

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395853</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/06/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CRAWFORD CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>20881 STATE HIGHWAY 198 SAEGERTOWN, PA 16433</b>		
STATE LICENSE NUMBER: <b>193002</b>				
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F 0000	INITIAL COMMENT	F 0000		
F 0553 SS=E	Based on an Abbreviated Complaint Survey completed on January 6, 2025, it was determined that Crawford Care Center was not in compliance with the following Requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0553		

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 0553  SS=E	Continued from page 1  483.10(c)(2)(3) Right to Participate in Planning Care  §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.  §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 0553	1. Resident #1 had a care plan meeting invite sent/phoned to resident and/or responsible party and a care plan conference was held on 1/21/25. Resident #2 had a care plan meeting invite sent/phoned to resident and/or responsible party and a care plan conference was held on 11/19/24. A Social Service Progress note reflects the care plan being held with the responsible party. Resident #3 had a care plan meeting invite sent/phoned to resident and/or responsible party and a care plan conference will be held on 1/27/25.  2. All residents were reviewed to ensure that the resident and/or responsible party were invited to participate in planning of care meeting by Social Worker and residents that had not had in last 3 months were identified. Care plan conferences for any residents and/or responsible party that had not had a right to participate in their plan of care will have one completed.	Completion Date: <b>02/18/2025</b> Status: <b>APPROVED</b> Date: <b>01/31/2025</b>

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F 0553  SS=E	Continued from page 2  This REQUIREMENT is not met as evidenced by:	F 0553	3. All interdisciplinary team were educated by the Vice President of Clinical Services on the policy related to care planning. The Nursing Home Administrator and/or designee will audit and review 20 residents weekly x 4 weeks and to ensure all residents and/or responsible party receive and invite to participate in plan of care.  4. Findings will be presented to Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 0553  SS=E	Continued from page 3  Based on review of facility policies and clinical records, and staff interviews, it was determined that the facility failed to ensure the resident and/or resident representative was offered the opportunity to participate in the development, review, and/or revision of their person-centered care plan for three of three residents reviewed (Residents R1, R2, and R3).  Findings include:  Facility policy entitled "Care Planning - Interdisciplinary Team," dated 1/18/24, indicated the interdisciplinary team is responsible for the development of resident care plans. Resident care plans are developed according to the timeframes and criteria established by 483.21. The resident, the resident's family and/or resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan.  Facility policy entitled "Quarterly Assessments and	F 0553		

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F 0553  SS=E	Continued from page 4  Care Plan," dated 1/18/24, indicated Quarterly MDS assessments are conducted to track the resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. Quarterly and annual care plan conferences invites are to be mailed to responsible party and resident to participate in plan of care with interdepartmental team.  Resident R1's clinical record revealed an admission date of 9/23/20, with diagnoses that included heart disease, bronchitis, obstructive and reflux uropathy (a condition where the flow of urine is blocked and flows backward from the bladder and sometimes into the kidneys), and maxillary sinusitis (a condition when the sinuses behind the cheekbones become inflamed or infected).  Resident R1's clinical record revealed an Annual MDS (Minimum Data Set - federally mandated standardized assessment conducted at specific intervals to plan resident care needs) assessment,	F 0553		

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F 0553  SS=E	Continued from page 5  with an Assessment Reference Date (ARD - a look back period of time for the MDS assessment) of 9/20/24. The clinical record lacked any evidence that the resident or resident representative was invited to or attended a care plan meeting in conjunction with the 9/20/24, Annual MDS.  Resident R2's clinical record revealed an admission date of 10/29/21, with diagnoses that included Alzheimer's disease (a disease that affects the brain resulting in mood disturbances, behaviors, and poor decision making), high blood pressure, high cholesterol, and hypothyroidism (a condition where the thyroid does not produce enough thyroid hormone).  Resident R2's clinical record revealed a Quarterly MDS assessment, with an ARD of 9/13/24. The clinical record lacked any evidence that the resident or resident representative was invited to or attended a care plan meeting in conjunction with the 9/13/24, Quarterly MDS.	F 0553		

