STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395774	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LANCASTER NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **035302**	**900 E KING STREET** **LANCASTER, PA 17602**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a follow-up survey completed on January 10, 2025, it was determined that Lancaster Nursing and Rehabilitation Center, continues to be out of compliance for staffing ratios from the surveys of October 31, 2024, September 11, 2024, and the original survey of June 18, 2024, in accordance with the updated staffing regulation requirements as of July, 2024 of the Commonwealth of Pennsylvania Long Term Care Regulations for the Health portion of the survey process.	F 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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P 5520		P 5520		

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

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	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. P 5520 Effective July 1, 2024 a minimum of 1 nurse aide per 10 resident during the day, 1 nurse aide per 11residents during the evening and 1 nurse aide per 15 residents overnight. 1. Findings of Nurse aide care ratios cannot be retroactively corrected. 2. The facility will provide 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.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **01/23/2025**

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 5520	Continued from page 2	P 5520	3. The scheduling coordinators will be educated on the requirements of 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. 4. NHA or designee will conduct random audits to verify that the requirements are met for nurse aides. Nurse aide ratios of 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. Audits will be conducted daily x 7 days then weekly for 3 weeks and then monthly for 2 months. Audit results will be presented at QAPI 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:
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P 5520	Continued from page 3 Based on review of nursing staff schedules on January 10, 2025, it was determined that the facility administrative staff failed to provide a minimum of one nurse aide per 10 residents during the day shift, one nurse aide per 11 residents during the evening shift, and one nurse aide per 15 residents for night shift, for four of seven days reviewed, January 3 through January 6, 2025. Findings include; The facility failed to meet the minimum staffing requirement on the following dates; On 1/3/25, the census was 374, on Evening shift the minimum hours required 255.00, the actual hours worked were 246.36. On 1/4/25, the census wa 372, on Day shift the minimum required hours were 279.0, the actual hours worked were, 261.71. On 1/5/25, the census was 374, on Night shift the minimum required hours were 187.0, the actual	P 5520		

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P 5520	Continued from page 4 hours worked were 186.66. On 1/6/25, the census was 374, on Day shift the minimum required hours were 280,50, the actual hours worked were 256.54. On Evening shift the minimum required hours were 255.0, the actual hours were 238.38. The above findings were relayed and confirmed during a telephone conversation with the NHA, on January 10, 2025 at 1:10 PM.	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 5 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	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. P 5530 Effective July 1, 2023 a minimum of 1 LPN per 25 residents during the day, 1LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. 1. Findings of LPN nursing staff care ratios cannot be retroactively corrected. 2. The facility will provide a minimum of 1 LPN per 25 residents during the day, 1LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. 3. The scheduling coordinators	Completion Date: **03/18/2025** Status: **APPROVED** Date: **01/23/2025**

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 6	P 5530	will be educated on the requirements of 1 LPN per 25 residents during the day, 1LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. 4. NHA or designee will conduct random audits to verify that LPN ratios on all shifts meet the requirements of 1 LPN per 25 residents during the day, 1LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. Audits will be conducted daily x 7 days then weekly for 3 weeks and then monthly for 2 months. Audit results will be presented at QAPI 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:
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P 5530	Continued from page 7 Based on review of Staffing schedules submitted on January 10, 2025, it was determined that the facility failed to provide the minimum of one Licensed Practical Nurse (LPN) per 25 residents during day shift, for two days of 7 days reviewed from January 1, 2025 through January 7, 2025. Findings include: Review of the staffing data provided by administrative staff, on January 10, 2025, revealed the following; that on January 4, 2025, and January 5, 2025, the minimum ratio on Day shift of 1:25 for Licenced Practical Nurse ratios, was not met as required by state regulation. On January 4, 2025, the census was 372, the minimum required hours were 119.0, but the actual staffing hours worked were 106.17. On January 5, 2025, the census was 374, the minimum required hours were 119.68, but the actual	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 8 hours worked were 114.89. The above findings were confirmed during a telephone conversation with the NHA on January 10, 2025, at 1:10 PM.	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 9 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	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. P 5640 Effective July 1, 2024 the total number of hours of general nursing care provided in each 24-hr period shall, when totaled for the entire facility, be a minimum of 3.20 hours of direct resident care for each resident. 1. Findings of PPD cannot be retroactively corrected. 2. The facility will have daily staffing meetings to review staffing levels and make the necessary adjustments as possible to meet the state minimum requirements of 3.2	Completion Date: **03/18/2025** Status: **APPROVED** Date: **01/23/2025**

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P 5640	Continued from page 10	P 5640	3. NHA or designee will provide re-education to facility nursing administration and scheduling that staffing levels must be a 3.2 or above and have the appropriate staff to perform care in the facility. 4. Facility leadership will complete random audits weekly x 4 and then monthly x 2 months to ensure the facility had a PPD of 3.2 or above. The audits will be reviewed by the QAPI committee and the QAPI committee will determine the need for further audits.	

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P 5640	Continued from page 11 Based on review of facility staffing data, for an 7 day period, January 1, 2025, through January 7, 2025, it was determined that the facility failed to ensure the total number of hours provided for Patients Per Day (PPD) that is, general nursing care hours provided over a 24 hour period , the minimum of of 3.2 hours per patient per day was not met as required by State Regulation, for 2 of 7 days reviewed. Findings include; Review of facility staffing data revealed the following dates were below 3.2 hours as required by State Regulation. On January 4, 2025, the ratio was 3.12, not 3.2 as required. On January 6, 2015, the ratio was 3.12, not 3.2 as required. The above findings were confirmed with the NHA,	P 5640		

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P 5640	Continued from page 12 on January 10, 2025 at 1:10 PM.	P 5640		

Certified End Page

LANCASTER NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 035302

SURVEY EXIT DATE: 01/10/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY