STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395400	A. BLDG: __00_____ B. WING: _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUSQUEHANNA HEALTH AND WELLNESS CENTER STATE LICENSE NUMBER: **084802**	**745 OLD CHICKIES HILL ROAD COLUMBIA, PA 17512**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a follow-up survey completed on January 17, 2025, for a revisit survey of November 8, 2024, it was determined that Susquehanna Health and Wellness Center, continues to be out of compliance with the following requirements of the Commonwealth of Pennsylvania Long Term Care Licensure Regulations for the Health portion of the survey process.	F 0000		

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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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. CNA ratios for the dates noted in the survey cannot be corrected as this is a past event. 2. Calculation of shift CNA ratios will be completed and reviewed daily for accuracy by the scheduler. 3. The facility has developed internal incentives to retain and attract new staff. Agency staff are being utilized in an effort to reach daily shift ratios. Programs such as apploi, indeed and CareerLink will be utilized to enhance recruiting effort. Indeed employment ads will be posted. The scheduler will look ahead for a minimum of 1 week at projected staffing patterns to enable more time to achieve appropriate CNA ratios as needed. 4. CNA ratios will be audited by scheduler and DON daily for 4 weeks, then 3 days per week x 2 months or until substantial compliance is achieved. Results will be reported to QAPI committee	Completion Date: **03/31/2025** Status: **APPROVED** Date: **01/31/2025**

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

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P 5520	Continued from page 1 Based on a review of facility staffing data, it was determined that the facility failed to ensure a minimum of one nurse aide per 10 residents on the day shift, a minimum of one nurse aide per 11 residents on the evening shift, and a minimum of one nurse aide per 15 residents on the night shift. For a 10 day period reviewed from January 6, 2025 through January 16, 2025. Findings include: Review of facility staffing data for the period of January 6, 2025 through January 16, 2025, revealed the following dates and shifts that did not meet the requirements of one nurse aide per 10 residents on the day shift, and one nurse aide per 15 residents on the night shift. Findings include: Day Shift	P 5520		

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P 5520	Continued from page 2 January 11, 2025 January 12, 2025 Night Shift January 15, 2025 The NHA was made aware of the Nurse Aid non compliance, as discussed during a telephone conversation On January 17, 2025, at approximately 3:30 PM.	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. LPN ratios for the dates noted in the survey cannot be corrected as this is a past event. 2. Calculation of shift LPN ratios will be completed and reviewed daily for accuracy by the scheduler. 3. The facility has developed internal incentives to retain and attract new staff. Agency staff are being utilized in an effort to reach daily shift ratios. Programs such as apploi, indeed and CareerLink will be utilized to enhance recruiting effort. Facility will utilize Indeed ads. The scheduler will look ahead for a minimum of 1 week at projected staffing patterns to enable more time to achieve appropriate LPN ratios as needed. 4. LPN ratios will be audited by scheduler and DON daily for 4 weeks, then 3 days per week x 2 months or until substantial compliance is achieved. Results will be reported to QAPI committee.	Completion Date: **03/31/2025** Status: **APPROVED** Date: **01/31/2025**

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P 5530	Continued from page 4 Based on a review of facility staffing data, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents on the day shift, one LPN per 30 residents on the evening shift and one LPN per 40 residents on the night shift. For a period of 10 days reviewed from January 6, 2025 through January 16, 2025. The facility staffing data for the 10 day period, revealed the following dates and shifts that did not meet the required minimum hours worked in accordance with State Regulations. Findings include: Day shift On January 3, 2025, the required hours were 52.16, but the actual hours were 49.75. On January 11, 2025, the required hours were 52.16, but actual hours were 49.25. On January 12, 2025, the required hours were 52.48, but the actual hours were 49.25.	P 5530		

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P 5530	Continued from page 5 Evening shift On January 13, 2025, the required hours were 43.73, and the actual hours were 40.25 The facility's failed to meet the minimum required hours for Licensed Practical Nurses, for 4 of 10 days, was discussed with the NHA on January 17, 2025, at approximately 3:30 PM.	P 5530		
P 5640		P 5640		

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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 PPD cannot be corrected as this it is an event in the past. 2. The PPD will be completed and reviewed daily for accuracy by the scheduler. 3. The facility continues to develop a recruitment plan to attract nursing staff. The facility scheduler, DON, HR and NHA will meet daily to review compliance with ratios. In the event of call offs, every effort to contact regular full-time and part-time staff as well a PRN and agency staff will be made by facility personnel. Programs such as apploi, indeed and CareerLink will be utilized to enhance recruiting effort. Recruiters will seek out applicants sourcing indeed, aploi for staff. Facility will offer 12 hour shifts to enhance employment offer. 4. PPD will be monitored daily by the scheduler and DON/designee. Facility compliance with PPD will be monitored through the monthly QAPI process. Ratios will be monitored daily by the scheduler	Completion Date: **03/31/2025** Status: **APPROVED** Date: **01/31/2025**

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P 5640	Continued from page 7	P 5640	and/or DON/designee. Audits of PPD will be completed by the DON/designee daily X 4 weeks then 3 times per week X two months or until substantial compliance is achieved. The results of the audits will be reviewed at the monthly QA meeting.	

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P 5640	Continued from page 8 Based on review of facility nursing staffing data, it was determined that the facility failed to ensure the total number of nursing care hours provided (PPD) in each 24-hour period met the required minimum of 3.20 hours of direct care per resident per day for 7 of 10 days reviewed. From January 6, 2025 through January 16, 2025. Findings include: Review of staffing documentation revealed the facility failed to meet the Minimum State PPD requirements for the following dates: January 7, 2025, the PPD was 3.05 January 11, 2025, the PPD was 3.17 January 12, 2025, the PPD was 2.95 January 13, 2025, the PPD was 3.09 January 14, 2025, the PPD was 3.12 January 15, 2025, the PPD was 2.95 January 16, 2025, the PPD was 2.99	P 5640		

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P 5640	Continued from page 9 The Nursing Home Administrator was made aware that a deficiency was identified for PPD's being below the Required 3.2 minimum at 3:30 PM on January 17, 2025.	P 5640		

Certified End Page

SUSQUEHANNA HEALTH AND WELLNESS CENTER

STATE LICENSE NUMBER: 084802

SURVEY EXIT DATE: 01/17/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY