document revealed that each line had a space for staff to document a "Skin Code" for each wound identified. Review of the "Skin/Wound Codes" section revealed that the codes indicated the type of wound identified, with an option of "O = Other specify."	F 0684		

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F 0684 SS=D	Continued from page 32 Review of the wounds identified, wound 1, 2, 3, and 9, revealed Employee 15 documented "O." Review of available clinical record revealed no further information on wound characteristics or type of wound was documented by Employee 15. Review of clinical records for Resident 240 revealed no assessment by a registered nurse of the wounds identified. Review Resident 240's progress notes revealed no documentation to the physician that Resident 240 was admitted with wounds that were not previously identified prior to admission. Review of the physician "Admission History and Physical Visit," dated January 28, 2025, completed by Physician 2, revealed the "Physical exam" subsection "Skin," stated, "no lesions noted of exposed skin." Review of the physician assessment failed to reveal that the physician was made aware or identified the area identified as wounds by	F 0684		

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F 0684 SS=D	Continued from page 33 Employee 15 upon Resident 240's admission. The facility wound nurse (Employee 18) did not assess the Resident's foot for wounds until January 29, 2025, and did not a progress note regarding assessing the areas until January 30, 2025, at 8:47 AM. During a staff interview with Employee 18 on January 30, 2025, Employee 18 revealed that the Resident had scabs (hard dark brown tissue composed of dried blood, platelets, and fibrin) on her feet but no wounds. However, subsequent observations of Resident 240's right great toe revealed an area at the right great toe consistent with a wound that was covered with eschar (dark, hard area similar to a scab but is composed of dead tissue, debris and dried blood). Review of the consultant wound progress note dated January 30, 2025, revealed Resident 240 was diagnosed with a full thickness arterial wound of the right great toe which was covered with eschar.	F 0684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 34 As of January 30, 2025, at 1:00 PM, the facility had no further information to provide regarding why an assessment of a previously unidentified wound(s) for Resident 240 was not performed by a Registered Nurse upon admission. 28 Pa code 211.12(d)(1)(3)(5) Nursing services	F 0684		
F 0686 SS=D		F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395058	A. BLDG: __00_____ B. WING: _____	01/30/2025

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F 0686 SS=D	Continued from page 35 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Resident 37 has been evaluated for infection. No signs or symptoms of wound infection noted at this time. All residents with wounds will be evaluated for symptoms of infection. Residents with symptoms of infection will be assessed by an RN and the physician or CRNP will be notified. Treatment application policy will be updated to include washing hands versus using alcohol-based hand sanitizer when hands are visibly soiled. Clarification of wound dressing date has been updated in treatment application policy to include dating dressing during equipment set up prior to removal of old dressing. All licensed staff will be educated on updated policy to ensure prevention of infection. A QA tool has been developed to review 10% of treatment applications weekly to ensure policy compliance and prevention of infection. The Quality Assurance (QA) Coordinator	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/12/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=D	Continued from page 36	F 0686	or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator will review the completed QA tool monthly and will report any trends or patterns at the quarterly Interdisciplinary Quality Assurance and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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	395058	A. BLDG: 00 B. WING:	01/30/2025

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F 0686 SS=D	Continued from page 37 Based on clinical record review, observation, and staff interviews, it was determined that the facility failed to ensure residents receive treatment and services consistent with professional standards to promote healing and prevent infection for one of two residents reviewed for pressure ulcers (Resident 37). Findings include: Review of Resident 37's clinical record on January 27, 2025, revealed diagnoses that included stage three pressure ulcer of the sacrum (wound that extends below the tissue of the skin caused by pressure over a bony prominence) and congestive heart failure (decreased ability of the heart to pump blood throughout the body). During wound dressing observations on January 29, 2025, at approximately 10:25 AM, Employee 15 (Licensed Practical Nurse) was observed preparing Resident 37 for the wound dressing change on Resident 37's sacral area.	F 0686		

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F 0686 SS=D	Continued from page 38 After repositioning Resident 37, Employee 15 observed Resident 37 had a bowel movement. Employee 15 cleaned Resident 37's bowel movement prior to starting the dressing change. During the observation, it was observed that Employee 15's gloves were visibly soiled with feces. After cleaning Resident 37's bowel movement and starting the wound dressing change, Employee 15 did not perform hand hygiene with soap and water. Instead, Employee 15 utilized an alcohol-based hand rub during glove changes between cleaning Resident 37's bowel movement and accessing Resident 37's wound. During the observation, it was observed that the dressing that was present on Resident 37 was not dated. After removing the old dressing and cleansing the wound, Employee 15 was observed retrieving a marker from her pocket with her bare hands. At which time, Employee 15 was observed holding two	F 0686		

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F 0686 SS=D	Continued from page 39 foam dressings one hand and using the marker to write on the new dressing. Employee 15 was observed returning the marker to her pocket. During a staff interview on January 29, 2025, at approximately 11:00 AM, Employee 15 confirmed that her pocket is not considered a clean area. During a staff interview on January 30, 2025, at approximately 10:15 AM, Nursing Home Administrator along with Employee 5 (Registered Nurse/Quality Assurance) confirmed that Employee 15 should have performed hand hygiene with soap and water between cleaning the bowel movement and starting the dressing change, that Employee 15's pocket was not considered a clean surface, and that facility should be labeling wound dressings when they are applied with date and time, and initials. 28 Pa code 211.12(d)(1)(3)(5) Nursing services	F 0686		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 40 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Resident 26 will be evaluated for safety with smoking. She will be offered a lock box for her room to keep her cigarettes and lighter in. A care plan will be developed ensuring residents' safety while smoking. All residents requesting to smoke off facility property will have a safety evaluation completed. Storage will be provided for cigarettes and cigarette lighting devices. A care plan will be developed to ensure resident safety while smoking. Facility smoking policy has been updated to include resident assessment for safety with smoking, providing proper storage of cigarettes and cigarette lighting devices, and care plan development to ensure safety. All facility staff will be updated on the revised policy. Staff will be educated that they are not permitted to assist residents with smoking while clocked in to work. A QA tool has been developed to review all residents that smoke	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/12/2025**

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F 0689 SS=D	Continued from page 41	F 0689	weekly to ensure policy compliance. The Quality Assurance (QA) Coordinator or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator will review the completed QA tool monthly and will report any trends or patterns at the quarterly Interdisciplinary Quality Assurance and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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F 0689 SS=D	Continued from page 42 Based on facility policy review, clinical records review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that the resident environment was free of accident hazards for one of 30 Residents reviewed (Resident 26). Findings include: Review of facility policy, Tobacco/smoking-communication, interventions, guidelines, last revised March 2, 2017, revealed that Rest Haven-York is a smoke and tobacco-free facility/campus. Review of Resident 26's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and narrowing of the airways, leading to difficulty breathing) and normal pressure hydrocephalus (a condition where excess cerebrospinal fluid [CSF] accumulates in the brain's ventricles [fluid-filled spaces] without an increase in intracranial pressure).	F 0689		

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F 0689 SS=D	Continued from page 43 Observation of Resident 26 on January 28, 2025, at 10:04 AM, revealed Resident 26 sitting in her wheelchair in the facility parking lot, next to Employee 9, smoking a cigarette. Interview with Resident 26 on January 29, 2025, at 9:34 AM, revealed that Resident 26 keeps her cigarettes and lighter in her room and that she has nowhere to lock them up, where they cannot be accessed by other residents. Review of Resident 26's medical record on January 28, 2025, failed to reveal any smoking evaluation for Resident safety. Review of Resident 26's care plan failed to reveal a care plan with a focus area related to safety while smoking. Review facility provided email from Resident 26's Representative dated December 11, 2024, at 12:33 PM, revealed that Resident 26 had a desire to	F 0689		

