

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395298</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER: <b>LAKWOOD REHABILITATION &amp; HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>147 OLD NEWPORT ST NANTICOKE, PA 18634</b>
STATE LICENSE NUMBER: <b>191502</b>	

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F 0000	INITIAL COMMENT	F 0000		
F 0623 SS=D	Based on an abbreviated complaint survey and revisit survey completed on December 30, 2024, it was determined that Lakewood Rehabilitation and Healthcare Center was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0623		

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 0623  SS=D	Continued from page 1  483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. The facility has provided Resident 2/resident representative with the facility transfer notice via certified mail. 2. The facility has reviewed resident's transfers and discharges for the past 14 days to ensure the notice of transfer has been provided. 3. DON/designee will re-educate licensed nursing staff to the facility process of notifying residents/resident representatives on facility transfers. 4. DON/designee will audit random resident transfers and discharges to ensure a written notice and the reason for transfer has been provided. Audits to be completed weekly for four weeks and monthly for two months. Audits to be submitted to QAPI for review and recommendations.	Completion Date: <b>01/21/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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F 0623  SS=D	Continued from page 2  (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i) (A) of this section; or (E) A resident has not resided in the facility for 30 days.  §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623		

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F 0623  SS=D	Continued from page 3  (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.  §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.  §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).  This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623  SS=D	Continued from page 4  Based on clinical record reviews and staff interviews, it was determined the facility failed to ensure provision of a written notice for a facility-initiated transfer to the hospital. Specifically, the facility failed to provide a written notice regarding the reason for the transfer to the resident and the resident's representative in a language and manner easily understood, for one resident out of 6 residents sampled (Resident 2).  Findings include:  A review of the clinical record revealed that Resident 2 was transferred to the hospital on December 29, 2024, due to a change in mental status and had not returned to the facility as of the conclusion of the survey on December 30, 2024.  Documentation related to the transfer indicated that the transfer was facility-initiated; however, there was no evidence that a written notice was provided to the resident or the resident's representative explaining the reason for the transfer in a language	F 0623		

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F 0623  SS=D	Continued from page 5  and manner that was easily understood.  During an interview with the Nursing Home Administrator (NHA) on December 30, 2024, at approximately 2:00 PM, the NHA confirmed that no written notice was provided to the resident or the resident's representative regarding the facility-initiated transfer on December 29, 2024.  This failure to provide the required written notice deprived the resident and their representative of critical information and the opportunity to understand and respond to the facility-initiated transfer to the hospital.  28 Pa. Code 201.14(a) Responsibility of license.  28 Pa. Code 201.29 (a) Resident Rights.	F 0623		
F 0625  SS=D		F 0625		

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F 0625  SS=D	Continued from page 6  483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.  This REQUIREMENT is not met as evidenced by:	F 0625	1. The facility has provided Resident 2/resident representative with the facility bed hold policy via certified mail. 2. The facility has reviewed resident's transfers and discharges for the past 14 days to ensure the bed hold policy has been provided. 3. DON/designee will re-educate licensed nursing staff to the facility process of notifying residents/resident representatives on facility bed hold policy. 4. DON/designee will audit random resident transfers and discharges to ensure the bed hold policy was provided. Audits to be completed weekly for four weeks and monthly for two months. Audits to be submitted to QAPI for review and recommendations.	Completion Date: <b>01/21/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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F 0625  SS=D	Continued from page 7	F 0625		

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F 0625  SS=D	Continued from page 8  Based on a review of clinical records, the facility's bed-hold policy, and staff and family interviews, it was determined the facility failed to provide written notice of the specifics of the facility's bed-hold policy, including the duration and reserve bed payment policy, to a resident's representative upon the resident's transfer to the hospital for one of six sampled residents (Resident 2).  Findings include:  A review Resident 2's clinical record revealed admission to the facility on December 14, 2024. The resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the resident's attention, orientation, and ability to register and recall new information a score of 13-15 equates to being cognitively intact) and a diagnosed intellectual disability.  Resident 2 was transferred to the hospital on December 29, 2024. Interview with the resident's representative on December 30, 2024, revealed that	F 0625		

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F 0625  SS=D	<p>Continued from page 9</p> <p>while a copy of the facility's bed-hold policy was provided at admission, no written notification or explanation of the bed-hold policy, including the duration, reserve bed payment requirements, or procedures for the resident's return, was provided at the time of the hospital transfer.</p> <p>There was no documented evidence that the facility provided the resident or the representative of the resident written information about the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) at the time of transfer, or within 24 hours, detailing the duration of bed-hold, if any, and the reserve bed payment policy and addressing permitting the return of residents to the next available bed.</p> <p>The Business Office Manager (BOM), interviewed on December 30, 2024, at 2:15 PM, stated that she provides written bed-hold notifications to residents or their representatives during business hours. She indicated that nursing staff is responsible for</p>	F 0625		

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F 0625  SS=D	Continued from page 10  providing the notifications when she is unavailable. However, she acknowledged no documentation existed to confirm this process was completed for Resident 2.  The Nursing Home Administrator (NHA), interviewed on December 30, 2024, at approximately 3:00 PM, confirmed the facility failed to provide the required written notice of the bed-hold policy to Resident 2 or the resident's representative upon transfer to the hospital. The NHA stated it is the facility's standard practice to send a copy of the bed-hold policy with the resident during transfers but admitted this practice was not documented in this instance.  The failure had the potential to affect the resident's right to understand the bed-hold process, secure their bed during hospitalization, and plan for their return to the facility, potentially compromising the resident's rights and ability to plan for continuity of care.	F 0625		

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F 0625  SS=D	Continued from page 11  28 Pa. Code 201.14(a) Responsibility of licensee  28 Pa Code 201.29 (a)Resident rights	F 0625		
F 0770  SS=D	483.50(a)(1)(i) Laboratory Services  §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.  This REQUIREMENT is not met as evidenced by:	F 0770	1. Physician was immediately notified on 12/30/24 of the ordered lab not being drawn as ordered on 11/22/24. NOR for CMP to be drawn on 12/31/24. Same completed. 2. Current residents with ordered labs have been reviewed to ensure labs have been obtained per physician order and completed. 3. DON/designee will re-educate licensed nursing staff were immediately to facility process for requisitioning of physician ordered labs. 4. DON/designee will perform random audits to ensure lab protocols are being followed and reviewed in a timely matter. Audits to be conducted weekly for four weeks and monthly for two months. Audits to be completed and submitted to QAPI for review and recommendations.	Completion Date: <b>01/21/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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F 0770  SS=D	Continued from page 12  Based on clinical record review and staff interview, it was determined the facility failed to ensure timely completion of prescribed laboratory services for one resident out of six sampled (Resident 1). This failure resulted in a delay in the monitoring and management of the resident's elevated potassium levels as ordered by the prescribing practitioner.  Findings included:  Clinical record revealed that Resident 1 was admitted to the facility on November 2, 20214, with diagnoses to include diabetes, heart failure and morbid obesity.  The resident's potassium levels (K+ normal range: 3.5-5.1 mmol/L Potassium is a mineral found in the foods you eat. It ' s also an electrolyte. Electrolytes conduct electrical impulses throughout the body. They assist in a range of essential body functions, including blood pressure, normal water balance, muscle contractions, nerve impulses, digestion, and heart rhythm) were documented as follows:	F 0770		

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F 0770  SS=D	<p>Continued from page 13</p> <p>November 15, 2024: 5.4 mmol/L (elevated) November 19, 2024: 5.4 mmol/L (elevated) November 20, 2024: 5.5 mmol/L (elevated)</p> <p>On November 20, 2024, at 1:31 PM, nursing documentation revealed the facility's physician assistant reviewed the lab results and noted the elevated potassium level of 5.5 mmol/L. New orders were written for Kayexalate ( a medication used to treat a high level of potassium in the blood) to treat hyperkalemia (high potassium) and to repeat a BMP (Basic Metabolic Panel a laboratory test that measures several important aspects of the blood, like electrolytes and blood sugar) on November 22, 2024.</p> <p>A review of Resident 1's clinical record revealed no evidence the ordered BMP was collected on November 22, 2024, as prescribed.</p> <p>During an interview on December 30, 2024, at 2:00 PM, the corporate nurse confirmed that she</p>	F 0770		

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STATE LICENSE NUMBER: <b>191502</b>				
(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 0770  SS=D	Continued from page 14  contacted the hospital lab and verified that the BMP lab test was not drawn. She was unable to provide an explanation as to why the nursing staff did not follow up to ensure the BMP was completed or why there was no notification to the prescribing practitioner regarding the missed laboratory study.  There was no documented evidence that facility staff attempted to reobtain the BMP after the lab test was missed or that the prescribing practitioner was notified of the failure to complete the ordered diagnostic testing in a timely manner.  The failure to monitor and address elevated potassium levels in a timely manner poses significant risks, including the potential for cardiac arrhythmias or other complications related to hyperkalemia. The facility failed to adhere to physician orders for prescribed laboratory testing and did not implement appropriate follow-up actions to ensure the resident's care needs were met.  28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services	F 0770		

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NAME OF PROVIDER OR SUPPLIER: <b>LAKWOOD REHABILITATION &amp; HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>147 OLD NEWPORT ST NANTICOKE, PA 18634</b>		
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P 5520	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	1. The facility cannot retroactively correct nurse aide staffing ratio. 2. DON/designee will conduct an initial audit of the past two weeks' schedule to determine if nurse aide ratio is in compliance. 3. DON/designee will re-educate the scheduler on the proper nurse aide staffing ratios. The facility will hold labor meetings Monday-Friday to verify ratios are made. 4. DON/designee will conduct random audits of nurse aide staffing weekly for four weeks, then monthly for two months thereafter to verify proper nurse aide ratios. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>01/21/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395298</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/30/2024</b>	
NAME OF PROVIDER OR SUPPLIER: <b>LAKWOOD REHABILITATION &amp; HEALTHCARE CENTER</b>  STATE LICENSE NUMBER: <b>191502</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>147 OLD NEWPORT ST NANTICOKE, PA 18634</b>		
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P 5520	<p>Continued from page 1</p> <p>Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for eight shifts out of 21 reviewed.</p> <p>Findings include:</p> <p>A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum nurse aide staff of 1:10 on the day shift, 1:11 on the evening shift, and 1:15 on the night shift based on the facility's census.</p> <p>December 23, 2024 - 8.33 nurse aides on the evening shift, versus the required 9 for a census of 99.</p> <p>December 24, 2024 - 7.87 nurse aides on the evening shift, versus the required 9.09 for a census of 100.</p> <p>December 24, 2024 - 5.03 nurse aides on the night shift, versus the required 6.67 for a census of 100.</p> <p>December 25, 2024 - 9.20 nurse aides on the day</p>	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395298</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/30/2024</b>
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P 5520	Continued from page 2  shift, versus the required 10 for a census of 100. December 25, 2024 - 7.8 nurse aides on the evening shift, versus the required 9.09 for a census of 100. December 25, 2024 - 4.20 nurse aides on the night shift, versus the required 6.67 for a census of 100. December 26, 2024 - 5 nurse aides on the night shift, versus the required 6.67 for a census of 100. December 27, 2024 - 4.53 nurse aides on the night shift, versus the required 6.53 for a census of 98.  On the above dates mentioned, no additional excess higher-level staff were available to compensate this deficiency.  An interview with the Nursing Home Administrator on December 30, 2024, at approximately 2:00 PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 3  Nursing services.  (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.  This REGULATION is not met as evidenced by:	P 5530	1. The facility cannot retroactively correct LPN staffing ratio. 2. DON/designee will conduct an initial audit of the past two weeks' schedule to determine if nurse aide ratio is in compliance. 3. DON/designee will re-educate the scheduler on the proper LPN staffing ratios. The facility will hold labor meetings Monday-Friday to verify ratios are made. 4. DON/designee will conduct random audits of LPN staffing weekly for four weeks, then monthly for two months thereafter to verify proper LPN ratios. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>01/21/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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P 5530	<p>Continued from page 4</p> <p>Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse staff to resident ratio was provided on each shift for six shifts out of 21 reviewed.</p> <p>Findings include:</p> <p>A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:25 on the day shift.</p> <p>December 22, 2024 - 3.22 LPNs on the day shift, versus the required 4 for a census of 100. December 22, 2024 - 2.72 LPNs on the evening shift, versus the required 3.33 for a census of 100. December 22, 2024 - 2.03 LPNs on the night shift, versus the required 2.5 for a census of 100. December 25, 2024 - 3.66 LPNs on the day shift, versus the required 4 for a census of 100. December 27, 2024 - 2.19 LPNs on the night shift, versus the required 2.45 for a census of 98.</p>	P 5530		

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P 5530	Continued from page 5  December 28, 2024 - 2.97 LPNs on the evening shift, versus the required 3.20 for a census of 96.  On the above dates mentioned, no additional excess higher-level staff were available to compensate this deficiency.  An interview with the Nursing Home Administrator on December 30, 2024, approximately 3:00 PM, confirmed the facility had not met the required LPN to resident ratios on the above dates.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395298</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/30/2024</b>
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P 5640	Continued from page 6  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	1. The facility cannot retroactively correct staffing PPD. 2. DON/designee will conduct an initial audit of the past two weeks scheduled to determine if PPD are in compliance. 3. DON/designee will re-educate the scheduler on the proper PPD. The facility will hold labor meetings Monday-Friday to verify PPD is made. 4. DON/designee will conduct random audits of facility PPD weekly for four weeks, then monthly for two months thereafter to verify proper PPD hours. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>01/21/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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P 5640	Continued from page 7  Based on a review of nurse staffing, state regulation, and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily.  Findings include:  A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.20 hours of general nursing care to each resident:  December 22, 2024 - 3.07 direct care nursing hours per resident. December 24, 2024 - 3.13 direct care nursing hours per resident. December 25, 2024 - 2.69 direct care nursing hours per resident.  The facility's general nursing hours were below minimum required levels on the dates noted above.  An interview with the Nursing Home Administrator	P 5640		

Pennsylvania Department of Health

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P 5640	Continued from page 8  on December 30, 2024, at approximately 3:00 PM, confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily.	P 5640			



# Certified End Page

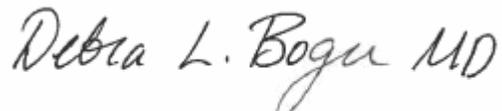
**LAKWOOD REHABILITATION & HEALTHCARE CENTER**

**STATE LICENSE NUMBER: 191502**

**SURVEY EXIT DATE: 12/30/2024**

**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