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F 0553  SS=E	Continued from page 6  Resident R3's clinical record revealed an admission date of 8/12/22, with diagnoses that included epilepsy (a chronic brain disorder that causes seizures), benign prostatic hyperplasia (a type of prostate gland enlargement that can cause urination difficulty), dysphagia (difficulty swallowing foods or liquids), and weakness.  Resident R3's clinical record revealed a Quarterly MDS assessment, with an ARD of 9/10/24. The clinical record lacked any evidence that the resident or resident representative was invited to or attended a care plan meeting in conjunction with the 9/10/24, Quarterly MDS.  During an interview on 12/30/24, at 1:50 p.m. the Social Worker confirmed the facility lacked evidence of care plan meetings for all residents prior to 10/01/24.  During an interview on 12/30/24, at 1:55 p.m. the	F 0553		

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F 0553  SS=E	Continued from page 7  Nursing Home Administrator (NHA) confirmed that the facility failed to ensure that the resident and/or resident representative was offered the opportunity to participate in the development, review, and/or revision of their person-centered care plan by not having care plan meetings between 5/01/24, and 10/01/24 for each resident, including Residents R1, R2 and R3.  28 Pa. Code 201.29(a) Resident Rights	F 0553		
F 0568  SS=B		F 0568		

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F 0568  SS=B	Continued from page 8  483.10(f)(10)(iii) Accounting and Records of Personal Funds  §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request.  This REQUIREMENT is not met as evidenced by:	F 0568	1. Resident R1 \$280.24 resident balance date 6/30/22 was previous ownership. New ownership did not occur until 11/1/23. New ownership although not their action made Resident R1 whole by placing \$280.24 back in resident fund. 2. All residents were reviewed for any other like transactions from previous owners on 1/17/2025 by the Business Office Manager. Resident #3 received her statement on 1/17/2025. All residents and/or responsible party received their statement on 1/17/2025. 3. The Nursing Home Administrator will audit weekly to ensure resident funds have receipts for transactions weekly for four weeks then monthly ongoing. The Nursing Home Administrator will audit monthly to ensure that residents and/or responsible party receive their statement quarterly for resident funds. 4. Findings will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	Completion Date: <b>02/18/2025</b> Status: <b>APPROVED</b> Date: <b>01/31/2025</b>

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F 0568  SS=B	Continued from page 9  Based on review of facility policy, and facility provided documentation, and staff interviews, it was determined that the facility failed to ensure that resident financial records were made available through quarterly statements for two of two residents reviewed (Residents R1 and R3).  Findings include:  Facility policy entitled "Resident Personal Funds" dated 1/18/24, revealed the resident has a right to manage his or her financial affairs to include the right to know, in advance, what charges a facility may impose against a resident's personal funds. Accounting and Records - The individual financial record must be available to the resident through quarterly statements and upon request.  Resident R1's clinical record revealed an admission date of 9/23/20, with diagnoses that included heart disease, bronchitis, obstructive and reflux uropathy (a condition where the flow of urine is blocked and flows backward from the bladder and sometimes	F 0568		

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F 0568  SS=B	<p>Continued from page 10</p> <p>into the kidneys), and maxillary sinusitis (a condition when the sinuses behind the cheekbones become inflamed or infected).</p> <p>Facility documentation indicated that the facility was responsible for handling Resident R1's finances through a resident trust fund account which had a balance of \$280.24 on 6/30/22. Further corresponding facility documentation dated 7/07/23, revealed \$3,715.65 as the balance.</p> <p>Resident R3's clinical record revealed an admission date of 8/12/22, with diagnoses that included epilepsy (a chronic brain disorder that causes seizures), benign prostatic hyperplasia (a type of prostate gland enlargement that can cause urination difficulty), dysphagia (difficulty swallowing foods or liquids), and weakness.</p> <p>Facility documentation indicated that the facility is responsible for handling Resident R3's finances through a resident trust fund account.</p>	F 0568		

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F 0568  SS=B	Continued from page 11  During an interview on 1/02/25, at 4:00 p.m. the Business Office Manager indicated that he/she had not provided quarterly financial statements at the end of the quarter, or within 30-days of the end of the quarter. He/She further confirmed the facility lacked evidence that Resident R1 was provided a receipt for the transaction regarding the \$280.24 funds in his/her trust account on 6/30/22.  28 Pa. Code 201.14(a) Responsibility of licensee  28 Pa. Code 201.18(b)(2) Management	F 0568		
F 0803  SS=D		F 0803		

