

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
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NAME OF PROVIDER OR SUPPLIER: PLEASANT ACRES REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 118 PLEASANT ACRES ROAD YORK, PA 17402
STATE LICENSE NUMBER: 250102	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F 0000		
F 0550 SS=E	Based on a Medicare/Medicaid Recertification, State Licensure ,Civil Rights and Abbreviated Complaint survey completed on March 20, 2025, it was determined that Pleasant Acres Rehabilitation and Nursing Center 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 0550		

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 0550 SS=E	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Resident 75 had a bra put on once identified. Employee 10 was educated on the "Proper use of earbud and phone in resident care areas" for speaking on the phone in residents' 150 room. Employee 13 was educated on providing privacy while performing examinations on all residents including 180 and 310. Staff were educated on the "Proper use of earbud and phone in resident care areas" due to concerns by resident 195. 2. To identify other residents that have the potential to be affected, the NHA/designee completed an observational audit on all floors to ensure staff are not using their phones or earbuds in resident care areas, to ensure female residents are dressed appropriately and to ensure	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

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F 0550 SS=E	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	physicians are providing privacy when examining residents. 3. Staff will be educated by staff development/designee on the facility "Cellphone Policy". Staff will be educated on dignity and residents rights in regards to residents dressing appropriately. Physicians will be educated by staff development/designee on dignity and resident rights in regards to providing privacy to residents while performing examinations. 4. The NHA/designee will conduct an observational audit 2x a week for 4 weeks on all floors on female residents to ensure they are dressed appropriately and dignified, that staff are not using cellphones and earbuds in resident care areas and lastly to ensure physicians are providing privacy when performing examinations on residents. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed.	

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F 0550 SS=E	Continued from page 3 Based on review of facility policy, clinical record review, observations, and interviews with staff and residents, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for five of 41 residents reviewed (Residents 75, 150, 180, 195, and 310). Findings include: Review of the facility policy, titled "Dignity and Respect" with a last reviewed and revised date of April 2024, revealed, "Residents shall be treated with dignity and respect at all times...Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." Review of Resident 75's clinical record revealed diagnoses that included Alzheimer's disease with early onset and secondary parkinsonism (different conditions that can cause movement symptoms similar to those associated with Parkinson's disease	F 0550		

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F 0550 SS=E	Continued from page 4 including tremor, slowed movements, and stiffness). Observation of Resident 75 on March 18, 2025, at 1:01 PM, revealed her independently ambulating around the nursing unit. Resident 75 was observed wearing a shirt made of thin fabric with no bra, which exposed her breasts underneath. During an immediate interview with Employee 14 (Nurse Aide) she revealed that Resident 75 does wear bras, and took Resident 75 back to her room to put one on. A follow-up observation of Resident 75, at 1:34 PM, revealed she was wearing the same shirt, with a bra, making her breasts no longer visible through her shirt. Review of Resident 75's upper body dressing task documentation for that morning revealed that it was documented at 10:00 AM that she was fully dependent on staff for that activity.	F 0550		

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F 0550 SS=E	Continued from page 5 Review of Resident 75's care plan failed to reveal a preference for not wearing undergarments. During an interview with the Director of Nursing (DON) on March 20, 2025, at 10:13 AM, she stated that another staff member had just noticed the concern with Resident 75 and was planning to address it when Employee 14 took Resident 75 to her room to redress her. Observation of Resident 150 on March 17, 2025, at 10:01 AM, revealed Resident 150 lying in bed. Employee 10 (Housekeeper) entered the room to sweep the floor while talking on her cell phone, via an in-ear device. Resident 150 attempted to ask Employee 10 if she was going to sweep the bathroom also, to which Employee 10 motioned for Resident 150 to stop talking and then told Resident 150, "I'm on the phone with my grandma." An interview with Resident 195 on March 17, 2025, at 10:34 AM, revealed that staff members often answer his call bell while talking on the phone	F 0550		

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F 0550 SS=E	Continued from page 6 via an in-ear device and he finds it very disrespectful. An interview with Nursing Home Administrator on March 18, 2025, at 1:15 PM, revealed that he would expect staff members to treat residents with dignity and respect. Review of Resident 180's clinical record revealed diagnoses that included dementia with behavioral disturbance (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and unspecified psychosis (abnormal condition of the mind that involves a loss of contact with reality). Review of Resident 310's clinical record revealed diagnoses that included Alzheimer's disease (gradually progressive brain disorder that causes problems with memory, thinking and behavior) and anxiety disorder (mental disorder characterized by feelings of worry about future events and/or fear in reaction to current events).	F 0550		

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F 0550 SS=E	Continued from page 7 Observation on March 17, 2025, at approximately 12:10 PM, revealed Residents 180 and 310 sitting in the dementia care unit dining room during meal service; other residents were present and eating their meals. Employee 13 (Physician) approached Residents 180 and 310, placed his stethoscope on their chests, and asked them questions about their health status. Employee 13 was not observed asking Resident 180 or 310 for permission to examine them in a common area with other residents present. During an interview with the DON on March 20, 2025, at 10:13 AM, she revealed the expectation that residents would be provided privacy during examinations. 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0550		

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F 0584 SS=E	<p>Continued from page 9</p> <p>483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment</p> <p>§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.</p> <p>The facility must provide-</p> <p>§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.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all</p>	F 0584	<p>This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies.</p> <p>1. Resident 338 had her fan cleaned of all dark grey fuzzy substances. M1 TV Room had all chairs cleaned so all spill stains and any debris on cushions and frames were removed. Three chairs were also removed off the unit because the cushions were cracked or ripped. Resident 178 had her medical pump and pole removed from the room and the feet of the pole was cleaned. M1 Dining Room chairs were cleaned and are free of any spills, stains and debris from the cushions and the frames. Resident 178 wheelchair was cleaned and is free of any dried food and debris. Resident 47 wheelchair was cleaned and is free of any dried food and debris. Resident 120 floor in their room was cleaned from dust/grit and is now free of any dark</p>	<p>Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025</p>

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F 0584 SS=E	Continued from page 10 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	build up on the edges of the walls and furniture. Resident 327 dresser had all labels removed from the drawers that did not bear the name of the resident. 2. To identify other residents that have the potential to be affected, the NHA/designee completed an observational audit on all floors to ensure the following: a. TV and Dining Room chairs are free from cracks and tears as well as to ensure the chair cushions and frames are free of spills, stains or debris. b. Resident floors are free of dust and grit and that wall edges and furniture is free of dark spots. c. Resident rooms do not have unused medical poles in them and that the medical pole are clean. d. Resident wheelchairs are free of dried food and debris. e. Resident dressers are free of any labels that are not of the residents in the room. f. Resident personal fans are free of any fuzzy substances. 3. Staff will be educated by staff	

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F 0584 SS=E	Continued from page 11	F 0584	<p>development/ designee on a clean and safe environment, wheel chair cleaning, general housekeeping and medical equipment cleaning.</p> <p>4. The NHA/designee will conduct an observational audit on a random floor for 1x a week for five weeks to ensure:</p> <ul style="list-style-type: none"> a. Resident fans are cleaned b. Chairs are clean and not damaged in the TV lounges and dining rooms c. That resident wheelchairs are cleaned of any dried food and debris d. Medical equipment that is not used is removed from room and clean e. Resident dressers do not have old resident labels on them and lastly to ensure resident floors are clean of any dust and debris as well as any dark spots on the wall edges and furniture. <p>Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed.</p>	