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F 0689 SS=D	Continued from page 44 smoke cigarettes, and she would leave the facility to do so. Interview of the Nursing Home Administrator on January 28, 2025, at 1:30 PM, revealed that the facility was aware that the Resident was smoking and that they required her to leave the facility grounds to smoke. She also revealed that facility employees are not permitted to take the Resident out to smoke while clocked in to work. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0689		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 45 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	The dishwasher in kitchen is operating in accordance with facility guidelines, department policy, manufacturer's specifications and regulatory guidelines. The policy has been updated for dietary staff to notify dietary manager or dietician of dish washer water temperatures below 150 degrees. It is the responsibility of the manager/dietician to notify maintenance as needed for repair. Dietary staff have been educated on updated policy and notification procedures when dish washer water temperatures are below 150 degrees. A QA tool has been developed to review 10% of dish washer temperatures weekly to ensure dish washer water temperatures are above 150 degrees. The Quality Assurance (QA) Coordinator or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0812 SS=E	Continued from page 46	F 0812	will review the completed QA tool monthly and will report any trends or patterns at the quarterly Interdisciplinary Quality Assurance and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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F 0812 SS=E	Continued from page 47 Based on facility policy review, observation, review of select facility documentation, and staff interviews, it was determined that the facility failed to utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen. Findings include: Review of facility policy, titled "Machine Warewashing", last revised December 1, 2007, read, in part, "Purpose: To ensure that the dishwashing machine is operating in accordance with facility guidelines, department policy, manufacturers specifications and regulatory guidelines. Policy: The dish washing machine is serviced on a regular basis. Wash and rinse temperatures of the dish machine are monitored during each major use (3 times daily). Acceptable temperature ranges are: wash- minimum 150 degrees. If the machine operating temperatures are lower than the specified minimum temperature staff members will suspend the machine washing and notify the Dietary Supervisor, and/or the Food Service Director, and/or the Assistant Food Service	F 0812		

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F 0812 SS=E	Continued from page 48 Director and maintenance personnel. The following process will be used to assess machine operation: The holding tank temperature will be confirmed with a pocket thermometer. The booster heater will be checked to confirm that it is switched on. The holding tank may be emptied and reloaded with fresh water. Temperatures will be rechecked. If the temperature of the dish machine falls below 150 degrees, the bleaching system should be hooked up and booster heater turned off to utilize the low heat option." Observation of the January 2025 dish machine temperature log in the main kitchen on January 27, 2025, at 9:43 AM, revealed the wash temperature was below the minimum safe temperature of 150 degrees on January 9-12 during breakfast; January 9-14 during lunch; and January 8, 16, 21 and 22 during dinner. No corrective action was noted. Interview with Employee 2 (Food Service Director) on January 27, 2025, at 9:44 AM, revealed staff had not made her aware of the low temperatures in	F 0812		

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F 0812 SS=E	Continued from page 49 January 2025. Review of the dish machine temperature logs from May 2024 through January 2025, revealed "If minimum temperature is not met- Please contact maintenance." Review of the May 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on May 7-9, 11, 12, 14-17, 20, 23, 25-28, and 30 at breakfast; May 8, 9, 11, 12, 14-17, 20, 23, 25-28, and 30 at lunch; and May 10, 14, 16, 17, 20-24 at dinner. Further review failed to reveal notation of corrective action taken. Review of the June 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on June 5-11, 13, 25, 27, 28, and 30 at breakfast; June 2, 3, 5-11, 13, 14, 17, 18, 22-24, 27, 28, and 30 at lunch; and June 4, 5, 12, 13, 19, and 25 at dinner. Further review failed to reveal notation of corrective	F 0812		

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F 0812 SS=E	Continued from page 50 action taken. Review of the July 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on July 3-11, 15-21, 23, 25, and 29-31 at breakfast; July 2-11, 16-23, 26, 30 and 31 at lunch; and July 3 and 26 at dinner. Further review failed to reveal notation of corrective action taken. Review of the August 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on August 1, 3-5, 7, 8, 12-15, 17, 18, 22-24, 26-29, and 31 at breakfast; August 1, 3-5, 7, 8, 10, 12, 13, 15, 17, 18, 20, 22-24, 26-29 and 31 at lunch; and August 1, 3, 15, and 30 at dinner. Further review failed to reveal notation of corrective action taken. Review of the September 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees	F 0812		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 51 on September 1, 4, 5, 7, 10-12, 14, 15, 19, 22, 23, 25, 28, and 29 at breakfast; September 1, 4-7, 10-15, 19-23, 25, 28 and 29 at lunch; and September 2, 12, and 21 at dinner. Further review failed to reveal notation of corrective action taken. Review of the October 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on October 1, 8, 11-13, 17, 19-23, 26, 27, and 29-31 at breakfast; and October 8, 10-13, 17, 19-23, 26, 27, 30 and 31 at lunch. Further review failed to reveal notation of corrective action taken. Review of the November 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on November 5-11, 15-24 and 26-30 at breakfast; and November 1, 5-12, 18-24, and 27-30 at lunch. Further review failed to reveal notation of corrective action taken. Review of the December 2024 dish machine	F 0812		

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	395058	A. BLDG: __00_____ B. WING: _____	01/30/2025

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F 0812 SS=E	Continued from page 52 temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on December 1-13 and 20-25 at breakfast; December 1-9, 11-17, and 21-25 at lunch; and December 1 and 3 at dinner. Further review failed to reveal notation of corrective action taken. Interview with the Nursing Home Administrator on January 29, 2025, at 11:13 AM, revealed she was unable to provide information if the facility process was followed when the dish machine was running below the minimum acceptable wash temperature, and it is the facility's expectation that kitchen equipment is utilized in accordance with professional standards. 28 Pa. Code 201.18(b)(1) Management	F 0812		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 53 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Residents 24, 12, 37 have been evaluated for signs of infection- no symptoms noted. Surfaces in resident rooms have been properly disinfected. All residents will be monitored for symptoms of infection via review of nursing documentation and daily staff observations with care. All bedside tables have been disinfected. Enhanced barrier precautions and contact precautions policies updated to include staff will doff personal protective equipment prior to leaving resident room, place in a trash bag and dispose of in trash receptacle in hallway. Red bag receptacles will be placed in all resident rooms for residents requiring a dressing change or other care when trash may be soiled with blood or body fluids. Treatment application policy updated to include disinfecting all surfaces after completion of treatments. All staff will be educated on enhanced barrier precautions and	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/19/2025**

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F 0880 SS=E	Continued from page 54 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	contact precautions policies. Nursing staff will be educated on treatment application policy. Unit reviews by nursing supervisors will be completed to ensure compliance. A QA tool has been developed to review 10% of treatment applications weekly to ensure compliance with enhanced barrier precautions, contact precautions and treatment application policies to ensure compliance. The Quality Assurance (QA) Coordinator or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator will review the completed QA tool monthly and will report any trends or patterns at the quarterly Interdisciplinary Quality Assurance and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a	

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F 0880 SS=E	Continued from page 55	F 0880	period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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F 0880 SS=E	Continued from page 56 Based on observations, facility policy review, and staff interviews, it was determined that the facility failed to ensure staff implemented infection control policies to prevent the spread of infection by doffing PPE (personal protective equipment) prior to exiting the resident room in two of seven resident care areas observed (100 and 700 hall), and failed to properly disinfect resident areas after one of two dressing changes observed (Resident 12). Findings Include: Review of facility policy with the subject of, "PRECAUTIONS, CONTACT - Notification, Initiation, Communication, Prevention, Discontinuation," last revised March 30, 2021, revealed the policy's purpose stated, "To provide a uniform process through which facility is notified of potentially harmful microorganisms, contact precautions are initiated, risk is communicated, spread of microorganisms is prevented and contact precautions are discontinued." Review of the aforementioned policy's "Procedure"	F 0880		

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F 0880 SS=E	Continued from page 57 section revealed it included, "5. Obtain a container for dirty linens and place inside the resident's room...10. The following personal protective equipment will be used when caring for residents with a potentially harmful microorganism: a. Gloves - required when entering a resident's room, when anticipating direct contact with a resident, [the residents] environment or [the residents] equipment that could result in contamination of the hands; remove gloves and wash hands immediately before leaving the room..." Review of Resident 24's clinical record revealed diagnoses that included diabetes (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly) and peripheral vascular disease (a condition that affects the blood vessels outside the heart and brain). Review of Resident 24's current physician orders revealed an order for enhanced barrier precautions related to a wound, with a start date of November 24, 2024, and no end date.	F 0880		