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F 0803  SS=D	Continued from page 12  483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed  §483.60(c) Menus and nutritional adequacy. Menus must-  §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;  §483.60(c)(2) Be prepared in advance;  §483.60(c)(3) Be followed;  §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;  §483.60(c)(5) Be updated periodically;  §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and  §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.  This REQUIREMENT is not met as evidenced by:	F 0803	1. There were no actual resident complaint when the substitution was made to the menu. Dietary staff were educated on Menus and Menu policy, meeting resident needs, resident notification when a change is made to the menu, preparation in advance and followed by the regional dietary manager on January 14, 2025, which included notification of Menu Changes and Substitutions timely.  2. The Dietary Manager will monitor meal preparations to ensure that enough food is prepared for all meals.  3. Administrator /designee will audit random meal 5 times a week for 4 weeks, weekly for 4 weeks, then monthly ongoing to ensure menus are followed, that substitutions are posted timely, and that enough food was made to ensure dietary staff are following the menu.  4. The Administrator will submit Food Substitution Audits to the	Completion Date: <b>02/18/2025</b> Status: <b>APPROVED</b> Date: <b>02/03/2025</b>

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F 0803  SS=D	Continued from page 13	F 0803	Quality Assurance Performance Improvement Committee (QAPI) for review and recommendations at the monthly meeting.	

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F 0803  SS=D	Continued from page 14  Based on a review of facility policy, facility written menus, observations, and staff interviews, it was determined that the facility failed to follow their planned menu.  Findings include:  Facility policy entitled, "Menus" dated 1/18/24, revealed Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. A menu substitution log will be maintained on file.  Facility menus revealed a meal consisting of smothered chicken thigh, whole kernel corn, oven browned potatoes, cornbread, sliced pears and coffee or hot tea was to be provided for the residents' lunch meal on 12/30/24.	F 0803		

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NAME OF PROVIDER OR SUPPLIER: <b>CRAWFORD CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>20881 STATE HIGHWAY 198 SAEGERTOWN, PA 16433</b>		
STATE LICENSE NUMBER: <b>193002</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0803  SS=D	Continued from page 15  Observations of the 400-unit meal service on 12/30/24, at 1:15 p.m. revealed five residents received mashed potatoes instead of oven browned potatoes.  During an interview on 12/30/24, at 1:17 p.m. the Dietary Manager indicated mashed potatoes were provided to the five residents due to "running out" of the oven browned potatoes. The Dietary Manager further confirmed the residents were not notified of the food substitution.  During an interview on 12/30/24, at approximately 2:00 p.m. the Nursing Home Administrator indicated he/she is not sure why the dietary department would run out of food, other than not accounting for the new admissions and increased census in the past several weeks.  28 Pa. Code 211.6(a) Dietary services	F 0803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395853</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/06/2025</b>
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F 0809  SS=D	<p>483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime</p> <p>§483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.</p> <p>§483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.</p> <p>§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0809	<p>1. There were no adverse affects or issues with the residents meals not being served timely. Dietary staff will be educated on tray time and meal distribution policy by the Dietary Supervisor on January 14, 2025.</p> <p>2. The Dietary Manager will monitor the tray line to ensure that the tray line starts timely for all meals.</p> <p>3. Administrator/designee will audit random meals 5 times a week for 4 weeks, weekly for 4 weeks, then monthly ongoing to ensure meal distribution is timely as per meal teams.</p> <p>4. Findings will be presented to Quality Assurance Performance Improvement Committee for review and recommendations at the monthly meeting.</p>	<p>Completion Date: <b>02/18/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>01/31/2025</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395853</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/06/2025</b>	
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F 0809  SS=D	Continued from page 17  Based on a review of facility policy, facility meal schedules, observations, and staff interviews, it was determined the facility failed to follow their schedule for frequency of resident meals.  Findings include:  A facility policy entitled, "Meal Distribution," dated 1/18/24, revealed meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner.  Facility posting entitled, "Tray Service Schedule" noted: Lunch: 11:00 a.m. - 11:45 a.m. - Main Dining Room, 11:45 a.m. - 500 Hall, 11:55 a.m. - 600 Hall, 12:05 p.m. - 100 Hall, 12:15 p.m. - 300 Hall, 12:25 p.m. - 400 Hall.  Observations on 12/30/24, at 12:25 p.m., 12:35 p.m., and 12:50 p.m. of the dining rooms for the	F 0809		

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F 0809  SS=D	<p>Continued from page 18</p> <p>300 and 400 units revealed residents sitting in their wheelchairs and dining room chairs awaiting their lunch meal (both units are located in a secured dementia unit). At 12:57 p.m. (42 minutes beyond the scheduled service) the meal cart for the 300-unit dining room arrived with resident meals, followed by the meal cart for the 400-unit dining room arriving at 1:05 p.m. (40 minutes beyond the scheduled service). The last tray was observed being delivered to a resident at 1:15 p.m. of the 400 unit.</p> <p>An interview with Registered Nurse Employee E1 on 12/30/24, at 12:45 p.m. revealed meals are often late for the residents.</p> <p>An interview on 12/30/24, at 1:17 p.m. with the Dietary Manager confirmed the lunch meal should have been delivered at 12:15 p.m. and 12:25 p.m. respectively, for the residents of the 300 and 400 units per the facility tray service-meal schedule.</p> <p>The Dietary Manager further confirmed the dietary staff were late on the delivery of the meal due to a</p>	F 0809		

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F 0809  SS=D	Continued from page 19  late start with preparation of the lunch meal and did not start serving the main dining room until 11:30 a.m.  28 Pa. Code 201.14(a) Responsibility of licensee	F 0809			

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395853</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/06/2025</b>
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P 5520		P 5520		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395853</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/06/2025</b>
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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	1. Education will be provided to the Director of Nursing, Assistant Director of Nursing, and the Scheduler no later than 01/24/2025 on the regulatory requirements for Resident to Nursing Assistant Staffing Ratios. The facility is holding a 5-day-a-week Staffing Meeting and Quality Call to ensure compliance. 2. The nursing assistant schedule will be reviewed by the Director of Nursing, Assistant Director of Nursing, and Scheduler to ensure that Nursing Assistant ratios are met prior to posting of the schedule. In the event of call-offs by staff, all other staff/agency will be contacted to cover any open shifts to ensure ratios are met. 3. An audit will be conducted by the Director of Nursing and/or designee daily for 2 weeks, then 3 times a week for 2 weeks, then 2 times a week for one week then weekly ongoing, to ensure that nursing assistant ratios are met for the evening and overnight shifts. The audit will be monitored by the	Completion Date: <b>02/18/2025</b> Status: <b>APPROVED</b> Date: <b>01/30/2025</b>

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P 5520	Continued from page 2	P 5520	Director of Nursing or Designee. 4. The Director of Nursing will submit all Ratio Audits to the QAPI (Quality Assurance and Performance Improvement Committee for review and recommendations at the monthly meeting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395853</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/06/2025</b>
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P 5520	Continued from page 3  Based on review of the facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one Nurse Aide (NA) per 10 residents for the day shift for two of 21 days (12/22/24, 12/25/24); and failed to ensure a minimum of one Nurse Aide (NA) per 11 residents for the evening shifts for three of 21 days (12/22/24, 12/25/24, and 12/27/24); and failed to ensure a minimum of one NA per 15 residents for the overnight shift for three of 21 days reviewed (12/24/24, 12/25/24, and 12/27/24).  Findings include:  Review of facility nursing staffing documents for the time periods from 12/17/24, through 12/23/24, and 12/24/24, through 1/30/24, revealed the following NA staffing shortages for the day shift where the NA ratios were not met:  12/22/24          census of 122 residents          10.28 NA worked and 12.20 were required. 12/25/24          census of 120 residents          9.28	P 5520		

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P 5520	Continued from page 4  NA worked and 12.0 were required.  Review of facility nursing staffing documents for the time periods from 12/17/24, through 12/23/24, and 12/24/24, through 12/30/24, revealed the following NA staffing shortages for the evening shift where the NA ratios were not met:  12/22/24          census of 122 residents          9.15 NA worked and 11.09 were required. 12/25/24          census of 120 residents          8.07 NA worked and 10.91 were required. 12/27/24          census of 119 residents          8.45 NA worked and 10.82 were required  Review of facility nursing staffing documents for the time periods from 12/17/24, through 12/23/24, and 12/24/24, through 12/30/24, revealed the following NA staffing shortages for the overnight shift where the NA ratios were not met:	P 5520		

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P 5520	Continued from page 5  12/24/24 census of 120 residents 7.78 NA worked and 8.0 were required. 12/25/24 census of 119 residents 5.01 NA worked and 7.93 were required. 12/27/24 census of 119 residents 5.39 NA worked and 7.93 were required.  During an interview on 1/03/25, at 2:35 p.m. the Assistant Director of Nursing confirmed the NA ratios were not met for the above days and shifts.	P 5520		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395853</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/06/2025</b>
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P 5640	Continued from page 6  Nursing services.  (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.  This REGULATION is not met as evidenced by:	P 5640	1. Additional Staffing Agencies have been added to the facility to provide additional nursing staff to meet the state minimum requirement of 3.20 hours of direct resident care for each resident in a 24-hour period. Education will be provided to the Director of Nursing, Asst. Director of Nursing and the Scheduler no later than 1/24/2025 to ensure that they understand the regulatory staffing requirement.  2. The nursing schedule consisting of all three (3) disciplines (RN/LPN/CNA) will be reviewed by the Scheduler, Director of Nursing and/or Asst. Director of Nursing to ensure that the requirement of 3.20 direct nursing care hours is met prior to posting of the schedule. In the event of call-offs by staff, all facility nursing staff and/or agency staff will be contacted to cover any open shifts to ensure the 3.20 direct nursing care ratio is met. The facility continues to utilize job boards and various recruiting venues to attract, interview, recruit, and hire new staff.	Completion Date: <b>02/18/2025</b> Status: <b>APPROVED</b> Date: <b>01/30/2025</b>

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P 5640	Continued from page 7	P 5640	<p>The facility conducts Recruitment and Retention Committee meetings weekly and has adopted a monthly rewards and recognition programs to retain current staff. The facility will conduct Staffing Meetings and Quality Calls with upper management five (5) days per week to ensure compliance.</p> <p>3. An audit will be conducted by the Director of Nursing and/or designee, daily for two (2) weeks, three (3) times per week for one (1) week, then weekly ongoing to ensure that 3.20 hours of direct nursing care ratio is met for the 24-hour period. The audit will be monitored by the Director of Nursing and/or Assistant Director of Nursing.</p> <p>4. The Director of Nursing will submit all Staffing Audits will be submitted to the Quality Assessment and Performance Improvement (QAPI) Committee at the monthly meeting for review and recommendation.</p>	

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P 5640	Continued from page 8  Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to provide the minimum number of general nursing care hours of 3.2 hours of direct resident care hours per resident in a 24-hour period for six of 21 days reviewed (12/22/24, 12/23/24, 12/24/24, 12/25/24, 12/27/24, and 12/29/24).  Findings include:  Review of facility nursing staffing documents for the time periods from 12/10/24, through 12/30/24, revealed that the hours of direct resident care was below 3.2 minimum per patient per day (PPD) on the following dates:  12/22/24    2.98 12/23/24    3.10 12/24/24    3.07 12/25/24    2.50 12/27/24    2.74 12/29/24    3.02	P 5640		

Pennsylvania Department of Health

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P 5640	Continued from page 9  During an interview on 1/03/25, at 2:35 p.m. the Assistant Director of Nursing confirmed the facility did not meet the 3.2 minimum hours of direct resident care on the above dates.	P 5640			

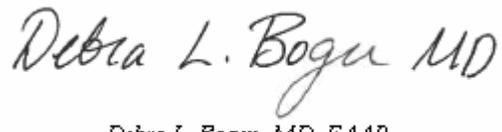


# Certified End Page

**CRAWFORD CARE CENTER**  
**STATE LICENSE NUMBER: 193002**  
**SURVEY EXIT DATE: 01/06/2025**

**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