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F 0584 SS=E	Continued from page 12 Based on observations and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, and home-like interior on two of five nursing units (Main 1 and fifth floor nursing units). Findings include: Observation in Resident 338's room on March 17, 2025, at 10:47 AM, revealed the black plastic fan on nightstand contained a dark grey fuzzy substance. Observation on March 20, 2025, at 10:31 AM, revealed the dark grey substance remained on the black plastic fan on the nightstand. During an interview with Employee 11 (Nurse Aide) on March 20, 2025, at 10:50 AM, it was revealed that she was aware of the dirty fan in Resident 338's room. It was also revealed that she told Employee 12 (Housekeeper) about it two days ago and requested that it be cleaned.	F 0584		

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F 0584 SS=E	Continued from page 13 Employee 12 was on the unit and Employee 11 asked her to clean Resident 338's. Employee 12 responded that she wasn't allowed to clean the fan. At 11:05 AM, Employee 12 was observed with Resident 338's fan entering the housekeeping closet. During an interview with Employee 1 (Assistant Nursing Home Administrator) it was revealed that housekeeping should've cleaned the fan when it was observed to be dirty. Observation on March 17, 2025, at 9:39 AM, in the Main 1 (locked dementia care unit) TV lounge revealed multiple chairs with dried liquid spills and other debris on the cushions and/or frames. Additionally, approximately three chairs were observed to have cracked or ripped cushions. Observations on March 17, 2025, at 9:53 AM; on March 18, 2025, at 9:41 AM; and on March 19, 2025, at 12:45 PM, in Resident 178's room revealed a medical pump and pole. The feet of the pole were covered in a dried liquid substance.	F 0584		

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F 0584 SS=E	Continued from page 14 Review of Resident 178's Medication Administration Record (MAR - form used to document physician orders as well as when and how medications are administered to a resident) revealed orders for intravenous hydration, which ended on March 14, 2025. Observations on March 17, 2025, at 10:00 AM, and on March 19, 2025, at 9:47 AM, in the Main 1 dining room revealed several chairs with dried liquid spills and other debris on the cushions and/or frames. Observation on March 17, 2025, at 12:14 PM, and on March 19, 2025, at 12:46 PM, revealed Resident 178's wheelchair had an accumulation of dried food and debris on the seat and arm rests. Observation on March 17, 2025, at 12:14 PM, and on March 19, 2025, at 12:52 PM, revealed 47's wheelchair had an accumulation of dried food and debris on the seat and frame.	F 0584		

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F 0584 SS=E	Continued from page 15 Observation of Resident 120's bedroom floor on March 18, 2025, at 9:46 AM, revealed it felt dusty/gritty and had a dark buildup around the edges of the walls and furniture. Observation on March 18, 2025, at 12:50 PM, in Resident 327's room revealed that each drawer of a dresser next to his bed was labeled with a resident's name. The names on the labels did not match any resident residing in that room. During an interview with the ANHA on March 20, 2025, at 10:16 AM, she revealed the expectation that Resident 47 and 178's wheelchair should have been clean, and that she was looking into the last time this had been done. During an interview with the Director of Nursing on March 20, 2025, at 10:17 AM, she acknowledged the concern with the pump and pole in Resident 178's room and confirmed that the pole had been removed and cleaned.	F 0584		

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F 0584 SS=E	Continued from page 16 During an interview with the Nursing Home Administrator on March 20, 2025, at 10:22 AM, he revealed the expectation that the chairs on Main 1 should be clean and in good condition. He also confirmed that the labels should not have been present on Resident 327's dresser, and that Resident 120's floor needed to be cleaned. 28 Pa. Code 201.18(e)(1)(2.1) Management	F 0584		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 17 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Resident 21 MDS was corrected to reflect resident was receiving hospice services. Resident 259 MDS was corrected to reflect that the physician did document the gradual dose reduction was contradicted for the Seroquel ordered September 25th, 2024. Resident 351 MDS was corrected that showed the resident discharged from the facility AMA. 2. To identify other residents that have the potential to be affected, the NHA/designee conducted an audit on hospice residents to ensure MDS is properly coded. The NHA/designee will conduct an audit on residents with gradual dose reductions in past 30 days to ensure MDS is coded properly for physician responses. The NHA/designee conducted an audit on the past 30	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

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F 0641 SS=D	Continued from page 18	F 0641	<p>days of discharges to ensure the MDS is coded properly.</p> <p>3. MDS staff will be educated by staff development/ designee on the importance of accurately completing MDS assessments and documentation.</p> <p>4. The NHA/designee will conduct an audit 1x a week for 4 weeks to ensure on residents on hospice services to ensure the MDS is coded properly. The NHA/designee will conduct an audit 1x a month for 3 months to ensure gradual dose reductions are coded properly based on physician documentation. The NHA/designee will conduct an audit 1x a week for 4 weeks on residents that discharge to ensure their MDS is coded properly on where they discharged. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed.</p>	

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F 0641 SS=D	Continued from page 19 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 41 residents reviewed (Residents 21, 259, and 351). Findings Include: Review of Resident 21's clinical record revealed diagnoses that include anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to brain cell death and potential long-term impairments) and gastro-esophageal reflux disease (a chronic condition where stomach contents flow back up into the esophagus, causing irritation and various symptoms). Review of Resident 21's Significant change MDS (Minimum Data Set is part of federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated December 19, 2024, revealed in Section O0110. Special Treatments, Procedures, and Programs, that	F 0641		

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F 0641 SS=D	Continued from page 20 Resident 21 has not been treated for in the previous 14 days while a resident. Review of Resident 21's physician's orders revealed an order from December 11, 2024, to admit Resident 21 to hospice services. Review of Resident 21's care plan revealed a care plan with a date initiated of December 12, 2024, with a focus area of, "I have been admitted to hospice related to end stage disease process." Interview with the Nursing Home Administrator (NHA) on March 20, 2025, at 8:58 AM, revealed that Resident 21's MDS completed on December 19, 2024, was marked in error and that Resident 21 had been receiving hospice services at that time. Review of Resident 259's clinical record revealed diagnoses that included dementia with behavioral disturbance (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and major	F 0641		

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F 0641 SS=D	Continued from page 21 depressive disorder (mental disorder characterized by at least two weeks of low mood that is present across most situations). Further review of Resident 259's clinical record revealed that, in response to a pharmacy recommendation, the physician documented on September 25, 2024, that a gradual dose reduction of her Seroquel (antipsychotic) medication was contraindicated because the benefits outweighed the risks. Review of Resident 259's December 5, 2024, quarterly MDS revealed that it was coded to indicate that the physician had not documented that a gradual dose reduction of her antipsychotic medication was contraindicated. During an interview with Employee 15 (Registered Nurse Assessment Coordinator) on March 20, 2025, at 9:36 AM, she confirmed that Resident 259's assessment should have captured the date that the physician documented that a gradual dose	F 0641		

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F 0641 SS=D	Continued from page 22 reduction of the antipsychotic was contraindicated. During an interview with the Assistant NHA on March 20, 2025, at 10:11 AM, she confirmed that she was aware that Resident 259's MDS was coded in error. Review of Resident 351's clinical record revealed diagnoses that included dementia and cirrhosis of liver (a chronic liver disease characterized by the replacement of healthy liver tissue with scar tissue, which can lead to liver failure and other complications). Review of Resident 351's clinical record revealed a progress note dated December 20, 2024, at 3:16 PM, indicating Resident 351 left AMA (against medical advice) with her daughter and returned to her home in the community. Review of Resident 351's discharge MDS dated December 20, 2024, revealed that Section A2105. Discharge Status was marked that Resident 351	F 0641		

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F 0641 SS=D	Continued from page 23 was discharged to a short-term general hospital (acute hospital). During an interview with the NHA on March 20, 2025, confirmed that Resident 351 did leave the facility AMA and returned home, and revealed the discharge MDS dated December 20, 2024, was marked inaccurately and should have reflected that Resident 351 was discharged to home instead, and that a modification has been made. 28 Pa Code 211.12 (d)(3)(5) Nursing Services	F 0641		
F 0656 SS=E		F 0656		

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F 0656 SS=E	Continued from page 24 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Resident 144's care plan was updated with a dementia diagnosis. Resident 161's current physician orders and care plan have been updated for enabler bars. Resident 221's care plan has been updated for having bilateral enabler bars. Resident 265's care plan has been updated to include a vision care plan. 2. To identify other residents that have the potential to be affected, the DON/designee completed an audit on residents with enabler bars to ensure residents have current orders and care plans in place. The DON/designee completed an audit on residents with a vision diagnosis to ensure they have a vision care plan. The DON/designee completed an audit on residents who have a	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

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F 0656 SS=E	Continued from page 25 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	dementia diagnosis have an accompanying care plan for dementia. 3. Nursing staff and social service staff will be educated by staff development/designee on developing/implementing comprehensive care plans. 4. The DON/designee will conduct an audit 1x a week for 4 weeks on new admissions and current residents that have a dementia diagnosis, ordered enabler bars and a vision diagnosis to ensure they have a care plan developed/implemented for dementia, enabler bars and vision. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed.	

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F 0656 SS=E	Continued from page 26 Based on clinical record review, observation, and resident and staff interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan for four of 41 records reviewed (Residents 144, 161, 221, and 265). Findings include: A review of Resident 144's clinical record revealed diagnoses that included dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) and anxiety disorder (a group of mental health conditions characterized by excessive and persistent fear or worry, significantly impacting daily life and functioning). A review of Resident 144's care plan dated March 2025 failed to reveal a care plan for the diagnosis of dementia. During an interview with the Director of Nursing (DON) on March 19, 2025, the DON thought that	F 0656		

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F 0656 SS=E	Continued from page 27 his care plan for traumatic brain injury and cerebrovascular accident was adequate. A dementia care plan for Resident 144 was developed on March 19, 2025, and presented to the surveyor. Review of Resident 161's clinical record revealed diagnoses that included cerebral vascular accident (aka stroke- damage to the brain from interruption of its blood supply) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Observation of Resident 161 on March 18, 2025, revealed the presence of bilateral enabler bars attached to his bed. Review of Resident 161's current physicians orders and care plan failed to reveal the Resident had enabler bars. Further review revealed the physician orders and	F 0656		

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F 0656 SS=E	Continued from page 28 care plan were not updated to include the enabler bars after the Resident returned from the hospital on October 26, 2024. The Director of Nursing (DON) was able to show that maintenance has been documenting safety checks on the enabler bars. During an interview with the DON on March 19, 2025, at 9:30 AM, the DON was able to reveal that Resident 161 was assessed and ordered enabler bars prior to his hospitalization on October 25, 2024, and agreed that the current care plan and physician orders should reflect enabler bars are being utilized by Resident 161. A review of Resident 221's clinical record revealed diagnoses that included heart failure (sometimes called congestive heart failure, which means the heart can't pump enough blood to meet the body's needs, often due to a weakened or stiff heart muscle) and a history of falls. An observation in Resident 221's room on March 17, 2025, at 11:01 AM, revealed enabler bars	F 0656		

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F 0656 SS=E	Continued from page 29 attached to both sides of the bed. Review of Resident 221's interdisciplinary plan of care revealed none developed regarding the use of the bilateral enabler bars. An interview with the DON on March 19, 2025, at 12:54 PM, revealed an enabler bars care plan has now been developed and added to Resident 221's interdisciplinary plan of care. A review of Resident 265's clinical record revealed diagnoses that included impaired visual function. An observation and interview with Resident 265 on March 17, 2025, at 11:55 AM, revealed her eyes to appear bloody and red. The interview revealed she received eye injections for macular edema (a condition where fluid accumulates in the macula, the central part of the retina responsible for sharp, central vision). Review of Resident 265's interdisciplinary plan of	F 0656		

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F 0656 SS=E	Continued from page 30 care revealed none developed to address any visual function, diagnoses, or treatment by the ophthalmologist. An interview with the Assistant Nursing Home Administrator on March 19, 2025, at 10:32 AM, confirmed a vision care plan has now been developed and added to Resident 265's interdisciplinary plan of care. 28 Pa. Code 211.10(c) Resident care policies	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 31 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Resident 161's care plan was updated to reflect residents choice to be a DNR. Residents 327's care plan was updated to reflect the information on the loop recorder monitor as well as the ordered care for the loop recorder implant. 2. To identify other residents that have the potential to be affected, the DON/designee conducted an audit on resident care plans to ensure they match the residents code status. The DON/designee conducted an audit on residents with a cardiac monitor device to ensure they have a care plan that includes the information on the device and the proper care/monitoring it requires. 3. Nursing staff and social service staff will be educated by staff development/designee on care plan	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
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F 0657 SS=D	Continued from page 32	F 0657	<p>revisions, updating code statuses in the care plan and implementing care plans on cardiac monitoring devices.</p> <p>4. The DON/designee will conduct an audit 1x a week for 4 weeks on new admissions and any residents that updated their code status to ensure their care plan reflects their code status. The DON/designee will conduct an audit 1x a week for 4 weeks on new admissions that have a cardiac monitoring device to ensure their care plan identifies the device as well as the information how to care/monitor the device. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
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F 0657 SS=D	Continued from page 33 Based on observations, clinical record review, and staff interviews, it was determined that the facility failed to review and revise the resident's care plan to reflect the resident's current status for two of 41 residents reviewed (Residents 161 and 327). Findings include: Review of Resident 161's clinical record revealed diagnoses that included cerebral vascular accident and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of Resident 161's POLST (Pennsylvania orders for Life-Sustaining Treatment) and advance directive (a form to make health care decisions for the individual if the individual loses the capacity to make health care decision) on March 19, 2025, revealed the Resident desired his code status be do not resuscitate (DNR). Review of Resident 161's March 2025 physician	F 0657		

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F 0657 SS=D	Continued from page 34 orders revealed the Resident desired his code status DNR. A review of Resident 161's care plan dated March 2025 stated, "wants to be full code." With a created date of September 30, 2024. A review of the progress notes revealed that code status was clarified to be DNR status on October 3, 2024, but the care plan was never corrected. Interview with the DON on March 19, 2025, at 10:30 AM, revealed the care plan should have matched Resident 161's physician orders, POLST and advance directive code status. Review of Resident 327's clinical record revealed diagnoses that included presence of a cardiac implant and atrial septal defect (abnormal hole in the wall between the two upper chambers of the heart). Review of Resident 327's physicians orders revealed an order to ensure each shift that the loop	F 0657		

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F 0657 SS=D	Continued from page 35 recorder monitor (small device implanted under the skin of the chest to continuously monitor and record the heart's electrical activity) was attached to the nightstand and was plugged in starting February 21, 2025. Review also revealed an order for quarterly remote loop recorder monitoring, starting February 21, 2025. Observation on March 18, 2025, at 12:40 PM, revealed that the loop recorder monitor was present on Resident 327's nightstand. Review of Resident 327's current care plan failed to reveal any information regarding the presence or care of his loop recorder implant. During an interview with the DON on March 20, 2025, at 10:22 AM, she revealed the expectation that this information should have been included on Resident 327's care plan. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0657		

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F 0658 SS=D		F 0658		

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F 0658 SS=D	Continued from page 37 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Resident 144's orders were changed after contacting the physician to administer medications through gastrostomy tube 2. To identify other residents that have the potential to be affected, the DON/designee conducted an audit on NPO residents to ensure physician orders are accurate for the method the resident is administered their medications. 3. Licensed staff will be educated by staff development/designee on accurately entering orders into the EMAR and medication administration 4. The DON/designee will conduct an audit 1x a week for 4 weeks on new admitting NPO residents and any new medication orders for NPO residents to ensure the physician	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
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F 0658 SS=D	Continued from page 38	F 0658	orders are correct in regards to the method the medication is administered to the resident. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
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F 0658 SS=D	Continued from page 39 Based on staff interviews, record review, and the facility's licensed staff scope of practice, it was determined that the facility failed to follow professional standards of practice when transcribing orders and administering medications to one of 41 residents reviewed (Resident 144). Findings include: Review of the Pennsylvania Nursing Practice Act for Licensed Practical Nurses (LPN), Chapter 21.145. revealed Functions of the LPN. (a) The LPN is prepared to function as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, experience in nursing and competency. The LPN participates in the planning, implementation and evaluation of nursing care using focused assessment in settings where nursing takes place. (1) An LPN shall communicate with a licensed professional nurse and patient's healthcare team members to seek guidance when the patient's care needs exceed the licensed practical nursing scope of practice.	F 0658		

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F 0658 SS=D	Continued from page 40 Review of the clinical record for Resident 144 revealed diagnoses that included dysphagia following nontraumatic subarachnoid hemorrhage (bleeding into the subarachnoid space of the brain) and gastrostomy tube status (a surgically created opening in the stomach through which a tube can be inserted for feeding and administering medications). Review of Resident 144's physician orders dated March 2025 NPO (Nothing by Mouth) diet, NPO texture, NPO consistency, effective September 26, 2024. On October 18, 2024, a physician order was written to "allow patient to have ~6 ice cubes x3 daily w/ staff/family supervision for pleasure every 24 hours as needed." During an interview on March 19, 2025, with Employee 18 (Speech-Language-Therapist), Employee 18 revealed that Resident 144 was evaluated and approved for ice chips to decrease	F 0658		

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F 0658 SS=D	Continued from page 41 atrophy of his swallowing mechanism and confirmed that all nutrition and medications are administered via his gastrostomy tube. Review of Resident 144's physician orders revealed several medications had a route ordered to administer PO (per os) indicating to administer by mouth, that included; "Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for Elevated Temperature Give 2 tablets (650 mg) by mouth every 6 hours as needed for elevated temperature >100.5 *Do not exceed 3 gms acetaminophen in 24 hours* Pharmacy Active 12/18/2024 03:31" "Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth two times a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE 3/20/25 10:42 AM"	F 0658		

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F 0658 SS=D	Continued from page 42 "Lorazepam 0.5 mg 1 tablet PO two times a day effective 10/27/2024 " Further review of the MAR (medication administration record) revealed that the orders were transcribed PO and staff were signing off as administered PO. During an interview on March 19, 2025, with Employee 19 (Licensed practical Nurse), Employee 19 informed the surveyor she was fully aware that Resident 144 had a gastrostomy tube, and that all medications are administered via the gastrostomy tube. During an interview with the Director of Nursing (DON) on March 20, 2025, at 10:30 AM, the DON informed the surveyor that all medication nurses provided statements that they are aware of the gastrostomy status for Resident 144 and administer all medications via the gastrostomy tube. The DON confirmed that the orders should have stipulated the gastrostomy route for administrations,	F 0658		

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F 0658 SS=D	Continued from page 43 and that staff should have contacted the physician to correct the ordered route of administration on the orders. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0658		
F 0677 SS=D		F 0677		

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F 0677 SS=D	Continued from page 44 483.24(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	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Resident 120's feet were cleaned and ADL care was provided. 2. To identify other residents that have the potential to be affected, the DON/designee will audit residents that are care planned for removing footwear/walking barefoot and check their feet for black soiling. 3. Staff will be educated by staff development/designee on providing ADL care and providing podiatry care 4. The DON/designee will conduct an audit 1x a week for 4 weeks on new admissions and residents with an updated care plan that has a focuses on self-care deficit in regards to removing footwear/walking barefoot to ensure ADL care is provided to their feet and no black soiling is present.	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

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F 0677 SS=D	Continued from page 45	F 0677	Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025	
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F 0677 SS=D	Continued from page 46 Based on observation, clinical record review, and staff interviews, it was determined that the facility failed to maintain adequate personal hygiene and grooming of residents dependent on staff for assistance with these activities of daily living for one of 41 residents reviewed (Resident 120). Findings include: Review of Resident 120's clinical record revealed diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and muscle weakness. Review of Resident 120's care plan revealed that she was a self care deficit and required assistance with most activities of daily living. Further review revealed that she removes her footwear and walks barefoot. Observation of Resident 120 on March 18, 2025, at 9:42 AM, revealed her asleep in bed. Her feet	F 0677		

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F 0677 SS=D	Continued from page 47 were exposed, and she was barefoot. A significant accumulation of dark black soiling was present on the soles of her feet. Observation of the floor in Resident 120's room revealed it felt dusty/gritty and had a dark buildup around the edges of the walls and furniture. During an immediate interview with Employee 16 (Nurse Aide) she confirmed that Resident 120 liked to go barefoot and, therefore, should have her feet washed daily. During an interview with the Director of Nursing on March 20, 2025, at 10:23 AM, she confirmed that Resident 120 does like to disrobe, independently ambulates, and staff wash her feet as needed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0677		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 48 483.25 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	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Resident 121's physician was notified of the MAR blanks from January 19th, 2025 for the following medications: Lantus 15 units, Lantus 46 units, Levothyroxine Sodium, Melatonin 3 Milligrams, Acetaminophen 325 Milligrams. Resident 121's physician was also notified of the MAR blank on January 19th, 2025 in regards to monitoring blood sugar levels before bedtime. Resident 221's physician was notified of catheter care not documented on the TAR from the following shifts and dates: Evening shift of January 5th, 2025, day and night shift on January 9th, 2025, day shift on January 14th, 2025, evening shift of January 31st, 2025, evening	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
NAME OF PROVIDER OR SUPPLIER: PLEASANT ACRES REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 PLEASANT ACRES ROAD YORK, PA 17402		
STATE LICENSE NUMBER: 250102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 49	F 0684	<p>shift of February 1st, 2025, day shift on February 5th, 2025, evening shift on February 14th, 2025, evening shift on February 15th, 2025 and evening shift on February 16th, 2025.</p> <p>Resident 221's physician was also notified of irrigation of the Foley was not documented on the TAR for the following shifts and dates: Evening shift on February 1st, 2025, day shift of February 5th, 2025, evening shift on February 14th, 2025, evening shift on February 15th, 2025 and evening shift on February 16th, 2025.</p> <p>Resident 338's physician was notified of the MAR blanks from January 19th, 2025 for the following medications: Atorvastatin Calcium 40MG, Melatonin Oral Tablet 3 MG, Ativan .5 MG, Baclofen Oral Tablet 10MG and Insulin Lispro.</p> <p>2. To identify other residents that have the potential to be affected, the DON/designee will audit January 19th, 2025 MARs for residents that were assigned to the same nurse and/or nurses who were assigned to</p>	

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F 0684 SS=D	Continued from page 50	F 0684	<p>resident 121 and to resident 338 on that day. The DON/designee will audit MAR's and TAR's of residents that have a catheter to ensure catheter care and irrigation of their Foleys are being documented on.</p> <p>3. Licensed and certified staff will be educated by staff development/designee on the importance of following physician orders in regards to medication administration, providing catheter care/Foley irrigation</p> <p>4. The DON/designee will conduct an audit 1x a week for 4 weeks on residents MARs to ensure there is no blanks on medication administration and blood sugar monitoring. The DON/designee will conduct an audit 1x a week for 4 weeks on residents with a catheter that catheter care is documented in the TAR and foley irrigation is documented in the TAR. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed</p>	

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F 0684 SS=D	Continued from page 51 Based on facility policy, review of the clinical records, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with physician orders for three of 41 residents reviewed (Residents 121, 221, and 338). Findings include: Review of facility policy, Medication Administration/Disposition, last revised September 6, 2023, read, in part, medications shall be administered in a safe and timely manner, and as prescribed by the physician. Medications must be administered within one hour of their prescribed time. The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method or rout of administration before giving the medication. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and use the corresponding code on the Medication	F 0684		

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F 0684 SS=D	Continued from page 52 Administration Record (MAR - an electronic record of medication administration) to indicate the medication was not given and the reason for not administering. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Review of Resident 121's clinical record documented diagnoses that included bipolar (a mental health condition alternating periods of elation and depression), schizoaffective disorder (mental disorder involving a breakdown in the relation between thought, emotion, and behavior leading to faulty perception, inappropriate actions and feelings, affects a person's ability to think, feel, and behave clearly), cognitive communication deficit (difficulties in communication stemming from impairments in cognitive process), diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), and hypothyroidism (the thyroid	F 0684		

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F 0684 SS=D	Continued from page 53 gland doesn't produce enough thyroid hormone). Review of Resident 121's January 2025 MAR revealed there was no documentation (the MAR was blank) for the following medications: Lantus (insulin glargine - long acting insulin used to treat elevated blood sugar) inject 15 units subcutaneously (under the skin), with a start date of November 15, 2024, at 6:30 AM; Lantus inject 46 units, with a start date of January 11, 2024, at 8:30 PM; Levothyroxine Sodium (medication use to treat hypothyroidism) 75 micrograms, with a start date of January 11, 2023, at 6:30 AM; Melatonin 3 milligrams for sleeplessness, with a start date November 27, 2023, at 8:30 PM; Acetaminophen Oral Tablet 325 milligrams give 2 tablets three times a day for pain, with a start date of July 19, 2023, at 8:30 PM; and Blood Sugar monitoring before meals and at bedtime, with a start date of January 10, 2023, not documented as completed at 6:30 AM and 8:30 PM.	F 0684		

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F 0684 SS=D	Continued from page 54 Review of Resident 121's progress note failed to document whether or not the aforementioned medications and blood sugar monitoring were administered/completed or rational for not following physician orders. A review of the facility's policy, titled "Catheter-Foley," recently revised May 2024, read, in part, "This policy provides the procedure to ensure the safe, sterile placement and removal of the Foley catheter. It also provides guidelines for catheter care and specimen collection from the catheter." A Foley Catheter is a device that drains urine from the urinary bladder into a collection bag outside of the body when you can't void the urine on your own. A review of Resident 221's physician orders revealed diagnoses that included hypertension (elevated blood pressure) and neuromuscular	F 0684		

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F 0684 SS=D	Continued from page 55 dysfunction of the bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should. Common symptoms include dribbling urine, loss of feeling that the bladder is full, and being unable to control urine [urinary incontinence]). A review of Resident 221's Treatment Administration Record (TAR) dated January 2025, revealed the following physician's order "Empty Foley drainage bag every shift and record output, every shift." A review of the TAR revealed the staff had not documented care to the Foley on the evening shift of January 5, 2025; the day and night shifts on January 9, 2025; the day shift on January 14, 2025; and the evening shift on January 31, 2025. A review of Resident 221's February 2025 TAR revealed the staff had not documented the Foley catheter care during the evening shift on February 1, 2025; the day shift on February 5, 2025; and the	F 0684		

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F 0684 SS=D	Continued from page 56 evening shifts on February 14, 15 and 16, 2025. Continued review of Resident 221's February 2025 TAR revealed the following physician's order "Irrigate Foley catheter with 60 mls [milliliters] of Sterile Normal Saline solution every shift for patency (the condition of being open, expanded, or unobstructed)." A review of the TAR revealed staff had not documented the irrigation of the Foley during the evening shift on February 1, 2025; the day shift of February 5, 2025; and the evening shifts on February 14 and 15, 2025. An interview with the Director of Nursing (DON), on March 20, 2025, at 10:05 AM, revealed an agreement that staff should be documenting the care to Resident 221's catheter per physician orders. Review of Resident 338's clinical record documented diagnoses that included diabetes mellitus, spinal stenosis (narrowing of the spinal	F 0684		

