STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395687	A. BLDG: 00 B. WING:	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORK NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 023802	7101 OLD YORK ROAD PHILADELPHIA, PA 19126

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F 0000	INITIAL COMMENT	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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F 0000	Continued from page 1 Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey and an Abbreviated survey in response to two complaints, completed February 4, 2025, it was determined that York Nursing And Rehabilitation 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 as they relate to the Health portion of the survey.	F 0000		

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F 0578 SS=D	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F 0578	Step1 Advance Directive for resident R96 reviewed with Responsible party: POLST updated to reflect updated Code status Step 2 All Hospice residents POLST to be audited to ensure that a resident's right to request or refuse medical treatments were accurately reflected in the resident's record Step 3 Social Services/nursing management will be educated to ensure that a resident's right to request or refuse medical treatments were accurately reflected in the resident's record Step 4 Admin/Designee will conduct weekly audits x 4, monthly x2. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0578 SS=D	Continued from page 3 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

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F 0578 SS=D	Continued from page 4 Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that a resident's right to request or refuse medical treatments were accurately reflected in the resident's record for one of 35 residents reviewed (Resident R96). Findings include: Review of Resident R96's clinical record revealed that the resident was admitted to the facility on November 21, 2021 with a diagnosis of dementia (progressive degenerative disease of the brain). On December 13, 2024 the resident was placed on hospice care. Further review of Resident R96 clinical record revealed the resident's advanced directive remained full code. On January 31, 2025 at 2:12 p.m., interview with Unit Manager Employee E14 confirmed and stated that Resident R96's POLTS (Physician Orders for Life-Sustaining Treatment- a medical form that outlines a patient's end-of-life care preferences)	F 0578		

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F 0578 SS=D	Continued from page 5 should have been discussed on December 13, 2024 when the resident went on hospice care and it was not discussed with the resident and/or responsible party related to the resident's advance directives. 28 Pa. Code 211.12(d)(5) Nursing services	F 0578		
F 0584 SS=D		F 0584		

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F 0584 SS=D	Continued from page 6 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	Step 1 The privacy curtain in room 139C was replaced. Furniture in room 140B was repaired, crack in the wall in room 140 was repaired. Ceiling tiles in 1 south nursing unit replaced. The dresser in room 152 was repaired. The baseboard was repaired and the PTAC cover was repaired, hole in the wall. The bedside tray table replaced room 152B. Clutter in 1 north shower room was immediately removed and the privacy curtain was installed between the second and the third stall. Step 2 A Facility-wide audit will be completed to ensure that furniture, walls, privacy curtains, baseboard, bedside tray tables, and PTAC covers are in good condition and that all shower rooms are clutter-free. Step3 Facility staff will be educated on the requirements to ensure that residents have a safe, clean, comfortable, and homelike environment. Step 4	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0584 SS=D	Continued from page 7 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	NHA/Designee will complete random audit weekly x4 monthly x2. Findings will be reviewed during QAPI meeting.	

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F 0584 SS=D	Continued from page 8 Based on observations and resident and staff interviews, it was determined the facility failed to provide services to maintain a clean and homelike environment for two of four nursing units. (First floor South and North Nursing Units). Findings include: The facility's policy titled " Resident's Rights-Safe/Clean/Comfortable/Homelike Environment" dated " April 1, 2022, indicated " It is the policy of the facility to provide a safe, clean, comfortable homelike environment such as manner to acknowledge and respect residents' rights". On January 28, 2025, at 11:33 a.m. observation in room 139 bed C revealed dirty privacy curtains with brown spots and black strikes on both sides of the curtain. On January 28, 2025, at 12:25 p.m., an observation was conducted with the Maintenance Director, Employee E18, in room 140B. The inspection	F 0584		

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F 0584 SS=D	Continued from page 9 revealed a loose closet door with two hinge screws that were not secure, as well as cracks in the wall around the heater that were not sealed. On January 28, 2025, at 1:06 p.m., an observation was conducted with the Maintenance Director, Employee E18, in the shower room on the 1st South nursing unit. . The inspection revealed 12 ceiling tiles with water damage, including one tile that had a large hole. On January 28, 2025, at 1:20 p.m. observation with the Maintenance Director, Employee E18 room 152 dresser was broken, baseboard was detached, heater P-Tac unit cover box was loose. Holes in the wall near the baseboard on the right side of the room. Broken tray tables in the B bed. On January 29, 2025, at 9:14 a.m., an observation was conducted with the Maintenance Director, Employee E18, in the 1 North shower room. The room was cluttered with various items, including:	F 0584		

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F 0584 SS=D	Continued from page 10 -The first shower stall containing three large trash cans. -The second shower stall holding a large trash can and three tray tables. -A mechanical lift stored in the middle of the shower area. -No privacy curtain between the second and third shower stalls. -The fourth shower stall containing three mechanical lifts. -A regular resident's chair placed near the sink. 28 Pa. Code 201.18 (e)(1)(2.1) Management. 28 Pa. Code 201.29 (a) Resident rights.	F 0584		
F 0607 SS=D		F 0607		

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F 0607 SS=D	Continued from page 11 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	Step 1 The background check for the DON was completed on 1/29/25 and the result was added to the personnel file. Step 2 HR director will complete an audit of all active employees to ensure that background checks are completed as required. Step3 HR personnel were educated on the requirement to complete background checks before onboarding. Step4 HR director/ designee will audit all new hires weekly x4 than monthly to ensure that criminal background checks were completed before onboarding. Findings will be reviewed in QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0607 SS=D	Continued from page 12 This REQUIREMENT is not met as evidenced by:	F 0607		

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F 0607 SS=D	Continued from page 13 Based on facility policy review, personnel file review, and staff interview, it was determined that the facility failed to perform criminal history background checks prior to hire for one of five personnel files reviewed (Employees 2). Findings Include: The facility policy titled " Employment Screenings for Potential Hires: Pennsylvania" dated, April 2, 2022, revealed under Procedure B. section " Criminal records check: i. in accordance with Act 13 and the Older adults Protective Services Act, the Facility will conduct a Criminal History Check as a condition of employment within the first 30 days of hire. This includes clearance through the Pennsylvania State Police". Review of the personnel file for Director of Nursing, Employee 2 revealed hiring date on November 11, 2024. Further review indicated that a Pennsylvania State Police background check was completed on January 29, 2025.	F 0607		

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F 0607 SS=D	Continued from page 14 An interview was conducted with the Nursing Home Administrator, Employee E1, on December 31, 2025, at 11:48 a.m. Employee E1 stated that the Human Services Director, Employee E9 had conducted a criminal background check at the time of hiring; however, it was not saved, and a more recent copy is unavailable. Additionally, documentation confirmed that the Director of Nursing, Employee E2, did not undergo a criminal background check until January 29, 2025. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.19(8) Personnel policies and procedures	F 0607		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 15 483.21(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	Step 1 Resident R192 person centered comprehensive smoking care plan reviewed and updated to reflect residents smoking status and safe smoking interventions Step 2 Care plan audit completed for all residents who are smokers to ensure that it reflects residents smoking status with safe smoking interventions included. Step 3 Social services, activities and nursing team educated on ensuring residents identified as smokers have comprehensive smoking care plan that reflects residents smoking status and safe smoking interventions Step 4 Admin/Designee will conduct weekly audits x 4, monthly x2. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0656 SS=D	Continued from page 16 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		

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F 0656 SS=D	Continued from page 17 Based on review of facility policies and clinical records, and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of two residents reviewed regarding a smoking (Resident R192) Findings include: Facility policy entitled, "Base Care plan, Comprehensive Care Plan and Ongoing care Plan Updates" Revised October 1, 2024, revealed " The facility will follow a uniform process for initiating the baseline care plan upon admission, the comprehensive care plan upon CCA (Care Area Assessment) completion, and ensuring care plan updated to reflect the resident's status". Resident R192's clinical record revealed that the resident was admitted to the facility on October 29, 2024, with diagnoses of dementia (progressive degenerative disease of the brain), mild cognitive impairment of uncertain or unknown etiology, adjustment disorder with mixed anxiety and	F 0656		

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F 0656 SS=D	Continued from page 18 depressed mood, and memory deficit following a nontraumatic intracranial hemorrhage. Additionally, the resident was identified as a smoker, and a smoking assessment was completed on October 30, 2024. Review of Resident R192's Minimum Data Set (MDS - a periodic assessment of care needs) upon admission dated November 5 , 2024, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated that the resident was cognitively intact. On January 30, 2025, at 9:46 a.m. Resident R192 was observed smoking during the normal routine time. A review of the current care plan, dated October 30, 2024, found no evidence of a comprehensive, person-centered plan of care addressing smoking interventions. During an interview on February 4, 2025, at 9:45	F 0656		

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F 0656 SS=D	Continued from page 19 a.m., the Director of Nursing, Employee E2, confirmed that Resident R192 was a smoker and acknowledged that no comprehensive care plan had been developed to address safe smoking interventions.	F 0656		
F 0677 SS=D	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	Step1 Resident R114, E22, R60, E23, E24 nails were trimmed and cleaned Step 2 All residents audited, nails cleaned and trimmed to ensure adequate personal hygiene and grooming for all residents who are dependent on staff for ADL Step3 Nursing staff educated on adequate personal hygiene and grooming for residents who are dependent on staff for assistance with ADL Step 4 Managers/ designee will conduct audits weekly x4, monthly x 2 as per facility protocol. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0677 SS=D	Continued from page 20 Based on clinical record review, observations, resident 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 two of 35 residents reviewed (Resident R114, and R60). Findings include: On January28, 2025, at 12:34 p.m. Resident R114 was observed to have long and dirty nails on his hands. Resident R114 reported that he prefers his nails to be cut short. Review of Resident R114's most recent annual Minimum Data Set (MDS) dated November 2, 2024, revealed him as totally dependent on one staff physical assistance for his activities of daily living. The resident's (BIMS - Brief Interview for Mental Status - a screen used to assist with identifying a	F 0677		

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F 0677 SS=D	Continued from page 21 resident's current cognition) indicated Resident R114 has intact cognition. A review of the comprehensive care plan for Resident R114 dated September 22, 2022, indicated " Resident R114 has potential for impairment to skin integrity r/t decreased mobility incontinence". Under interventions it further revealed "Keep fingernails short." On January 29, 2025, at 1:14 p.m. Resident R114 continued to have long nails. On January 30, 2025, at 11:00 a.m. the unit manager, Employee E22 confirmed the observations that Resident R114 nails were long and dirty and it was the responsibility of the nursing assistant to get them cut. On January 29, 2025, at 8:58 a.m. an interview and observation revealed Resident R60 had very long, dirty fingernails, when asked if this was his preference Resident R60 said" no, I can't cut them	F 0677		

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F 0677 SS=D	Continued from page 22 myself, the nurse said she would cut them for me but has not yet". Review of Resident R60's most recent quarterly Minimum Data Set (MDS) dated December 19, 2024, revealed him as independent; however, requires setup or clean-up assistance with personal hygiene The resident's (BIMS - Brief Interview for Mental Status - a screen used to assist with identifying a resident's current cognition) indicated Resident R60 has intact cognition. On January 30, 2025, at 11:20 a.m. interview with license nurse, Employee E23 revealed that the resident refuses care, will only let certain caregivers to help him. On January 30, 2025, at 2:36 p.m. an interview with Resident R60 revealed that license nurse, Employee E24 did cut his nails.	F 0677		

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F 0677 SS=D	Continued from page 23 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0677		
F 0689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Step1 The extension cord was removed from resident R35's room. Step2 The maintenance Director/ designee completed a facility-wide audit to ensure that extension cords are not in use. Step3 Facility staff educated on the requirement to ensure that extension cords are not in use and that the resident environment remains as free of accident hazards as possible. Step4 The maintenance director/designee will audit resident rooms weekly x 4, and monthly x2. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0689 SS=D	Continued from page 24 Based on facility policy review, clinical records review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that the resident environment was free of accident hazards for one of 35 residents reviewed (Resident 35). Findings include: The facility's policy titled " Resident's Rights-Safe/Clean/Comfortable/Homelike Environment" dated " April 1, 2022, indicated " It is the policy of the facility to provide a safe, clean, comfortable homelike environment such as manner to acknowledge and respect residents' rights". On January 28, 2025, at 12:21 p.m., an observation in Resident R35's room revealed a long electrical extension cord with five outlets plugged into a wall outlet behind the resident's bed. The cord extended across the room to power a television placed on a dresser. During an interview, Resident R35 stated that they had purchased the extension cord for their	F 0689		

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F 0689 SS=D	Continued from page 25 television and video player, with the facility's permission. On January 28, 2025, at 12:25 p.m., an observation was confirmed by the Maintenance Director, Employee E18, who reported that facility does not allow the electrical extension cords to be used in residents room as it is a hazardous item. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18 (e)(1)(3) Management.	F 0689		
F 0692 SS=D		F 0692		

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F 0692 SS=D	Continued from page 26 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Step 1 Resident R67 weight obtained Step 2 All residents requiring weekly weights related to weight loss audited to ensure weights obtained according to physician orders Step 3 Nursing staff educated on ensuring weekly weights are obtained as ordered by the physician Step 4 Managers/ designee will conduct audits weekly x4, monthly x 2 to per facility protocol. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0692 SS=D	Continued from page 27 Based on review of facility policy, review of clinical records, and staff interviews, it was determined that the facility failed to identify, implement, monitor, and modify interventions consistent with the residents needs and current professional standards of practice, to maintain acceptable parameters of nutritional status for one of eight residents reviewed. (Resident R67) Findings: Review of facility policy titled "Weight Assessment and Intervention" dated February 2022 revealed the nursing staff and dietician will communicate to prevent, monitor, and intervene for undesirable weight loss for the residents. The dietician will review monthly weights and determine if significant weight loss has occurred. Significant weight loss is defined as more or less 5% one month, and more or less 10% within 6 months. The dietician with the interdisciplinary team will make recommendations and care plan interventions.	F 0692		

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F 0692 SS=D	Continued from page 28 Review of Resident R67's annual Minimum Data Set (MDS- a federal mandated assessment for residents) dated November 7, 2024, revealed this resident was admitted to this facility on January 28, 2022 with diagnoses of coronary artery disease (blockage of arteries), hepatitis (inflammation of the liver), and dementia (group of symptoms that include problems with memory, thinking or language). Resident is 65 inches, and 160 lbs. currently prescribed a therapeutic diet with no indication of any swallowing disorder or impairment. Review of resident R 67's care plan initiated January 31, 2022, and revised on August 13 2024, revealed that this resident has a nutritional problem or potential nutritional problems related to a diagnosis of anemia (low levels of red blood cells), history of nasal cancer, bipolar (disorder that cause intense shifts in moods), depression, hypertension(high blood pressure), GERD (gastroesophageal reflux disease-stomach acid rising into the esophagus, also called heartburn), obesity, and history of significant	F 0692		

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F 0692 SS=D	Continued from page 29 weight changes. The goals listed include: maintain adequate nutritional status as evidenced by no significant weight changes, have no signs or symptoms of malnutrition, have no signs or symptoms of dehydration and or fluid overload and maintain skin integrity. Interventions include monitor, document, and report any signs of symptoms of dysphasia, pocketing, choking, coughing, drooling, and holding. Obtain and monitor lab diagnostic work and weight is ordered revised on April 1st, 2024 Review of resident 67's Nutrition assessment dated November 7, 2024, revealed the resident did trigger for significant weight loss times six months. The resident was assessed as consuming 1800-2160 calories daily. The summary of findings revealed the resident was eating 50 to a 100 percent of his meals. The resident also was ordered a house shake twice a day with good acceptance. Weight is stable since initial weight loss. Review of Resident r67's weight history revealed	F 0692		

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F 0692 SS=D	Continued from page 30 documented weights on August 9, 2024, of 205.0 lbs. and September 11, 2024, of 163.4 lbs. and a confirmed weight on September 26, 2024, of 163.2 lbs. representing a weight loss of 20.29% (41.6lbs.). Review of Resident R67's clinical record, and physician orders dated September 25, 2024, revealed an order for weekly weights for the time span of four weeks. Review of the Resident R67's clinical record revealed no documetned evidence that weights were obtaiend four weeks as ordered by the physician. Continued Review of resident r67's clinical record physician orders dated January 13, 2025, revealed resident is ordered a four-ounce house shake three times a day for weight maintenance. Interview with dietitian employee E5 on February 4, 2025, at 10:47 a.m. revealed that it is his professional practice when assessing residents for weight loss to notify their disciplinary team of any significant weight loss and to include interventions	F 0692		

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F 0692 SS=D	Continued from page 31 such as speech therapy, speak to president's physician, review any therapeutic diet, observe meals and interview residents. Employee E5 confirmed that he was aware of resident's weight loss and acknowledged the resident's weight has been trending downward this month. When was alerted to resident's initial significant weight loss in September, 2024, he believed it to be caused by the scale malfunction. Employee E5 confirmed not testing the scale or practicing the above protocols for resident's weight loss. Interview with Employee E20, medical doctor on February 4, 2025, at 11:38 a.m. confirmed that Resident R67 was his patient and had significant weight loss in one month and this employee was made aware of it at that time. Employee E20 confirmed he saw resident October 21, 2024, and his documentation did not address the weight loss and did not provide any new orders relating to the weight loss. Employee E20 acknowledged that more interventions are warranted.	F 0692		

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F 0692 SS=D	Continued from page 32 28 Pa. Code 211.5 (f) Clinical records 28 Pa. Code 211.12 (c)(5) Nursing services	F 0692		

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F 0692 SS=D	Continued from page 33	F 0692		
F 0695 SS=D	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Step 1 Resident R31, R88, R163 oxygen settings updated as per Physician orders Step 2 All residents with Physician orders for oxygen audited to ensure oxygen concentrators are set appropriately. All oxygen concentrators audited to ensure they are free from dust/debris Step 3 Nursing staff educated to ensure appropriate respiratory care and services provided as per physician orders Housekeeping staff educated on the requirement to ensure oxygen concentrators are free of dust/ debris Step 4 Managers/ designee will conduct audits weekly x4, monthly x 2 to per facility protocol. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 34 Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for three of 35 residents reviewed (R31, R88, R163). Findings include: Review of the Facility Policy and Guidelines for Implementation of Oxygen Administration, dated June 2016, indicated that the nurse should review and follow the physician's orders while administering Oxygen via nasal canula. Review of Resident R163's clinical record revealed; the resident was initially admitted to the facility on April 12, 2024; diagnosed with Acute Respiratory Failure with Hypoxia (a condition where the lungs are unable to adequately exchange oxygen, leading to low blood oxygen levels {hypoxia}, which can occur suddenly (acute) or develop over time (chronic, causing significant breathing difficulties and potential complications depending on the severity	F 0695		

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F 0695 SS=D	Continued from page 35 and duration of the issue; essentially, it means the body isn't getting enough oxygen due to impaired lung function, either rapidly or gradually); Malignant Neoplasm of Upper Lobe, Left Bronchus of Lung (a cancerous tumor located in the upper lobe of the left lung). Review of clinical record indicated that Resident R163 was ordered of April 15, 2024, oxygen at 2 Liters/Min (minute0, via Nasal Cannula, continuously, every shift for supplementary Oxygen. Observation conducated on January 28, 2025, at 10:33 a.m., revealed that R163 was administered oxygen at 4 liters/Min, via nasal canula., and not 2 liters/min, as ordered by the physician; and the same was confirmed with a Director of Nursing, Employee E2 at the time of the finding. A review of the clinical record of Resident R88 revealed an admission date of December 19, 2022, with a diagnosis of dependence on supplemental oxygen.	F 0695		

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F 0695 SS=D	Continued from page 36 Review of clinical record indicated that Resident R88 was ordered on January 2, 2023, oxygen at 2 liters/min, via Nasal Cannula, continuously, every shift for supplementary oxygen. On January 28, 2025 at 11:28 a.m. observation of Resident R88's oxygen level was confirmed to be at 3 liter by the License nurse, Employee E10. Review of Resident R31's clinical record revealed a diagnosis of chronic obstructive pulmonary disease (lung disease) with physician orders for 3 liters of continuous supplemental oxygen. On January 28,2025 at 2:30 p.m. Resident R31 was observed using the oxygen on the incorrect setting of 4 liters and the concentrator was covered in dust. Immediately after, the Unit Manager Employee E14 confirmed the order was for 3 liters and the concentrator was not clean. 28 Pa. Code 211.10(c) Resident care policies	F 0695		

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F 0695 SS=D	Continued from page 37 28 Pa. Code 211.12(d)(5) Nursing services	F 0695		
F 0729 SS=D	483.35(d)(4)-(6) Nurse Aide Registry Verification, Retraining §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related	F 0729	Step 1 Protocol to immediately check the annotation list was initiated on 10/24/24. Moving forward the facility will review the annotation list quarterly to ensure that no current staff members are listed. Step 2 HR director will complete an audit of all current employee files to ensure that no current employees are not listed in the most recent annotation list. Step 3 HR personnel educated on the requirement to check the annotation list quarterly to ensure that no current employees are listed in the annotation list. Step 4 HR director/ designee will audit new hires weekly x4 than monthly to ensure that new hires are not listed on the annotation list	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0729 SS=D	Continued from page 38 services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by:	F 0729		

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F 0729 SS=D	Continued from page 39 Based on a review of facility's job descriptions and personnel files, as well as staff interviews, it was determined that the facility failed to check the annotation list which becomes available on quarterly bases to verify the nurse aide certification to be valid to allow individuals to work as a nurse aide for one of three nurse aides reviewed (Employee E8). Findings include: The facility policy titled " Employment Screenings for Potential Hires: Pennsylvania" dated, April 2, 2022, revealed "Prior to an offer of employment, the hiring manager should ensure all candidates for employment are properly interviewed and the following screens are completed: a. Attempt for two former employee references: i Ideally verification should include: 1. Dates of employment 2. Position held 3. Salary or hourly wage rate; i. When there is no prior employment, references can be obtained from schools, churches, or personal associations. a. Verification of license or certification if applicable"	F 0729		

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F 0729 SS=D	Continued from page 40 The facility's job description for Nurse Aide, undated, revealed that a nurse aide certification was necessary to perform functions of the position. Review of information submitted to the State Survey Office on October 24, 2024 , stated the facility became aware during a routine license audit that a Nursing assistant (NA), Employee E8 had her Nurse Aide certificate revoked on 7/15/2024 "due to substantiated finding on file with the Pennsylvania Nurses Aide registry from a different facility."The employee was immediately suspended pending termination. The facility reviewed the employee file and noted that Employee E8 was hired on 12/14/2021 with a valid NA certification. The facility last verified her certificate on 7/13/2023 when the certificate was reviewed. The NA registration on file was current with an expiration date of 7/7/2025. The facility interviewed the Human Services (HR) Director, Employee E9 who reported that the facility was never made aware that Employee E8's NA license was revoked. The Employee E8 last shift worked was on 10/24/2024	F 0729		

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F 0729 SS=D	Continued from page 41 from 7am-1:33p.m. Employee E8 was terminated on 10/24/2024". A personnel file for Nursing Aide, Employee E8 revealed that she/he was hired on 12/14/2021 with a valid NA certificate dated effective from 7/7/2017 - 7/7/2023, then NA certificate was renewed until 7/7/2025. On 10/24/2024 a screening was conducted for Employee E8 which revealed that the NA certification was revoked on 7/15/2024. Facility conducted an interview dated 10/24/2024 with the Human Service Director, employee E9 who revealed " I was in the process of auditing staff licenses and discovered that Employee E8 license was revoked. I called Employee E8 to my office and she stated that she was aware that her license was revoked. She stated she renewed it in 2023. I asked her to log into credentials to download her current license. The website also showed that her license was revoked. Employee was send home suspended pending the outcome of the investigate".	F 0729		

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F 0729 SS=D	Continued from page 42 Interview with the Nursing Home Administrator, Employee E1 on 01/30/2025, at 12:13 p.m. confirmed that Nurse Aide's certification for Employee E8 was revoked on 07/15/2024. Facility was conducting an audit and ran her certification license and discovered it was revoked. Employee E8 was suspended, and facility called the Department of Health field office to become aware why facility was not notified. Department of Health (DOH) notified the facility that every quarter there is a annotation list that comes out which would show if there is any certified aids' licenses were revoked due to a substantiated cases. Employee E1 was not aware of the annotation list to be available. Employee E1 obtained the annotation for 07/01/2024 and Employee E8 was not listed on the list. Then, 10/01/2024 annotation list was obtained and Employee E8 was listed as her license was revoked. On January 30, 2024, at 12:57 p.m. an interview was held with the HR director, Employee E9 who reported that she was doing an audit and discovered	F 0729		

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F 0729 SS=D	Continued from page 43 that Employee E8 had a revoked license. She interviewed the Employee E8 who did not disclose the revoke license and was asked to log into her credentials and the result revealed as a revoked license. Employee E8 was suspended and then terminated. Facility was not aware of the annotation list which would show a list of staff whose licenses have been revoked. Immediately, facility implemented a protocol to check the annotation list for their current staff and for any agency staff who are coming in to provide care for their residents. 28 Pa. Code 201.29 (b) Personnel Policies and Procedures.	F 0729		
F 0742 SS=D		F 0742		

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F 0742 SS=D	Continued from page 44 483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by:	F 0742	Resident R139 R157 PTSD trauma informed comprehensive care plans updated to include person centered interventions. Step 2 All residents with PTSD diagnosis was designated a comprehensive person-centered care plan. Step 3 Social Services department educated on comprehensive person-centered care-plan related to PTSD Step 4 Managers/ designee will conduct audits weekly x4, monthly x 2 to per facility protocol. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0742 SS=D	Continued from page 45 Based on review of facility policy, review of resident clinical records, interview with staff, it was determined that the facility failed to develop a comprehensive person-centered care plan relating to post traumatic stress disorder (PTSD) for two of two residents reviewed with this diagnosis of PTSD. (resident R 139, and R157) Findings include: Review of facility policy titled "Trauma informed care" dated October 24th, 2022, revealed that the facility ensures that residents who are trauma survivors receive culturally competent, trauma informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause traumatization of the resident. This includes training and assisting staff to create an environment where the resident feels safe. The facility will assess each resident to ensure	F 0742		

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F 0742 SS=D	Continued from page 46 they receive the appropriate treatment and services. The facility will ensure employees have education training or in service in caring for residents identified with mental and psychological disorders as well as residents with a history of Trauma and or post-traumatic stress this water. Appropriate staff will also be educated in implementing nonpharmacological interventions when appropriate. Trauma training will be part of our orientation program for all new employees and will be provided on an ongoing basis .Trauma specific interventions for a resident will be placed in our individualized person-centered care plan upon a mission and assessment. Care plans and interventions will be reviewed quarterly and more often is necessary, based on any change in residents physical and psychosocial well-being. As we evaluate our interventions, we will be sensitive to the need for professional referral to psychological mental health services and personnel as well as ways to communicate our plans with staff in order to enlist their support. The Social service department initially will identify any trauma and or PTSD by supplied	F 0742		

