

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396049	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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NAME OF PROVIDER OR SUPPLIER: JAMESON NURSING AND REHAB CENTER STATE LICENSE NUMBER: 069402	STREET ADDRESS, CITY, STATE, ZIP CODE: 3349 WILMINGTON RD NEW CASTLE, PA 16105
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(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
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	"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

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P 5520	Continued from page 2	P 5520	<p>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.</p> <p>5.The facility has developed a monthly recruitment and retention committee meeting.</p> <p>6.Nurse Aide positions are actively posted in recruitment.</p> <p>7.Nursing Home Administrator/designee will audit staffing daily for three weeks and monthly for three months to ensure staffing ratios are being met.</p> <p>8.Admission intake will be reviewed in relationship to staffing.</p> <p>9.Outcomes will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	

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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		



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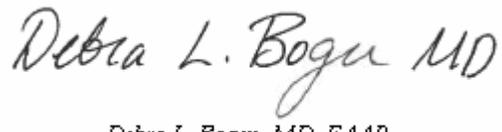
JAMESON NURSING AND REHAB CENTER

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, 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