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F 0684 SS=D	Continued from page 57 column that causes pressure on the spinal cord), and hemiplegia left non-dominant side (paralysis or weakness on one side of the body). Review of Resident 338's January 2025 MAR failed to document the following medication were administered on the following dates: Atorvastatin Calcium (medication used to treat elevated cholesterol levels) 40 milligrams, with a start date of November 5, 2024, at 8:30 PM; Melatonin Oral Tablet 3 milligrams give 3 tablets for insomnia, with a start date of November 5, 2024, at 8:30 PM; Ativan 0.5 milligrams every 12 hours for anxiety, with a start date of November 20, 2024, at 8:30 PM; Baclofen Oral Tablet 10 milligram every 8 hours for spasms, with a start date of November 8, 2024, at 6:00 AM and 10:00 PM; and Insulin Lispro (fast acting insulin used to treat elevated blood sugar) Subcutaneous Solution Pen injector Inject as per sliding scale: if 0 - 150 milliliter/deciliter (ml/dl- unit of measure) = 0 units;	F 0684		

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F 0684 SS=D	Continued from page 58 151 - 200 ml/dl = 2 units; 201 - 250 ml/dl = 4 units; 251 - 300 ml/dl = 6 units; 301 - 350 ml/dl = 8 units; 351 - 400 ml/dl = 10 units, before meals and at bedtime, with a start date of November 5, 2024, at 8:30 PM on January 19th and 24th. Review of Resident 338's progress note failed to document whether or not the aforementioned medications were administered or rational for not following physician orders. During an interview with the DON on March 20, 2025, at 10:09 AM, it was revealed that the MAR should be completed at time of administration or at time of resident refusal. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12 (d) (5) Nursing services	F 0684		
F 0698 SS=D		F 0698		

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F 0698 SS=D	Continued from page 59 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Resident 96's physician was notified that the dry weight per physician order was not documented on Monday evening shift on January 6th, 20th and 27th, 2025. Resident 96's physician and dialysis center was notified that communication sheets were not completed on the following dates in January 2025: 1st, 3rd, 8th, 10th, 13th, 15th, 17th, 20th, 22nd, 24th, 27th, 29th and the 31st. In March 2025: 12th and 14th. 2. To identify other residents that have the potential to be affected, the DON/designee will audit dialysis residents to ensure physician orders are being followed in regards to documenting resident's dry weight. The DON/designee will also audit dialysis resident's communication	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

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F 0698 SS=D	Continued from page 60	F 0698	<p>sheets to ensure they are completed.</p> <p>3. Staff will be educated by staff development/designee on the importance of following physician orders in regards to taking dry weights. The DON/designee will contact dialysis centers and educate them on the importance of completing communication sheets. The DON/designee will educate licensed staff on contacting the dialysis center when communication sheets are not completed.</p> <p>4. The DON/designee will conduct an audit 1x a week for 4 weeks on dialysis residents to ensure their dry weights are taken per physician orders as well as audit dialysis communication sheets to ensure they are completed by the dialysis center. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed.</p>	

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F 0698 SS=D	Continued from page 61 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of two residents reviewed who received dialysis services (Resident 96). Findings Include: Review of facility policy, Dialysis Management, last revised March 28, 2024, read, in part, interchange of information necessary for the care of the resident, communication form is placed in the binder after completion of the pre dialysis assessment and sent to dialysis with the resident; dialysis center personnel to complete Dialysis communication form and return to facility; upon return the facility is to review information provided on the communication form and address as priorate; facility is to complete post-dialysis information/data and place in resident's medical record; and obtain resident's dry weigh from dialysis center, post treatment documentation.	F 0698		

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F 0698 SS=D	Continued from page 62 Review of Resident 96's clinical record documented diagnoses that included congestive heart failure (the heart doesn't pump blood as it should), diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), chronic kidney disease stage 5 (kidneys are severely damaged and unable to filter waste and fluid from the blood), bipolar disorder (a mental health condition alternating periods of elation and depression). Review of Resident 96 March 2025, physician orders included: Dialysis Monday, Wednesday, and Friday, chair time at 10:30 AM, with a start date of September 12, 2024; record post-dialysis dry weight (weight after resident dialyzed - without excess fluid) on weight tab upon return from dialysis- use dialysis scale weekly every evening shift every Monday, with a start date of November 4, 2024. Review of Resident 96's weight history and January	F 0698		

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F 0698 SS=D	Continued from page 63 2025 Medication Administration Record (documentation of medication or services per physician orders) failed to document dry weight per physician orders, Monday evening shift on January 6th, 20th, and 27th, 2025. Review of Resident 96's dialysis communication sheets revealed none were not completed for following dates in January 2025: 1st, 3rd, 8th, 10th, 13th, 15th, 17th, 20th, 22nd, 24th, 27th, 29th, and 31st. Review of Resident 96's dialysis communication sheets revealed none were not completed for following dates in March 2025: 12th and 14th. During an interview with the Director of Nursing (DON) on March 20, 2025, at 10:09 AM, it was revealed that the dialysis communication sheets should be completed, that the dialysis center has a history of not completing the post dialysis vital sign section, and that the facility had contacted the center to discuss the importance of completing the	F 0698		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0698 SS=D	Continued from page 64 communication forms. During an interview with the DON on March 20, 2025, at 11:51 AM, it was revealed the dry weight should've been obtain and documented per physician orders, and that the facility could utilize the dry weight documented on the dialysis communication form from dialysis that day. 28 Pa Code 211.5(f) Clinical records 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services	F 0698		
F 0756 SS=D		F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
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F 0756 SS=D	Continued from page 65 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Residents 90's physician has updated a rationale for not attempting a GDR on a pharmacist recommended GDR for resident 90's psychoactive medications. Resident 144's physician has updated a rationale and response for disagreeing on a pharmacist recommended GDR for resident 144's psychoactive medications. 2. To identify other residents that have the potential to be affected, the DON/designee will audit pharmacist recommended GDRs for past 30 days to ensure physicians document a response and rationale for disagreeing with GDR or not attempting the GDR. 3. Physicians will be educated by the DON/designee on the importance of providing	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
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F 0756 SS=D	Continued from page 66 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756	documentation on a rationale and a response to pharmacy recommended GDR's 4. The DON/designee will conduct an audit 1x a month for 3 months on pharmacy recommended GDR's on psychoactive medications to ensure physicians provide documentation of a response and rationale for either not attempting the GDR or disagreeing with it. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025	
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F 0756 SS=D	Continued from page 67 Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews were completed by a consultant pharmacist and responded to in a timely manner by the attending physician or prescriber for two of 41 residents reviewed (Residents 90 and 144). Findings include: Review of facility policy, titled Medication Regimen Reviews, reviewed May 2024, revealed, "4. If the Attending Physician declines or otherwise rejects the Consultant Pharmacist's non-urgent Recommendation, an explanation as to the rationale for the rejection shall be documented in the Resident's medical record." Review of Resident 90's clinical record revealed diagnoses that included schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms such as hallucinations or delusions, and symptoms of a mood disorder, such	F 0756		

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F 0756 SS=D	<p>Continued from page 68</p> <p>as mania and depression) and anxiety disorder (group of mental health conditions characterized by excessive and persistent fear or worry, significantly impacting daily life and functioning).</p> <p>Review of Resident 90's electronic medical record on revealed a review of psychoactive medications, dated December 23, 2024, in which the pharmacist recommended a GDR (gradual dose reduction) for Resident 90's psychoactive medications. The physician responded to this request by the pharmacist by disagreeing. The physician failed to include a rationale for not attempting the GDR.</p> <p>Interview with the Director of Nursing (DON) on March 20, 2025, at 10:30 AM, revealed that they do not have any documents to show that a rationale was provided by the physician for disagreeing with the GDR attempt recommendation made for Resident 90 on December 23, 2025.</p> <p>Review of Resident 144's clinical record revealed diagnoses that included depressive disorder (a</p>	F 0756		

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F 0756 SS=D	Continued from page 69 mental health condition characterized by persistent low mood, loss of interest, and other symptoms that can significantly impact daily life) and anxiety disorder. Review of Resident 144's electronic medical record revealed a review of psychoactive medications, dated August 25, 2024, in which the pharmacist recommended a GDR for Resident 144's psychoactive medications. The physician responded to this request by the pharmacist by disagreeing. The physician failed to include a rationale for not attempting the GDR and failed to date the response. Interview with the DON on March 20, 2025, at 10:40 AM, revealed that they do not have any documents to show that a rationale was provided by the physician for disagreeing with the GDR attempt recommendation made for Resident 144 on August 25, 2024. 28 Pa. Code 211.10(c) Resident care policies	F 0756		

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F 0758 SS=E	<p>483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use</p> <p>§483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the</p>	F 0758	<p>This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies.</p> <ol style="list-style-type: none"> Resident 92's physician gave an end date for the residents Lorazepam medication. To identify other residents that have the potential to be affected, the DON/designee will audit psychoactive medications ordered by resident 92's physician to ensure they have an end date. Physicians will be educated by DON/designee on the importance of including an end date on psychoactive medications The DON/designee will conduct an audit 1x a week for 4 weeks of any new admissions with psychoactive medications and current residents who receive a new order for psychoactive medications to ensure physicians ordered stop dates on these medications. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed 	<p>Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025</p>

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F 0758 SS=E	Continued from page 71 attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

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F 0758 SS=E	Continued from page 72 Based on policy review, clinical record review, and staff interview, it was determined that the facility failed to provide a rationale and duration for expending a PRN (as needed) psychotropic dedication beyond 14 days for one of 41 residents reviewed (Resident 92). Findings include: Review of facility policy, titled Psychotropic medication use, including use in dementia residents, reviewed November 1, 2024, revealed, "PRN orders for psychotropic drugs, other than antipsychotics, may not exceed 14 days. Rationale for use extending beyond the 14 days must be documented in the medical record and indicate duration of the PRN order. " Review of Resident 92's clinical record revealed diagnoses that included anxiety disorder (group of mental health conditions characterized by excessive and persistent fear or worry, significantly impacting daily life and functioning) and depression (major loss	F 0758		

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F 0758 SS=E	Continued from page 73 of interest in pleasurable activities, characterized by change in sleep patterns, appetite, and or daily routine). Review of Resident 92's physician's orders revealed an order for Lorazepam (anxiety medication) gel every 2 hours as needed for agitation/anxiety, with a start date of January 28, 2025, and no end date. Review of Resident 92's electronic medical record on revealed a review of psychoactive medications, dated February 18, 2025, in which the pharmacist recommends that the physician attempt a gradual dose reduction of psychoactive medications. The physician declined the gradual dose reduction but failed to provide a rationale for extending the PRN psychotropic medication beyond 14 days and neglected to add a stop date to the order. Interview with the Nursing Home Administrator on March 20, 2025, at 10:30 AM, revealed that the expectation is that the physician would provide a rationale and duration for PRN psychotropic	F 0758		

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F 0758 SS=E	Continued from page 74 medications extended beyond 14 days. 28 Pa. Code 211.12(d)(5) Nursing services	F 0758		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 75 483.60(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	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. The dish machine final rinse temperature was adjusted by the maintenance department and the correct log is in place to correctly record final rinse temperatures. 2. The NHA/designee will audit final rinse temperature log from March 18th, 2025 until week 1 audits begin. 3. Dietary staff has been educated by staff development/designee on dishwashing machine temperatures 4. The NHA/ designee will conduct an audit 1x a week for 4 weeks on dishwashing final rinse temperatures to ensure temperatures are at 180 degrees F or higher. Results of the audits will be reviewed at the QAPI meeting to determine if future action/audits are needed	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

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F 0812 SS=E	Continued from page 76 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards regarding the operation of the dish machine in the kitchen. Findings include: Review of facility policy, Dish Machine Temperatures, revised April 5, 2024, read, in part, dish machine final rinse temperatures should be maintained at temperature not less than those established by the Food and Drug Administration, high temperature dish machine will be no less than 180 degrees Fahrenheit (F). Observation of the dish machine on March 17, 2025, at 9:32 AM, the final rinse temperature registered 176 degrees F. Observation of the dish machine temperature log for March 1st through 17th, 2025, breakfast read, in part, the final rinse temperature was documented	F 0812		

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F 0812 SS=E	Continued from page 77 below 180 degrees F for all meals. During an interview with the Employee 8 (Food Service Director) on March 17, 2025, at 9:34 AM, it was revealed the final rinse temperature should be 180 degrees F . It was also revealed that the documented final rinse temperatures on the log were below the standard of 180 degrees F. During an interview with the Employee 1 (Assistant Nursing Home Administrator) on March 18, 2025, at 1:30 PM, it was revealed that the facility Maintenance Department repairs the dish machine, and a request was submitted to Maintenance to assess the final rinse temperature. It was also revealed that the facility utilized the incorrect temperature log and, therefore, the Dietary Department failed to submit a maintenance request to evaluate the final rinse temperature. It was confirmed that the final rinse temperature should be 180 degrees F, and that Maintenance did recalibrate the temperature for final rinse cycle. 28 Pa code 211.6(f) - Dietary Services	F 0812		

Pennsylvania Department of Health

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P 5520		P 5520		

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

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. CNA staffing ratios for dayshift were not met on December 20th, 21st and 22nd, 2024; March 15th and 16th, 2025. CNA staffing ratios for evening shifts were not met on December 20th and 21st, 2024; March 13th and 14th, 2025. CNA staffing ratios were not met on the night shift on March 16th and 17th, 2025. The facility has robust retention and recruitment activities in place. Nursing leadership did all things reasonably possible to meet the required ratios through bonuses, day off on another day, split shifts, extra day pay. All unscheduled staff were contacted and supplemental staffing were contacted to send replacement staff with little avail. Ancillary staff were available and assisted in various tasks such as call	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
NAME OF PROVIDER OR SUPPLIER: PLEASANT ACRES REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 PLEASANT ACRES ROAD YORK, PA 17402		
STATE LICENSE NUMBER: 250102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 5520	Continued from page 2	P 5520	<p>bell attendant, delivery and removal of meal trays, delivery of water, bed making and performance of other tasks within their scope of practice. There were no negative outcomes to residents. The facility will continue to ensure schedule reflects the required staffing ratios and address call offs. Staff and supplemental staffing have been reminded of the importance of them reporting to work as assigned.</p> <ol style="list-style-type: none"> 2. No residents were affected. 3. To prevent this from reoccurring, the NHA/designee completed education with the staffing coordinators on the Pennsylvania Regulation for CNA Staffing Ratios. Nursing supervisors will be educated to make phone calls to replace call offs and no shows. 4. To monitor and maintain ongoing compliance, the NHA/designee will audit 5 schedules weekly x 4 Weeks to ensure CNA ratios are being met every shift. Audit results will be reviewed with QAPI Committee meeting monthly to determine the need for further audits. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
NAME OF PROVIDER OR SUPPLIER: PLEASANT ACRES REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 PLEASANT ACRES ROAD YORK, PA 17402		
STATE LICENSE NUMBER: 250102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 5520	Continued from page 3 Based on staffing document review and staff interview, it was determined that the facility failed to ensure a required minimum of one Nurse Aide (NA) per 10 residents on the day shift for five of the 14 days reviewed (December 20, 21, and 22, 2024; March 15 and 16, 2025), one NA per 11 residents on evening shift for four of the 14 days reviewed (December 20 and 21, 2024; March 13 and 14, 2025), and one NA per 15 residents on night shift for two of seven days reviewed (March 15 and 16, 2025) as calculated by full time equivalent (FTE - Number of staff required calculated by determining the required number of hours of full-time shifts worked to meet the minimum staff to resident ratio). Findings include: A review of staffing information for the day shift of December 20, 2024, revealed a resident census of 362, which resulted in a minimum NA FTE of 36.20; submitted information revealed the facility provided 35.77.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025	
NAME OF PROVIDER OR SUPPLIER: PLEASANT ACRES REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 250102		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 PLEASANT ACRES ROAD YORK, PA 17402		
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P 5520	<p>Continued from page 4</p> <p>A review of staffing information for the day shift of December 21, 2024, revealed a resident census of 360, which resulted in a minimum NA FTE of 36.00; submitted information revealed the facility provided 34.99.</p> <p>A review of staffing information for the day shift of December 22, 2024, revealed a resident census of 357, which resulted in a minimum NA FTE of 35.70; submitted information revealed the facility provided 29.28.</p> <p>A review of staffing information for the day shift of March 15, 2025, revealed a resident census of 359, which resulted in a minimum NA FTE of 35.90; submitted information revealed the facility provided 34.38.</p> <p>A review of staffing information for the day shift of March 16, 2025, revealed a resident census of 358, which resulted in a minimum NA FTE of 35.80; submitted information revealed the facility provided 25.23.</p>	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
NAME OF PROVIDER OR SUPPLIER: PLEASANT ACRES REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 PLEASANT ACRES ROAD YORK, PA 17402		
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P 5520	Continued from page 5 A review of staffing information for the evening shift of December 20, 2024, revealed a resident census of 362, which resulted in a minimum NA FTE of 32.91; submitted information revealed the facility provided 31.74. A review of staffing information for the evening shift of December 21, 2024, revealed a resident census of 360, which resulted in a minimum NA FTE of 32.73; submitted information revealed the facility provided 31.57. A review of staffing information for the evening shift of March 13, 2025, revealed a resident census of 357, which resulted in a minimum NA FTE of 32.45; submitted information revealed the facility provided 31.97. A review of staffing information for the evening shift of March 14, 2025, revealed a resident census of 358, which resulted in a minimum NA FTE of 32.55; submitted information revealed the facility	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
NAME OF PROVIDER OR SUPPLIER: PLEASANT ACRES REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 PLEASANT ACRES ROAD YORK, PA 17402		
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P 5520	Continued from page 6 provided 32.41. A review of staffing information for the night shift of March 15, 2025, revealed a resident census of 359, which resulted in a minimum NA FTE of 23.93; submitted information revealed the facility provided 21.97. A review of staffing information for the night shift of March 16, 2025, revealed a resident census of 358, which resulted in a minimum NA FTE of 23.87; submitted information revealed the facility provided 22.00. An interview with the Nursing Home Administrator on March 20, 2025, at 9:56 AM, confirmed the facility did not meet the minimum number of the required NA FTE on those dates and shifts.	P 5520		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
NAME OF PROVIDER OR SUPPLIER: PLEASANT ACRES REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 PLEASANT ACRES ROAD YORK, PA 17402		
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P 5640	Continued from page 7 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	This provided submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrongdoing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Staffing PPD for December 20th and 21st, 2024; March 16th, 2025 were under the minimum staffing PPD of 3.20. The facility has robust retention and recruitment activities in place. Nursing leadership did all things reasonably possible to meet the required PPD through bonuses, day off on another day, split shifts, extra day pay. All unscheduled staff were contacted and supplemental staffing were contacted to send replacement staff with little avail. Ancillary staff were available and assisted in various tasks such as call bell attendant, delivery and removal of meal trays, delivery of water, bed making and performance of other tasks within their scope of practice. There were no negative outcomes to residents. The facility will continue	Completion Date: 05/06/2025 Status: APPROVED Date: 04/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2025
NAME OF PROVIDER OR SUPPLIER: PLEASANT ACRES REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 PLEASANT ACRES ROAD YORK, PA 17402		
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P 5640	Continued from page 8	P 5640	<p>to ensure schedule reflects the required PPD and address call offs. Staff and supplemental staffing have been reminded of the importance of them reporting to work as assigned.</p> <p>2. No residents were affected.</p> <p>3. To prevent this from reoccurring, the NHA/designee completed education with the staffing coordinators to schedule the staffing for 3.20 and above to maintain required PPD. Nursing supervisors will be educated to make phone calls to replace call offs and no shows.</p> <p>4. To monitor and maintain ongoing compliance, the DON/designee will audit 5 schedules weekly x 2 Weeks to ensure staffing PPD is 3.20 or above. Audit results will be reviewed with QAPI Committee meeting monthly to determine the need for further audits.</p>	

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P 5640	Continued from page 9 Based on a review of staffing information furnished by the facility and a staff interview, it was determined that the facility failed to ensure that the total number of nursing care hours provided in each 24-hour period was a minimum of 3.20 hours of direct care for each resident for three of the 14 days reviewed (December 20 and 21, 2024; and March 16, 2025). Findings Include: A review of staffing information provided by the facility from December 16 - 22, 2024, revealed the facility provided the following direct care hours for each resident: 3.15 hours on December 20, 2024; and 3.14 hours on December 21, 2024; therefore, it did not meet the state minimum of 3.20 direct care hours per resident per day. A review of staffing information provided by the facility dated March 13 - 19, 2025, revealed the facility provided 2.81 direct care hours for each resident on March 16, 2025: therefore, it did not	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/20/2025
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P 5640	Continued from page 10 meet the state minimum of 3.20 direct care hours per resident per day. An interview with the Nursing Home Administrator on March 20, 2025, at 9:56 AM, confirmed the facility did not meet the minimum number of direct care nursing hours required on those dates.	P 5640			



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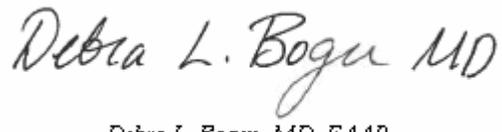
PLEASANT ACRES REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 250102

SURVEY EXIT DATE: 03/20/2025

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, 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