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F 0742 SS=D	Continued from page 47 questionnaire and gather trigger information through Medical records/ assessments, family members. Review of Resident R139's Quarterly Minimum Data Set(MDS) dated November 2, 2024 revealed that Resident R139 was admitted in to facility October 12, 2022 with diagnosis including Bipolar (Bipolar disorder is a mental health condition that causes extreme mood swings between depression and mania or hypomania. Learn about the types, symptoms,) and PTSD (Post traumatic stress disorder is a mental health condition caused by a traumatic event that affects your ability to function normally. Review of resident R 139's clinical record psychology note dated December 7, 2023, revealed that resident R139 has a history of PTSD and bipolar disorders. The psychological notes indicated the resident suffered trauma as a child. Review of Resident 139's care plan noted PTSD associated with other concerns, however, did not	F 0742		

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F 0742 SS=D	Continued from page 48 develop any identification, plan of care, or goals for this disorder. Resident R139's care plan consists of identification of diagnosis and or health concerns including this resident has a history of shower refusal related to history of PTSD, with interventions including education of noncompliance, encourage participation, explain care activities, and paired care. Further review of resident R139's care plan revealed the focus of anti-anxiety medications usage related to PTSD with the goal of resident will be free from discover or adverse reactions related to anti-anxiety therapy. Interventions of this focus and goal include administer medications and monitor document report any adverse reactions The final notation of the diagnosis of PTSD in resident R 139's care plan can be detected under the focus of nutritional problem related to the diagnosis of diabetes two, anemia and PTSD, history of homelessness, morbid obesity, consumption of medication that may cause weight loss.	F 0742		

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F 0742 SS=D	Continued from page 49 The care plan reviewed contained the diagnosis of post traumatic stress disorder but lacks any goals, implementations, or outcomes directly relating to the diagnosis of PTSD. Review of Resident R157 quarterly minimum date set (MDS- a federal mandated assessment for all residents) dated November 4, 2024 revealed resident R157 was admitted into the facility on December 10, 2021 diagnosis including schizophrenia (a mental disorder characterized by disruptions in thought process, perceptions, emotional responsiveness, and social interactions) , depression, and PTSD. Review of Resident R157's comprehensive care plan revealed no documented evidence that Resident R157's diagnosis of PTSD care planned and developed related to the treatment and services for PTSD. Interview with Employee E2 Director of Nursing on	F 0742		

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F 0742 SS=D	Continued from page 50 February 4, 2025 at 12:40 p.m .acknowledged that care plans are incomplete with goals, implementation, and evaluation for the specific diagnosis and care needs of post traumatic stress disorder. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0742		
F 0804 SS=E		F 0804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0804 SS=E	Continued from page 51 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	Step1 R130, R44, R17, R82, R146, R126, R86, R165, R136, R147 R112, R121, R60, R111, R56 and R32 preferences reviewed and updated. Work order initiated to repair pellet heaters. Alternative process for warming plates initiated Step2 Audit completed to ensure that all equipment designed to help maintain proper food temps are functioning properly. Food satisfaction survey completed with residents who are AAOX3 to ensure that food preference are met. Step 3 Kitchen staff educated on proper use of pellet heaters to ensure plates are warmed as per facility protocol. Nursing staff educated on ensuring trays are delivered immediately upon arrival of units Step 4 Admin/Designee will conduct weekly audits x 4, monthly x2. All results will be presented at QA for further review.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0804 SS=E	Continued from page 52 Based on observations, resident and staff interviews, and a review of facility documentation, it was determined that the facility failed to provide food and drink that was palatable and served at palatable temperatures for five of ten residents reviewed (Residents R112, R121, R60, R56 and R32). Findings include: Interview with Resident R112 on January 28, 2024, at 10:55 a.m. revealed that since the new people took over in the kitchen, they keep bringing me breakfast items with pork, like bacon. "I cannot eat pork, they know I cannot have pork it makes me sick, why do they do this? I do not eat a lot of the food it just is not good, especially at night, and the nurse has to go down to the kitchen for two sandwiches every night either grilled cheese or turkey, why can't they just send me two sandwiches on my tray so that she does not have to go all the way down there every night?" Interview with Resident R121 on January 28, 2024,	F 0804		

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F 0804 SS=E	Continued from page 53 at 11:00 a.m. revealed that food does not look right, "I can't eat the platters, so I have to ask for sandwiches, I get 2 grilled cheese sandwiches for supper, the meals are always late." Interview with Resident R60 on January 28, 2024, at 11:03 a.m. revealed "staff did not offer me breakfast the past few days, the food here sucks, it's really bad." Interview with Resident R56 on January 28, 2024, at 11:05 a.m. revealed that the "food here is terrible, it is all mushed together, I haven't had a salad since these people took over, the trays are dripping wet-they used to have a place mats, now you get one napkin and it is wet, disgusting, they do not have hot dogs any more, they serve mashed potatoes all the time, no baked potato or any other kind, I send the food back all the time and end up ordering out a hoagie or Chinese food." Interview with Resident R32 on January 28, 2024, at 11:07 a.m. revealed that her ticket says cold	F 0804		

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F 0804 SS=E	Continued from page 54 cereal (her preference) and that last two days she has been given hot cereal (grits/cream of wheat) and that her food is not always warm. Observation on January 29, 2024, at 12:05 p.m in kitchen where starter is placing cold pellets out of the dish room right on the tray. Starter said the machine (pellet heater) was not working. The person serving the hot food was taking plates which were stacked well above the plate warmer and the plates were barely warm to the touch. On January 28, 2025, at 12:53 p.m. an interview was held with Resident R111 revealed that "food is disgusting I can eat waffles, pancakes, toast are good, everything else is horrible. It's the taste, the look". On January 29, 2025, at 10:30 a.m. a resident council meeting was held with 10 alert and oriented residents (R130, R44, R17, R82, R146, R126, R86, R165, R136, R147) . It was reported that food remains an issue, with residents expressing that	F 0804		

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F 0804 SS=E	Continued from page 55 only one out of the three daily meals is satisfactory. Dinners are often served cold, while breakfast and lunch are frequently delayed. Additionally, meal delivery trucks from the kitchen arrive on schedule but remain on the unit for an extended period before nursing staff distribute the meals to residents. Observations during a test tray conducted on January 29, 2024, revealed that the tray cart left the kitchen at 12:17 p.m and the last tray was passed at 12:30 p.m. Temperatures were taken by the Food Service Director (FSD), Employee E4, revealed that the bread stuffing was only 125 degrees and the roast cauliflower was only 122 degrees, and the apple juice was 50 degrees and the diced pears were 50.5 degrees all outside the acceptable temperature range for palatability. An interview with the FSD, on January 29, 2024, at 12:35 p.m. confirmed that these food items were outside the acceptable temperature and therefore not palatable.	F 0804		

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F 0804 SS=E	Continued from page 56 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management	F 0804		
F 0812 SS=D		F 0812		

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F 0812 SS=D	Continued from page 57 483.60(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	Step 1 Bag of French fries and box of peanut butter cookie dough secured to prevent exposure to circulating air. Storage area rearranged to ensure that all items are stacked less than 18 inches from the ceiling and other fixtures as required. The oven was cleaned throughout. Step 2 Walk in freezer, food storage areas and food prepping equipment audited to ensure that all items were stored, secured and or maintained in accordance with food safety requirements. Step3 Dietary staff were educated on the requirement to ensure that food procurement, storage and preparation are done in accordance with state and federal food safety requirements. Step 4 Admin/Designee will conduct audit weekly audits x 4, monthly x2. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0812 SS=D	Continued from page 58 Based on observations and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety. Findings include: A tour of the Food Service Department was conducted on January 28, 2025, at 10:00 a.m. with Employee E3, Food Service Director (FSD), revealed the following concerns: Observation in the receiving dock revealed dozens of empty plastic 5 gallon chemical containers sitting outside the loading dock door. Observation in the walk-in freezer revealed a bag of frozen French fries with hole in bag, and a box of frozen peanut butter cookie dough open to the circulating air. Observation in the walk-in cooler revealed a yellow	F 0812		

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F 0812 SS=D	Continued from page 59 substance spilled on floor which had cracks in the steel plating with sharp rusty edges with food substances in the cracks. The broken flooring moved as weight was put on it causing a tripping hazard. Observation of the floor in the corner next to the prep sink revealed a thick black substance on the floor. Observation in the dry storage area revealed multiple boxes of napkins, cups and other disposable paperware on multiple shelves all stacked less than the required 18" from the ceiling or other fixtures. Observation of the convection oven revealed that the lower over has a heavy buildup of burned on food substances on doors, base and walls of the inside of the oven. Interview with the FSD on January 28, 2025, at 10:15 a.m. confirmed the above findings.	F 0812		

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F 0812 SS=D	Continued from page 60 28 Pa. Code 201.14(a) Responsibility of licensee	F 0812		
F 0842 SS=D		F 0842		

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F 0842 SS=D	Continued from page 61 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Step 1 R603 Resident discharged from facility Step 2 Current residents that have used prn pain medications over the last 30 days will be reviewed to ensure medication administration was documented, non-pharm interventions were documented, and a pain assessment was conducted prior to medication administration Step 3 All nursing staff educated on ensuring observations, medications administered, services performed, etc., will be documented in the resident's clinical records. Step 4 Managers/ designee will conduct audits weekly x4, monthly x 2 to ensure medication administration policy is followed as per facility protocol. All results will be presented at QA for further review	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0842 SS=D	Continued from page 62 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842 SS=D	Continued from page 63 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=D	Continued from page 64 Based on review of clinical records , interview with staff and facility policy, it was determined that the facility failed to maintain complete and accurate records for one of 35 resident records reviewed (Resident R603). Findings include: Review of facility policy titled, "Charting and Documentation," dated April 1, 2022 states, "Observations, medications administered, services performed, etc., will be documented in the resident's clinical records." Resident R603 was admitted to the facility on September 27, 2023 diagnosed with unspecific dementia with unspecified severity with agitation. Review of Resident R603 nursing progress note dated, January 20, 2025 indicated 500 milligrrams (mg) of acetaminophen was given to Resident R603 when the resident complained of pain. Interview with Licensed Practical Nurse (LPN)	F 0842		

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F 0842 SS=D	Continued from page 65 Employee E17 confirmed the acetaminophen was given at approximatley 2:00 p.m. with a positive effect and was sleeping at 3:30 p. m. before the nurse ended her shift. Further review of Resident R603 electronic administration record revealed the LPN failed to document the resident's acetaminophen was given for pain. Continue review of Resident R603's nursing progress note dated January 20, 2025 revealed Registered Nurse Emplyee E15 documented pain medication was given to Resident R603 with postive relief. Interview with Employee E15 on January 30, 2025 at 4:30 p.m. confirmed the nurse gave the pain medication. Further review of Resident R603 electronic administration record revealed Employee E15 failed to document that the resident's acetaminophen was	F 0842		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0842 SS=D	Continued from page 66 given for pain. 28 Pa Code 211.12(d)(5) Nursing services	F 0842		
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 0880	Step 1 Resident R4, R171 audited to ensure proper EBP signage (alerting staff of resident needs), bins and PPE available Step 2 All Residents identified with wounds treatment pass were audited to ensure proper PPE was utilized Step 3 Wound team educated on EBP protocols and proper PPE to be utilized with wound care Step 4 Unit Managers/ designee will conduct audits weekly x4, monthly x 2 to per facility protocol. All results will be presented at QA for further review.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395687	A. BLDG: __00_____ B. WING: _____	02/04/2025

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F 0880 SS=D	Continued from page 67 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 0880		

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F 0880 SS=D	Continued from page 68 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 69 Based on review of facility policy and procedures, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices related to the use of appropriate protective equipment for wound care of two of two residents observed. (resident R4 and R 171). Findings: Review of facility policy titled "Isolation Steps; Categories of Transmission-Based Precautions" revised September 26th, 2022, revealed standard precautions shall always be used when caring for residents regardless of suspected or confirmed infection status. Transmission based precaution shall be used when caring for residents who are documented or suspected to have communicable disease or infections that can be treated submitted to others. Enhanced barrier precautions expand the use of personal protective equipment (ppe) beyond situations in which exposure to blood and bodily fluids is anticipated and refers to the use of gowns and gloves during high contact resident care activities that provide opportunity for transfer of multi-drug-resistant organisms MDRO to staff hands and clothing. All residents with any of the following conditions should use enhanced barrier precautions: infection or colonization with a novel or targeted MDRO., open wounds, indwelling medical devices (central line, urinary catheter, feeding tube, and tracheostomy). For any	F 0880		

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F 0880 SS=D	Continued from page 70 of the above personal protective equipment (PPE) must include wear a gown and gloves for all in our actions that may involve contact with the resident or resident's environment for high contact activities such as dressing, bathing, transferring, providing hygiene, changing linens, therapy, changing briefs or assisting with toileting, to voice care, and wound care. Review of Residents R4's Minimum Data Set (MDS- federal mandated assessment for residents) admission assessment dated December 1, 2024, revealed that the resident entered the facility November 27, 2024, with diagnosis including anemia (low levels of red blood cells), stroke (poor blood flow to the brain causing cell death), and hemiplegia (paralysis that effects on side of the body). Further review of the admission assessment revealed that Resident R4 has an open lesion listed under skin conditions. Observation on the first-floor nursing unit on January 28, 2025, at 9:48 a.m. of Licensed nurse, Employee E19, wound nurse, providing wound care to Resident R4. Employee E19 was observed as wearing (personal protective equipment (PPE) consisting only of gloves. Employee E19 was not wearing required enhanced barrier precaution of a gown. Review of Residents R171's quarterly Minimum Data Set (MDS)dated November 20, 2024, revealed that this resident entered the facility June 9, 2024, with a diagnosis of	F 0880		

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F 0880 SS=D	Continued from page 71 paraplegia (paralysis in both legs). This resident has been assessed of having an unhealed pressure ulcer stage 3. Review of resident 171 wound notes dated January 31, 2025, revealed Resident R171 was being treated for wound care of right lower extremity pressure ulcer and left ankle trauma wound. Observation of Licensed nurse, Employee E19, wound nurse, and Licensed nurse Employee E 14 on January 28, 2025, at 10:30 a.m. providing wound care to Resident R171. Both licensed nurses Employee E 19 and Employee E 14 were observed only wearing gloves, neither employee wearing required enhanced barrier precaution PPE gowns. Interview with Employee E19 on January 28, 2025, at 10:48 a.m. verified that both residents R4 and R 171 were residents that require use of gowns and gloves. Interview with Employee E14 on January 28, 2025, and 11:00a.m. indicated that resident R171 was not on enhanced barrier precaution, the two wounds that were treated did not qualify as requiring PPE, that directly contradicted the facility policy . 28 Pa. Code 211.12 (d)(1)(5) Nursing services 28. Pa. Code 201.14(a) Responsibility licensee	F 0880		

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F 0925 SS=E		F 0925		

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F 0925 SS=E	Continued from page 73 483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 0925	Step1 The facility has partnered with all state pest management services. The facility immediately reviewed the pest control program and is now following the recommendation of all state pest control. The facility increased the frequency of pest control services from once a week to twice a week. Facility power-washed food tray charts and wheelchairs. The leak behind the cooking area was fixed and the kitchen was deep-cleaned throughout. Step 2 The maintenance director, HSKP Manager, and NHA completed environmental rounds throughout the facility to identify areas with pest control issues. All issues identified were added to the pest control log and will be treated by All state pest management services. Step 3 Facility staff were educated on the pest control protocol and the requirement to immediately report any pest observation using the pest control log on each unit.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0925 SS=E	Continued from page 74	F 0925	Step 4 NHA/designee will audit weekly x4 and monthly x2. Findings will be reviewed during QAPI.	

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F 0925 SS=E	Continued from page 75 Based on observations of the physical environment, interviews with staff and reviews of the pest control operators reports, it was determined that the facility was not maintaining an effective pest control program. Findings include: Based on observations of the physical environment interviews with staff and reviews of the pest control operators reports, it was determined that the facility was not maintaining an effective pest control program. A review of the facility policy titled "Pest Control" dated, April 1, 2022, revealed "Bedrock Care shall maintain an effective pest control program". On January 28, 2025, at 10:49 a.m. observation of 2 flies were seen on the 1st floor South nursing unit. On January 28, 2025, at 11:32 a.m. interview with Resident R4 revealed an observation of a fly in the	F 0925		

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F 0925 SS=E	Continued from page 76 room. Resident R4 reported that flies are often present. On January 28, 2025, at 12:14 p.m., an observation of the lunch meal service on the second floor near Room 212 revealed the presence of flies around the tray cart and on a wheelchair in the hallway outside the room. On January 29, 2025, at 10:30 a.m. on the first floor of activity room during the resident council meeting flies were observed flying in the room. A review of the pest control logbook on the 1st South Nursing unit revealed on : -January 7, 2025 - one mouse room 132 -January 15, 2025 - "Nets" location S Services -January 22, 2025- Mice in room 134 A review of the pest control invoices on January 30, 2025, indicated "inspected and treated kitchen and	F 0925		

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F 0925 SS=E	Continued from page 77 baseboards throughout. Recommended better sanitation practices in kitchen. Observed heavy drain/fruit fly activity behind cooking area and water leaks throughout cooking area. Recommended leaks to be fixed". On January 31, 2025, an interview with the Administrative, Employee E1 confirmed that flies and nets are an issue in the facility. Facility has increased their pest control treatment from ones a week to two times a week. 28 Pa. Code 201.18(a)(b)(1) Management 28 Pa. Code 201.14(a) Responsibility of licensee	F 0925		

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P 4860	Medical records. (d) Records of discharged residents shall be completed within 30 days of discharge. Medical information pertaining to a resident ' s stay shall be centralized in the resident ' s record. This REGULATION is not met as evidenced by:	P 4860	Step1 Discharge Summary for resident R200 was completed Step 2 The facility Completed an audit discharge record for the last 30 days to ensure that a discharge summary was completed. Step3 Medical record staff and physician educated on the requirement to ensure that a discharge summary is completed within 30 days of discharge Step 4 Medical record Director/ designee will audit discharged records weekly x 4 monthly x 2 to ensure that a discharge summary was completed. Findings will be reviewed during QAPI	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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

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P 4860	Continued from page 1 Based on review of closed clinical records and interview with facility staff, it was determined that the facility failed to complete a discharge summary within the required 30 days of death for one of three residents reviewed upon discharge. (Resident R200). Findings include: Review of Resident R200's clinical record revealed that the resident was admitted to the facility on June 28, 2021, and died on November 13, 2024. Review of the closed clinical record of Resident R200 revealed that the facility failed to complete a discharge summary within the required 30 days of death and it was not completed until January 31, 2025. An interview with the facility Nursing Home Administrator, Employee E1 on January 31, 2025, at 1:30 p.m. confirmed this finding.	P 4860		

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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	Step 1 The facility is currently staffed at or above state minimum requirements. Step 2 The facility will partner with agencies to ensure that nurse aid requirements are met and to better manage last-minute callouts and unexpected events related to staffing. Step 3 The staff coordinator and other administrative staff involved in coordinating staffing educated on federal and state CNA staffing requirements. Step 4 The NHA or designee will audit staffing levels weekly x4 and monthly x2. Results will be reviewed during the monthly QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

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P 5520	Continued from page 3 Based on review of facility staffing data, it was determined that the facility did not ensure a minimum of one nurse aide (NA) per 10 residents on day shift, one nurse aide (NA) per 11 residents on evening shift and/or a minimum of one nurse aide (NA) per 15 residents on night shift for the three weeks. (August 9, 2024, - August 9, 2024, December 21, 2024 - December 27, 2024, and January 24, 2025 - January 30, 2025). Findings include: Review of facility's 'nursing staff ratio' for the weeks of August 9, 2024, - August 9, 2024, December 21, 2024 - December 27, 2024, and January 24, 2025 - January 30, 2025, revealed that facility did not meet ratio's as follows: August 9, 2024 - Evening shift (3:00 p.m.- 11:00 p.m.) a minimun (min) of 149.32 hours; Actual (Act) hours worked. 144.0. Night shift (11:00 a.m.- 7:00 a.m.) Min. 109.5 Act. 96.0 August 10 - Evening Min. 145.23 Act. 144.0; Night	P 5520		

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P 5520	Continued from page 4 Min. 106.5 Act. 88.0 August 11 - Evening Min. 144.55 Act. 128.0; Night Min. 106.0 Act. 98.0 August 12 - Day Min. 161.25 Act. 152.0; Night Min. 107.5 Act. 96.0 August 13 - Day Min. 162.75 Act. 152.0; Night Min. 108.5 Act. 96.0 August 14 - Day Min. 162.0 Act. 152.0 December 22 - Day Min. 151.50 Act. 96.0. December 23 - Day Min. 153.00 Act. 96.0. December 24 - Day Min. 152.25 Act. 112.0. December 25 - Day Min. 152.25 Act. 144.0. December 26 - Day Min. 153.00 Act. 128.0. December 27 - Day Min. 152.25 Act. 136.0. January 24 - Day Min. 166.40 Act. 120.0; Eve. Min. 151.27 Act. 128.0; Night Min. 110.93 Act. 80.0. January 25 - Day Min. 165.60 Act. 128.0; Eve. Min. 150.55 Act. 120.0. January 26 - Day Min. 165.60 Act. 120.0; Eve. Min. 150.55 Act. 88.0.	P 5520		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORK NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 023802	7101 OLD YORK ROAD PHILADELPHIA, PA 19126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5520	Continued from page 5 January 27 - Day Min. 162.40 Act. 120.0; Eve. Min. 147.64 Act.144.0; Night Min. 108.27 Act. 104.0. January 28 - Day Min. 163.20 Act. 112.0; Night Min. 108.80 Act. 104.0. January 29 - Day Min. 166.40 Act. 160.0; Night Min. 110.93 Act. 72.0. The above findings were discussed with facility's administration on January 31, 2025, at 2:30 p.m. 28 Pa. Code 211.12 (f.1)(2) Nursing services	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 6 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	Step 1 The facility is currently staffed at or above state minimum requirements. Step 2 The facility will partner with agencies to ensure that LPN minimum requirements are met, allowing for better management of last-minute callouts and unexpected staffing events. Step 3 The staff coordinator and other administrative staff involved in coordinating staffing educated on federal and state CNA staffing requirements. Step 4 The NHA or designee will audit staffing levels weekly x4 and monthly x2. Results will be reviewed during the monthly QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 7 Based on review of facility staffing data for the three weeks including August 9, 2024, - August 9, 2024, December 21, 2024 - December 27, 2024, and January 24, 2025 - January 30, 2025, it was determined that the facility did not ensure a minimum of one licensed practical nurse (LPN) per 25 residents on day shift and on LPN per 40 residents on night shift on nine of twenty-one days reviewed. (weeks of August 9, 2024, - August 9, 2024, December 21, 2024 - December 27, 2024, and January 24, 2025 - January 30, 2025) Findings include: Review of facility's 'nursing staff ratio' for the weeks of August 9, 2024, - August 9, 2024, December 21, 2024 - December 27, 2024, and January 24, 2025 - January 30, 2025, revealed that facility did not meet LPN ratio as follows: Day Shift (7:00 a.m.- 3:00 p.m.) as follows: August 10, 2024 - Minimum Required (Req) hours 68.16; Actual hours 66.0	P 5530		

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P 5530	Continued from page 8 August 11, 2024 - Minimum Req. 67.84; Actual hours 66.0 August 13, 2024 - Minimum Req. 69.44; Actual hours 66.0 August 14, 2024 - Minimum Req. 69.12; Actual hours 66.0 August 15, 2024 - Minimum Req. 70.40; Actual hours 66.0 December 23, 2024 - Minimum Req. 67.32; Actual hours 66.0 January 24, 2025, - Minimum Req. 68.64; Actual hours 66.0 January 30, 2025, - Minimum Req. 68.97; Actual hours 66.0 Night Shift as follows: January 26, 2025, - Minimum Req. 42.69; Actual hours 41.25 The above findings were discussed with facility's administration on January 31, 2025, 2024, at 2:30 p.m.	P 5530		

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P 5530	Continued from page 9 28 Pa. Code 211.12 (F1)(4) Nursing Services	P 5530		
P 5640	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	The facility is currently staffed at or above state minimum requirements. Step 2 The facility will partner with agencies to ensure the state minimum requirement of 3.2 hours of direct resident care is met, allowing for better management of last-minute callouts and unexpected staffing events. Step 3 The staff coordinator and other administrative staff involved in coordinating staffing educated on federal and state CNA staffing requirements. Step 4 The NHA or designee will audit staffing levels weekly x4 and monthly x2. Results will be reviewed during the monthly QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 10 Based on review of facility staffing sheets, it was determined that the facility failed to provide a minimum of 3.2 hours of direct resident care for each resident in a 24 period for sixteen out of twenty-one sampled days. (weeks of August 9, 2024, - August 9, 2024, December 21, 2024 - December 27, 2024, and January 24, 2025 - January 30, 2025) Findings include: Review of facility nursing staffing sheets for the weeks of August 9, 2024, - August 9, 2024, December 21, 2024 - December 27, 2024, and January 24, 2025 - January 30, 2025, revealed the following days where the staffing hours of direct resident care fell below the required 3.2 hours: August 9, 2024 - 2.08 hrs. August 10, 2024 - 2.86 hrs. August 11, 2024 - 2.87 hrs. August 12, 2024 - 3.09 hrs. August 13, 2024 - 2.99 hrs.	P 5640		

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P 5640	Continued from page 11 August 14, 2024 - 3.04 hrs. August 15, 2024 - 2.98 hrs. December 22, 2024 - 3.05 hrs. December 23, 2024 - 2.98 hrs. December 24, 2024 - 2.96 hrs. January 24, 2025 - 2.61 hrs. January 25, 2025 - 2.86 hrs. January 26, 2025 - 2.54 hrs. January 27, 2025 - 2.87 hrs. January 28, 2025 - 3.06 hrs. January 29, 2025 - 2.43 hrs. During interview on January 31, 2025, at 2:00 p.m., with facility administration confirmed that the facility failed to meet the nursing hour requirements for these four days.	P 5640		

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P 5640	Continued from page 12	P 5640		

Certified End Page

YORK NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 023802

SURVEY EXIT DATE: 02/04/2025

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