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F 0880 SS=E	Continued from page 58 Observation of Employees 7 and 8 on January 27, 2025, at 10:11 AM, revealed them wearing protective gowns while providing care to Resident 24, who is on enhanced barrier precautions. After Employees 7 and 8 completed providing the care, they exited Resident 24's room and entered the hallway, still wearing the protective gowns. Employees 7 and 8 then removed their gowns and disposed of them in the garbage can located in the hallway. Interview with the Nursing Home Administrator (NHA) on January 28, 2025, at 1:15 PM, revealed that the garbage cans are located in the hallway because of a lack of space in the resident rooms, and that her expectation is that the employees would have removed their gowns and gloves before exiting the Resident room and put them in a garbage bag; which they could then place into the garbage can that was located in the hallway. Review of facility policy, Precautions, Enhanced	F 0880		

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F 0880 SS=E	Continued from page 59 Barrier, last revised November 11, 2024, failed to reveal a location that PPE should be removed and disposed of. Review of Resident 12's clinical record revealed diagnoses that included pressure ulcer (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body) and heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively). Observation of a dressing change completed by Employee 6 on January 29, 2025, at 9:31 AM, revealed Employee 6 completed a dressing change on Resident 12's ankle. After completing the dressing change, Employee 6 gathered up the garbage from the supplies used, including the bandage that was removed from Resident 12's ankle and the gauze that was used to clean the pressure ulcer on her ankle, and placed them into a biohazard garbage bag. Employee 6 then sat that garbage bag on Resident 12's bedside table. Employee 6 finished gathering her supplies and exited Resident	F 0880		

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F 0880 SS=E	Continued from page 60 12's room and disposed of the garbage in the appropriate receptacle. At no time did Employee 6 cleanse Resident 12's bedside table after sitting the garbage bag filled with biohazard garbage on it. Interview with the NHA on January 29, 2025, at 1:15 PM, revealed that her expectation would be that the Employee would have cleansed the bedside table after it was contaminated. Review of Resident 37's clinical record on January 27, 2025, revealed diagnoses that included stage three pressure ulcer of the sacrum (wound that extends below the tissue of the skin caused by pressure over a bony prominence) and congestive heart failure (decreased ability of the heart to pump blood throughout the body). Further review of Resident 37's clinical record revealed that Resident 37 was on contact precautions due to an infection with a multi-drug resistant organism (MDRO).	F 0880		

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F 0880 SS=E	Continued from page 61 During wound dressing observations on January 29, 2025, at approximately 10:25 AM, Employee 15 (Licensed Practical Nurse) was observed preparing Resident 37 for the wound dressing change on Resident 37's sacral area. Employee 15 was assisted with repositioning the Resident, including handling Resident 37's foley catheter bag. During the dressing change observation, Employee 15 was observed placing Resident 37's foley catheter bag on the Resident's bed during repositioning. After Resident 37 was repositioned, Employee 19 handled Resident 37's foley catheter bag and hung it on the bed frame. Employee 15 then placed a red biohazard bag onto the Resident's bed in the approximate same location that the foley bag was placed earlier. After the dressing change, Employee 15 and Employee 19 exited the room while wearing gown and gloves (personal protective equipment utilized while providing care to Resident 37). Employee 15 was observed holding the red biohazard bag with	F 0880		

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F 0880 SS=E	Continued from page 62 her gloved hand. Both Employee 15 and 19 removed the gloves and gowns while in the hallway. Employee 15 was then observed handling the red biohazard bag with her bare hand. Employee 15 was then observed walking through the hall of the Evan unit to the nurses' station while holding the red bag. Employee 15 then retrieved a key attached to a piece of metal from the wall at the nurses' station. Employee 15 was then observed opening a utility closet, unlocking a freezer, and placing the red biohazard bag into the freezer, after which Employee 15 exited the room and returned the key to it's hanging apparatus on the wall at the nurses' station. Finally, Employee 15 washed her hands with soap and water at the nurses' station. During a staff interview directly after the observation, Employee 15 was asked if she knew when the key she had utilized was last cleaned. Employee 15 responded that she did not know. When asked if the key is ever cleaned, Employee 15 responded that she did not know.	F 0880		

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F 0880 SS=E	Continued from page 63 Interview with the NHA on January 29, 2025, at approximately 1:00 PM, the NHA again confirmed that staff should be removing gown and gloves while in the room, placing them in a bag and then exiting the room to dispose of the gown and gloves in the disposal bin outside of the resident room. During a staff interview on January 30, 2025, at approximately 10:15 AM, the NHA agreed that the observation of Employee 15 transporting the red biohazard bag with her bare hand and touching other surfaces during that time was an infection control concern. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0880		

Pennsylvania Department of Health

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P 5640		P 5640		

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

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P 5640	Continued from page 1 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	There has been no negative effect on residents due to nursing hours <3.20 Staffing hours have been evaluated for future schedules to ensure compliance with State Regulation of a minimum of 3.20 hours of direct care for each resident daily. RN Nursing Supervisors have been educated on staffing requirements. A policy has been developed to ensure minimum staffing requirements are met to the best of the facilities ability via communication with current staff and staffing agencies in the event of terminations, resignations, call-offs and failure of staff to report to work, resulting in staffing levels below minimum requirements. Nursing hours will be evaluated daily by RN nursing supervisors to ensure compliance. A QA tool has been developed to review 10% of nursing hours weekly	Completion Date: **03/28/2025** Status: **APPROVED** Date: **02/13/2025**

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P 5640	Continued from page 2	P 5640	to ensure minimum staffing levels are met to the best of the facilities ability per policy. The Quality Assurance (QA) Coordinator or designee will complete the QA review on a weekly basis and re-educate staff not following policy and procedure. The QA Coordinator will review the completed QA tool monthly and will report any trends or patterns at the quarterly Interdisciplinary Quality Assurance and Quality Performance (QAPI) meeting. The QAPI Committee will review the reports at their quarterly meeting and make recommendations for any deficient patterns identified. They will continue to monitor quarterly until the solutions are sustained for a period of two quarters. Decreasing or elimination of this tool will occur only upon recommendation of the Interdisciplinary QAPI Committee at their quarterly meeting.	

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P 5640	Continued from page 3 Based on a review of facility staffing documentation and a staff interview, it was determined that the facility failed to meet the minimum of 3.20 hours of direct resident care for each resident for 13 days of three weeks reviewed (July 1, 4-7, 2024; October 6-8 and 12, 2024; and January 23-25 and 29, 2025). Findings include: A review of facility-submitted staffing information revealed the following dates had not met the minimum of 3.20 hours of direct resident care for each resident: July 1, 2024, the facility provided 3.09. July 4, 2024, the facility provided 3.12. July 5, 2024, the facility provided 3.06. July 6, 2024, the facility provided 3.07. July 7, 2024, the facility provided 3.07. October 6, 2024, the facility provided 3.05. October 7, 2024, the facility provided 3.10.	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395058	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REST HAVEN-YORK STATE LICENSE NUMBER: 440902	1050 S GEORGE STREET YORK, PA 17403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5640	Continued from page 4 October 8, 2024, the facility provided 3.14. October 12, 2024, the facility provided 3.13. January 23, 2025, the facility provided 3.14. January 24, 2025, the facility provided 3.01. January 25, 2025, the facility provided 3.18. January 29, 2025, the facility provided 3.15. An interview with the Nursing Home Administrator on January 30, 2025, at 10:11 AM, confirmed the facility was not meeting the minimum requirement of 3.20 hours of direct resident care on those dates.	P 5640		

Certified End Page

REST HAVEN-YORK

STATE LICENSE NUMBER: 440902

SURVEY EXIT DATE: 01/30/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY