STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395767	A. BLDG: 00 B. WING:	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ROSE VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **185502**	**1201 RURAL AVENUE** **WILLIAMSPORT, PA 17701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and Civil Rights Compliance survey completed on December 20, 2024, it was determined that Rose View 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.	F 0000		
F 0641 SS=D		F 0641		

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 0641 SS=D	Continued from page 1 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. The plan of correction represents the facility's credible allegation of compliance. F0641 1. MDS corrections were submitted for residents 102 and 108. 2. Current residents with MDS completed from January 6 2025 through January 20 2025 will be reviewed to determine accuracy of section I 2000. Current residents with MDS completed from January 6 2025 through January 20 2025 will be reviewed to determine accuracy of section A2105. 3. Education will be completed with Social Services on accuracy of section A 2105 of the MDS.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/09/2025**

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F 0641 SS=D	Continued from page 2	F 0641	Education will be provided to the RNAC on accuracy of section I 2000 of the MDS. 4. Random audits will be completed by DON or designee weekly for 4 weeks then monthly for 2 months of residents MDS to ensure accuracy of sections A 2105 and I 2000. Results of audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	

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F 0641 SS=D	Continued from page 3 Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for two of 23 residents reviewed (Residents 102 and 108). Findings include: Review of Resident 102's clinical record revealed that the facility admitted her with a diagnosis of pneumonia (an infection in the air sacs in one or both lungs) on September 6, 2024. Review of Resident 102's resolved diagnosis list indicated that her pneumonia infection was resolved on October 10, 2024. A Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated November 15, 2024, indicated the facility assessed her as still having pneumonia. There was no documented evidence in Resident 102's clinical record to indicate that she had a pneumonia infection.	F 0641		

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F 0641 SS=D	Continued from page 4 Interview with the Administrator on December 19, 2024, at 9:11 AM confirmed that Resident 102's November 15, 2024, MDS was coded in error regarding having pneumonia. Review of Resident 108's closed clinical record revealed an MDS assessment dated November 11, 2024, that indicated Resident 108 was discharged from the facility to a hospital setting. Physician progress note documentation dated November 11, 2024, at 11:29 AM indicated that Resident 108 was discharged home. Interview with the Nursing Home Administrator on December 20, 2024, at 10:58 AM confirmed Resident 108 was discharged home and the November 11, 2024, MDS was coded in error. §483.20(g) Accuracy of Assessments Previously cited 12/1/23	F 0641		

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F 0641 SS=D	Continued from page 5 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0641		
F 0684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	F0684 1. The bowel protocol medication administration cannot be retroactively implemented for resident 48. 2. Audit will be completed for current residents' bowel elimination records from January 6 2025-January 13 2025 to ensure that appropriate bowel protocol interventions are being administered. 3. Education will be provided to licensed staff on ensuring that the bowel protocol is being followed. 4. Random audits will be completed by the DON or designee weekly for 4 weeks then monthly for 2 months to ensure appropriate bowel protocol interventions are being administered. Results of audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/09/2025**

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F 0684 SS=D	Continued from page 6 Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding bowel protocol medication administration for one of 23 residents reviewed (Resident 48). Findings include: Clinical record review for Resident 48 revealed a medical provider progress note dated November 4, 2024, at 2:17 PM that indicated she was having difficulty passing stool. Review of Resident 48's bowel elimination records revealed that staff documented no bowel movements for November 27, 28, 29, and 30, 2024, and December 7, 8, 9, 10, or 11, 2024. Clinical record review for Resident 48 revealed the following physician orders to promote bowel movements: Milk of Magnesia Suspension 400 MG (milligrams)	F 0684		

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F 0684 SS=D	Continued from page 7 per 5 ML (milliliters) (MOM, laxative that pulls water into bowel to soften bowel contents) Give 30 ml by mouth as needed (PRN) for constipation if no BM (bowel movement) on day four give with the 7-3 shift morning medication pass. Bisacodyl Suppository 10 MG (Dulcolax, stimulant laxative medication administered via suppository form into the rectum to treat constipation by increasing fluid/salts in the intestines) Insert one suppository rectally PRN for constipation if MOM is ineffective on day five. Give with the 7-3 shift morning medication pass. Fleet's Enema 7-19 GM (grams) per 118 ml (Sodium Phosphates, liquid medication inserted into the rectum to treat constipation) Insert 1 applicator rectally PRN for constipation if Dulcolax is ineffective administer on day six. Administer with the 7-3 shift morning medication pass. There was no documentation on Resident 48's medication administration record (MAR) indicating	F 0684		

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F 0684 SS=D	Continued from page 8 that staff initiated her bowel protocol, or that she refused her bowel protocol medications, for the dates noted above. Interview with the Director of Nursing on December 20, 2024, at 9:55 AM confirmed the above noted findings that the facility failed to provide the highest practicable care related to Resident 48's bowel protocol medication administration. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0684		
F 0685 SS=D		F 0685		

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F 0685 SS=D	Continued from page 9 483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 0685	F0685 1. Resident 41's glasses will be delivered. 2. Current residents will be audited to ensure they have received their glasses if recommended by their optometrist. 3. Education will be completed with social services on ensuring residents receive their glasses timely. 4. Audits will be completed by the Social Services Director or designee monthly for 3 months to validate that residents with recommendations for new glasses receive them. Results of audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/09/2025**

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F 0685 SS=D	Continued from page 10 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to obtain proper treatment to maintain vision for one of one resident reviewed for vision concerns (Resident 41). Findings include: An interview with Resident 41 on December 17, 2024, at 11:06 AM revealed that she saw the eye doctor "a long time ago," and Resident 41stated that she never received her new glasses. Observation of Resident 41's overbed table at this time revealed there was a pair of broken eyeglasses with one of the lenses missing. Review of Resident 41's clinical record revealed see saw Health drive eye care group on June 7, 2024. Health drive recommended new glasses for Resident 41 and to deliver them upon arrival. Interview with the Nursing Home Administrator on December 20, 2024, at 10:52 AM confirmed	F 0685		

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F 0685 SS=D	Continued from page 11 Resident 41 never received the new glasses ordered on June 7, 2024. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0685		
F 0699 SS=D	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure 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 re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	F0699 1. Resident 57 and his wife reported no triggers to his PTSD and would not discuss further. 2. Audit of current residents with diagnoses of PTSD will be audited to ensure they have specific triggers in their PTSD care plans. 3. Education will be completed with social services on identifying and care planning specific triggers for a resident with the diagnosis of PTSD. 4. Random audits will be completed weekly by the Social Services Director or designee for 4 weeks then monthly for 2 months to ensure residents with a diagnosis of PTSD have specific triggers in their PTSD care plans. Results of audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/09/2025**

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F 0699 SS=D	Continued from page 12 Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder to provide culturally, competent, trauma-informed care and eliminate or mitigate re-traumatization for one of two residents reviewed for PTSD (Resident 57). Findings include: Clinical record review for Resident 57 revealed that the facility admitted him on March 1, 2023. Clinical record review for Resident 57 revealed that he had a current diagnosis of Post Traumatic Stress Disorder (PTSD, a mental health disorder that is caused by an extremely stressful or terrifying event). Review of Resident 57's current care plan revealed a care plan problem entitled, "has a mood problem related to PTSD and Adjustment disorder and may display moods of being withdrawn from people. Some triggers include not able to go home	F 0699		

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F 0699 SS=D	Continued from page 13 independently or to be at home with family." The goal and interventions were noted as follows: Resident 57 will have improved mood state through the review date Administer medications as ordered. Monitor/document for side effects and effectiveness. Assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these. Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Discuss with resident, if appropriate about long term care and needing assistance. Provide active listening and support when feeling overwhelmed or upset. Interview with the Nursing Home Administrator on December 19, 2024, at 11:30 AM revealed that Resident 57 was admitted with the diagnosis of PTSD. She stated that they spoke to Resident 57's	F 0699		

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F 0699 SS=D	Continued from page 14 wife yesterday and that she did not know what triggers him but indicated that he would wake up and go out into another room when he would have issues related to his PTSD, but he would not talk about it. She confirmed that the facility did not ask Resident 57's wife about his PTSD until after the surveyor brought it to their attention on December 18, 2024, at 2:50 PM. The facility failed to identify care plan triggers that may retraumatize Resident 57 related to his diagnosis of PTSD. 28 Pa Code 211.12 (d)(3)(5) Nursing services	F 0699		
F 0812 SS=D		F 0812		

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F 0812 SS=D	Continued from page 15 483.60(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	F0812 1. Grout in the dishroom around the dish machine area was cleaned and a vendor will be secured to complete the grout replacement. A vendor will be secured to fix the vinyl tiles around the ice machine and production area inside the entrance area. The threshold from the kitchen to the dish machine room was cleaned. 2. Audit will be completed of the dish room to ensure the grout is present and kitchen floor to ensure there are no cracked or broken vinyl tiles. Other thresholds in the kitchen will be checked to ensure they do not have black buildup. 3. Education will be completed with maintenance staff on maintaining the kitchen floor tiles and grout. Education will be completed with dietary staff on keeping the kitchen thesholds free of black buildup. 4. Random audits will be completed by the Dietary Manager or designee weekly for 4 weeks then monthly for 2 months to ensure the	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/09/2025**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=D	Continued from page 16	F 0812	threshold from the kitchen to the dish room is free of black buildup. Results of audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395767	A. BLDG: __00_____ B. WING: _____	12/20/2024

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F 0812 SS=D	Continued from page 17 Based on observation and staff interview, it was determined the facility failed to maintain the food preparation and dishwashing area in a safe and sanitary manner in the facility's main kitchen. Findings include: An observation of the facility's main kitchen with Employee 1, dietary manager, on December 17, 2024, at 8:25 AM revealed the following: Flooring tiles surrounding the dish machine area were absent of grout with observed liquid and food debris buildup in between the tiles. Multiple vinyl tiles in the kitchen entrance area outside the dish room, surrounding the ice machine and production area inside the entrance area were broken and cracked with dirt and debris buildup. The broken and cracked tiles are susceptible to harboring food/dirt debris presenting sanitation concerns in a food preparation area.	F 0812		

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F 0812 SS=D	Continued from page 18 The flooring where the tile meets the wall and transition strip from the kitchen to the dish machine room was observed with significant black buildup. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on December 19, 2024, at 2:30 PM. 483.60 (i)(2) Food storage safe and sanitary Previously cited 1/29/24 28 Pa. Code 201.14(a) Responsibility of licensee	F 0812		
F 0883 SS=D		F 0883		

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F 0883 SS=D	Continued from page 19 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	F0883 1. Resident 5 refused to have his pneumococcal vaccine administered and it was documented. 2. Audit will be completed of current residents to ensure those residents who consented to receive the pneumococcal vaccine have received it or documented refusal. 3. Education will be provided to the Infection Preventionist on ensuring those residents who consent to the pneumococcal vaccine receive it. 4. Random audits will be completed weekly for 4 weeks then monthly for 2 months to ensure residents who have newly consented to receiving the pneumococcal vaccine are offered it. Results of audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/09/2025**

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F 0883 SS=D	Continued from page 20 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

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F 0883 SS=D	Continued from page 21 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident received the pneumococcal immunization for one of five residents reviewed for immunization concerns (Resident 5). Findings include: Clinical record review revealed that the facility admitted Resident 5 on December 3, 2018. Review of Resident 5's immunization history revealed no evidence of a recommended pneumococcal vaccine. Review of a Pneumococcal Immunization Informed Consent dated November 18, 2024, revealed Resident 5's responsible party gave the facility permission to administer the pneumococcal vaccination. During an interview with the Nursing Home Administrator on December 20, 2024, at 11:53 AM	F 0883		

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F 0883 SS=D	Continued from page 22 it was confirmed that there was no documented evidence that Resident 5 was offered the pneumococcal immunization after the facility received the November 18, 2024 consent. 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Previously cited deficiency 12/1/23 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0883		

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P 1210	Management. (2) Protection of personal and property rights of the residents, while in the facility, and upon discharge or after death, including the return of any personal property remaining at the facility within 30 days after discharge or death. This REGULATION is not met as evidenced by:	P 1210	P1210 1. A signed belonging sheet cannot be retroactively produced for resident 108. 2. Audit will be completed of residents who have discharged from facility from January 6 2025 to January 13, 2025 to ensure that disposition of their personal property was completed. 3. Education will be provided to licensed nursing staff on ensuring disposition of residents personal property is completed and documented at time of discharge. 4. Random audits will be completed by the DON or designee weekly for 4 weeks then monthly for 2 months on residents who have discharged from facility to ensure disposition of their personal property is completed. Results of audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/09/2025**

