STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396049	A. BLDG: 00 B. WING:	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
JAMESON NURSING AND REHAB CENTER STATE LICENSE NUMBER: **069402**	**3349 WILMINGTON RD** **NEW CASTLE, PA 16105**

(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 February 4, 2025, it was determined that Jameson Nursing and Rehab Center failed to correct the deficiency cited during the survey of December 31, 2024 under the requirements of the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	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:

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 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	"The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements." 1. The facility cannot correct that the nurse aide staffing ratio was not met on 1/29/25, 2/2/25 and 2/3/25. There were no adverse effects to residents on the identified dates. 2.The scheduler will be re- educated regarding the state ratios by the Nursing Home Administer/designee. 3.The Director of Nursing and RN Supervisors will be re-educated on staffing ratios by the Nursing Home Administrator/designee. 4.Twice a day staffing meetings will	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/24/2025**

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	be held Monday through Friday to review the schedule with ratios. Nursing supervisors will monitor on weekends. If the facility is projected to not meet staffing ratios the scheduler/or designee will call off duty facility staff and will utilize pick up bonuses. 5.The facility has developed a monthly recruitment and retention committee meeting. 6.Nurse Aide positions are actively posted in recruitment. 7.Nursing Home Administrator/designee will audit staffing daily for three weeks and monthly for three months to ensure staffing ratios are being met. 8.Admission intake will be reviewed in relationship to staffing. 9.Outcomes will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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P 5520	Continued from page 3 Based on review of 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 on the day shift for three of six days reviewed (1/29/25, 2/02/25, and 2/03/25) and failed to ensure a minimum of one NA per 11 residents on the evening shift for one of six days (2/03/25). Findings include: Review of nursing staffing documents for the time period from 1/29/25 to 2/03/25, revealed the following NA shortages for the day shift: 1/29/25 facility census of 69 residents 6.07 NA's worked and 6.90 were required. 2/02/25 facility census of 68 residents 6.07 NA's worked and 6.80 were required. 2/03/25 facility census of 69 residents 4.89 NA's worked and 6.90 were required.	P 5520		

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P 5520	Continued from page 4 Review of nursing staffing documents for the time period from 1/29/25 to 2/03/25, revealed the following NA shortages for the evening shift: 2/03/25 facility census of 68 residents 4.63 NA's worked and 6.18 were required. During an interview on 2/04/25, at 2:45 p.m. the Nursing Home Administrator confirmed the facility failed to meet the minimum NA to resident ratio on the above dates and shifts.	P 5520		

Certified End Page

JAMESON NURSING AND REHAB CENTER

STATE LICENSE NUMBER: 069402

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