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

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P 1210	Continued from page 1 Based on clinical record review and staff interview, it was determined that there was no evidence that identified the disposition of a resident's personal belongings following discharge from the facility for one of three closed records reviewed (Residents 108). Findings include: Closed clinical record review revealed the facility admitted Resident 108 on February 8, 2024. A physician's progress note dated November 11, 2024, at 11:29 AM revealed Resident 108 was discharged home. A review of Resident 108's personal belongings inventory form revealed that it was not signed by the resident/responsible party upon discharge from the facility. Further review of Resident 108's closed clinical record revealed no documentation to indicate the disposition of Resident 108's personal belongings.	P 1210		

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P 1210	Continued from page 2 Interview with the Nursing Home Administrator and Director of Nursing on December 19, 2024, at 2:31 PM confirmed the above noted findings related to the disposition of Resident 108's personal belongings.	P 1210		
P 5280		P 5280		

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P 5280	Continued from page 3 Pharmacy services. (j.1) The facility shall have written policies and procedures for the disposition of medications that address all of the following: (1) Timely and safe identification and removal of medications for disposition. (2) Identification of storage methods for medications awaiting final disposition. (3) Control and accountability of medications awaiting final disposition consistent with standards of practice. (4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition. (5) A method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice. This REGULATION is not met as evidenced by:	P 5280	P5280 1. A disposition of medication for resident 110 cannot be retroactively produced. 2. Audit will be completed of residents who have discharged from facility from January 6 2025 to January 13 2025 to ensure that a disposition of medication is completed upon discharge. 3. Education will be provided to licensed nursing staff on ensuring a disposition of medication is completed upon resident discharge. 4. Random audits will be completed by DON or designee weekly for 4 weeks then monthly for 2 months on residents who have discharged from facility to ensure disposition of medication is completed. Results of audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/09/2025**

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P 5280	Continued from page 4 Based on closed clinical record review and staff interview, it was determined that the facility failed to document the accounting and disposition of medications in the clinical record upon discharge for one of three residents reviewed (Resident 110). Findings include: Closed clinical record review for Resident 110 revealed that the resident expired at the facility on November 19, 2024. There was no documented evidence in Resident 110's closed clinical record regarding the disposition of the following medications: Atorvastatin (helps lower cholesterol) 40 mg (milligrams), Cyanocobalamin (vitamin supplement) 500 mcg (micrograms), Insulin Glargine (used to manage blood sugar) 100 units/ml (milliliter), Melatonin (helps with sleep) 3 mg, Metoprolol Succinate (treats high blood pressure and heart disease) 24 mg, Pantoprazole Sodium (treats acid reflux) 40 mg, Magnesium Oxide (mineral supplement) 400 mg,	P 5280		

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P 5280	Continued from page 5 Metformin HCL (treats high blood sugar) 500 mg, and Ranolazine (treats chest pain) 500 mg. Interview with the Nursing Home Administrator on December 20, 2024, at 11:45 AM confirmed there was no evidence of the disposition of Resident 110's medications upon the resident's death.	P 5280		
P 5520		P 5520		

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P 5520	Continued from page 6 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. Findings of nurse aide nursing staff care ratios cannot be retroactively corrected. 2. Facility will provide a minimum of one nurse aide per 10 residents during day shift and one nurse aide per 11 residents on evening shift and one nurse aide per 15 residents on overnight shift. Staffing team will meet daily Monday-Friday to review staffing needs and create plans to ensure nurse aide coverage. 3. Scheduling manager will be educated on the requirements there must be a minimum of one nurse aide per 10 residents during day shift and a minimum of one nurse aide per 11 residents on evening shift and one nurse aide per 15 residents on overnight shift. 4. Director of Nursing or Designee will conduct random audits to verify that nurse aide day shift, evening shift ratios and overnight shift meet the requirements weekly for 4 weeks and then monthly for 2 months thereafter. Audit results will be presented at the QAPI meeting for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/14/2025**

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P 5520	Continued from page 7 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide per 10 residents during the day shift for 15 of the 21 days reviewed, failed to ensure a minimum of one nurse aide per 11 residents during the evening shift for eight of the 21 days reviewed and failed to ensure a minimum of one nurse aide per 15 residents during the overnight shift for 17 of the 21 days reviewed. Findings include: A review of nursing care hours provided by the facility dated from November 10, 2024, through November 16, 2024, November 24, 2024, through November 30, 2024, and December 14, 2024, through December 19, 2024, revealed the following: Day shift: November 10, 2024, census of 112 with 9.62 NAs, required 11.20 November 11, 2024, census of 112 with 10 NAs,	P 5520		

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P 5520	Continued from page 8 required 11.20 November 13, 2024, census of 109 with 10 NAs, required 10.90 November 14, 2024, census of 108 with 10.02 NAs, required 10.80 November 15, 2024, census of 108 with 10.50 NAs, required 10.80 November 24, 2024, census of 109 with 8.09 NAs, required 10.90 November 25, 2024, census of 109 with 9.52 NAs, required 10.90 November 26, 2024, census of 109 with 8.24 NAs, required 10.90 November 29, 2024, census of 107 with 10.38 NAs, required 10.70 December 13, 2024, census of 110 with 8.34 NAs, required 11 December 14, 2024, census of 111 with 10.87 NAs, required 11.10 December 15, 2024, census of 112 with 9.40 NAs, required 11.20	P 5520		

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P 5520	Continued from page 9 December 16, 2024, census of 111 with 9.50 NAs, required 11.10 December 17, 2024, census of 111 with 9.88 NAs, required 11.10 December 18, 2024, census of 111 with 9.87 NAs, required 11.10 Evening shift: November 11, 2024, census of 111 with 9.75 NAs, required 10.09 November 12, 2024, census of 110 with 9.28 NAs, required 10 November 25, 2024, census of 110 with 9.25 NAs, required 10 November 30, 2024, census of 111 with 9.50 NAs, required 10.09 December 13, 2024, census of 112 with 9.15 NAs, required 10.18 December 15, 2024, census of 111 with 9.56 NAs, required 10.09	P 5520		

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ROSE VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **185502**	**1201 RURAL AVENUE** **WILLIAMSPORT, PA 17701**

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P 5520	Continued from page 10 December 16, 2024, census of 111 with 10 NAs, required 10.09 December 17, 2024, census of 112 with 10.08 NAs, required 10.18 Overnight shift: November 10, 2024, census of 112 with 6.56 NAs, required 7.47 November 11, 2024, census of 111 with 6.17 NAs, required 7.40 November 12, 2024, census of 110 with 6.03 NAs, required 7.33 November 13, 2024, census of 108 with 6.36 NAs, required 7.20 November 14, 2024, census of 107 with 6.08 NAs, required 7.13 November 15, 2024, census of 110 with 5.37 NAs, required 7.33 November 16, 2024, census of 110 with 5.40 NAs, required 7.33 November 24, 2024, census of 109 with 6.56 NAs,	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395767	A. BLDG: 00 B. WING:	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ROSE VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 185502	1201 RURAL AVENUE WILLIAMSPORT, PA 17701

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P 5520	Continued from page 11 required 7.47 November 27, 2024, census of 109 with 6 NAs, required 7.27 November 28, 2024, census of 107 with 6.15 NAs, required 7.13 November 29, 2024, census of 109 with 6.28 NAs, required 7.27 November 30, 2024, census of 110 with 5.37 NAs, required 7.33 December 13, 2024, census of 111 with 5.39 NAs, required 7.40 December 14, 2024, census of 112 with 6.53 NAs, required 7.47 December 16, 2024, census of 111 with 6.36 NAs, required 7.40 December 17, 2024, census of 112 with 5.84 NAs, required 7.47 December 18, 2024, census of 111 with 6 NAs, required 7.40 Interview with the Administrator on December 19, 2024, at 10:00 AM, confirmed the above findings.	P 5520		

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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ROSE VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **185502**	**1201 RURAL AVENUE WILLIAMSPORT, PA 17701**

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P 5530	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	P5530 1. Findings of LPN nursing staff care ratios cannot be retroactively corrected. 2. Facility will provide a minimum of one Licensed Practical Nurse per 25 residents during the day shift, a minimum of one LPN per 30 residents during the evening shift and a minimum of one LPN per 40 residents during the evening shift. Staffing team will meet daily Monday-Friday to review staffing needs and create plans to ensure LPN coverage. 3. Scheduling manager will be educated on the requirements of one Licensed Practical Nurse per 25 residents during the day shift, a minimum of one LPN per 30 residents during the evening shift and a minimum of one LPN per 40 residents during the evening shift. 4. Director of Nursing or Designee will conduct random audits to verify that LPN day shift, evening shift and night shift meet the requirements weekly for 4 weeks and then monthly for 2 months thereafter. Audit results will be presented at the QAPI meeting for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/14/2025**

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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ROSE VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **185502**	**1201 RURAL AVENUE WILLIAMSPORT, PA 17701**

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P 5530	Continued from page 13 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift for six of the 21 days reviewed, one LPN per 30 residents during the evening shift for one of the 21 days reviewed, and one LPN per 40 residents during the overnight shift for 14 of the 21 days reviewed. Findings include: A review of nursing care hours provided by the facility dated from November 10, 2024, through November 16, 2024, November 24, 2024, through November 30, 2024, and December 13, 2024, through December 19, 2024, revealed the following Day shift: November 13, 2024, census of 109 with 4.16 LPNs, required 4.36 November 14, 2024, census of 108 with 4 LPNs, required 4.32	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 14 November 16, 2024, census of 110 with 4.06 LPNs, required 4.40 November 25, 2024, census of 109 with 4 LPNs, required 4.36 November 26, 2024, census of 109 with 4.03 LPNs, required 4.36 December 18, 2024, census of 111 with 4.15 LPNs, required 4.44 Evening shift: November 27, 2024, census of 109 with 3.44 LPNs, required 3.63 Overnight shift: November 10. 2024, census of 112 with 2.03 LPNs, required 2.80 November 11. 2024, census of 111 with 2.04 LPNs, required 2.78 November 12. 2024, census of 110 with 2 LPNs,	P 5530		

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P 5530	Continued from page 15 required 2.75 November 13. 2024, census of 108 with 2.08 LPNs, required 2.70 November 14. 2024, census of 107 with 2 LPNs, required 2.68 November 15. 2024, census of 110 with 2 LPNs, required 2.75 November 16. 2024, census of 110 with 2.07 LPNs, required 2.75 November 24. 2024, census of 109 with 2 LPNs, required 2.73 November 25. 2024, census of 109 with 2 LPNs, required 2.73 November 28. 2024, census of 107 with 2 LPNs, required 2.68 November 29. 2024, census of 109 with 2 LPNs, required 2.73 November 30. 2024, census of 110 with 2.06 LPNs, required 2.75 December 14, 2024, census of 112 with 2 LPNs, required 2.80	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 16 December 15, 2024, census of 111 with 2 LPNs, required 2.78 Interview with the Administrator on December 19, 2024, at 10:00 AM confirmed the above findings.	P 5530		
P 5640		P 5640		

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 17 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	P5640 1. Findings of nursing staff care hours cannot be retroactively corrected. 2. Facility will provide a minimum of 3.2 hours nursing care hours per patient day. Staffing team will meet daily Monday-Friday to review staffing needs and create plans to ensure adequate coverage. 3. Scheduling manager will be educated on the requirement of providing a minimum of 3.2 nursing care hours per patient per day. 4. Director of Nursing or Designee will conduct random audits to verify that facility is providing a minimum of 3.2 nursing care hours per patient per day weekly for 4 weeks and then monthly for 2 months thereafter. Audit results will be presented at the QAPI meeting for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/14/2025**

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 18 Based on review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure the total of nursing care hours provided in each 24-hour period was a minimum of 3.2 hours per patient day (PPD), effective July 1, 2024, for 20 of the 21 days reviewed. Findings include: Review of nursing staff care hours for November 10, 2024, through November 16, 2024, November 24, 2024, through November 30, 2024, and December 13, 2024, through December 19, 2024, revealed that the facility failed to meet the minimum hours per patient day for the following days: November 10, 2024, 2.93 hours PPD November 11, 2024, 2.92 hours PPD November 12, 2024, 3.07 hours PPD November 13, 2024, 2.99 hours PPD November 14, 2024, 3.01 hours PPD November 15, 2024, 2.95 hours PPD November 16, 2024, 2.95 hours PPD	P 5640		

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P 5640	Continued from page 19 November 24, 2024, 2.88 hours PPD November 25, 2024, 2.97 hours PPD November 26, 2024, 3.12 hours PPD November 27, 2024, 3.19 hours PPD November 28, 2024, 3.18 hours PPD November 29, 2024, 3.18 hours PPD November 30, 2024, 2.96 hours PPD December 13, 2024, 2.81 hours PPD December 14, 2024, 3.04 hours PPD December 15, 2024, 2.93 hours PPD December 16, 2024, 3.06 hours PPD December 17, 2024, 3.03 hours PPD December 18, 2024, 3.03 hours PPD Interview with the Administrator on December 19, 2024, at 10:00 AM confirmed the above findings.	P 5640		

Certified End Page

ROSE VIEW NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 185502

SURVEY EXIT DATE: 12/20/2024

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
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