STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET** **NEW CASTLE, PA 16101**

(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, State Licensure, and Civil Rights Compliance Survey completed on December 13, 2024, it was determined that Haven Convalescent Home 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 0000		
F 0880 SS=E		F 0880		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET** **NEW CASTLE, PA 16101**

(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 0880 SS=E	Continued from page 1 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Policy on Enhanced Barrier Precautions was added to the Facility Infection Control Policies. All residents of the facility who require Enhanced Barrier Precautions were ordered enhanced barrier precautions by their physician. Appropriate signage was placed on the doors of the residents who were ordered enhanced barrier precautions and appropriate PPE was made available. A letter was mailed out to each resident's responsible person concerning enhanced barrier precautions. Nursing was in-serviced by the Director of Nursing on 12/19/2024 on Enhanced Barrier Precautions. Infection preventionist or nurse designee will monitor residents on Enhanced Barrier to ensure that the appropriate signage and PPE is provided and that staff are donning, doffing and utilizing the appropriate PPE as needed when caring for these residents. Monitoring will occur at least once a week on all 3 shifts weekly for 4 weeks and then at least	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET NEW CASTLE, PA 16101**

(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 0880 SS=E	Continued from page 2 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	monthly until deemed in compliance by facility QAPI Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET** **NEW CASTLE, PA 16101**

(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 0880 SS=E	Continued from page 3	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET** **NEW CASTLE, PA 16101**

(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 0880 SS=E	Continued from page 4 Based on a review of clinical records, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) during observation of a wound and foley catheter (tubing inserted into the bladder to drain urine) for one of 19 residents reviewed (Resident R78). Findings include: No facility policy on EBP provided. Resident R78's clinical record revealed an admission date of 11/08/24, with diagnoses that included chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe), anemia (low red blood cells in the blood which carries oxygen), hyperlipidemia (high levels of fats-cholesterol and triglycerides in the blood), and dementia (a disease affecting mood, behavior and decision making).	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: 081102	725 PAUL STREET NEW CASTLE, PA 16101

(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 0880 SS=E	Continued from page 5 Observation of a wound dressing change on 12/11/24, at 10:30 a.m. revealed that Registered Nurse (RN) Employee E1 and Nursing Assistant (NA) Employee E2 failed to don (put on) proper personal protective equipment (PPE) by not wearing a gown during the dressing change of Resident R78's sacral wound. During an interview with RN Employee E1 on 12/12/24, at approximately 1:00 p.m. it was confirmed that a gown should have been worn as part of EBP during the dressing change for Resident R78's sacral wound. Observation of Resident R78's room revealed that there was no signage alerting persons entering the room of EBP for infection control and no PPE available outside of the room for use. During an interview on 12/11/24, at approximately 2:20 p.m. the Director of Nursing (DON) confirmed that the facility had nine residents with foley	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: 081102	725 PAUL STREET NEW CASTLE, PA 16101

(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 0880 SS=E	Continued from page 6 catheters, two residents with a feeding tube, two residents with a colostomy, seven residents with a wound, and two residents with a dialysis catheter, but did not have EBP maintained for these residents. The DON further confirmed that employees should be wearing gloves and gowns when providing care for these residents. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: 081102	725 PAUL STREET NEW CASTLE, PA 16101

(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
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:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET** **NEW CASTLE, PA 16101**

(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
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	Facility Staffing Coordinator was reeducated on current CNA staffing ratios according to current census and shifts. Facility will attempt to utilize facility staff and temporary staffing agencies as needed. Facility weekly Schedule will be made in accordance with current Pennsylvania DOH Staffing guidelines and facility census. Nursing Supervisors to be in-serviced on staffing guidelines by 1/8/2025. For the shifts on the dates indicated all residents in the facility received the care that they required, and the facility received no complaints from residents, their responsible person(s) or employees. Schedule and census will be monitored daily per shift by RN Nursing Supervisor for call offs and changes in census. Adjustments will be made as needed by Director of Nursing, RN Nursing Supervisor or Staffing Coordinator. Facility will utilize facility staff and or temporary Staffing Agencies to fill in shifts as needed according to type of nursing	Completion Date: **02/14/2025** Status: **APPROVED** Date: **01/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: 081102	725 PAUL STREET NEW CASTLE, PA 16101

(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
P 5520	Continued from page 2	P 5520	service personal that is needed. Assistant Administrator or designee will monitor schedules at least weekly x 4 weeks and then every 2 weeks until deemed in compliance by facility QAPI Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET** **NEW CASTLE, PA 16101**

(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
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 NA per 15 residents on the overnight shift for 18 of 21 days reviewed (8/01/24, 8/02/24, 8/04/24 through 8/07/24, 11/10/24 through 11/15/24, and 12/06/24 through 12/12/24). Findings include: Review of 21 days of nursing staffing documents for the time periods from 8/01/24 to 8/07/24, 11/10/24 to 11/16/24, and 12/06/24 to 12/12/24 revealed the following NA shortages for the overnight shift: 8/01/24 facility census of 89 residents 5.00 NA's worked and 5.93 were required. 8/02/24 facility census of 89 residents 5.75 NA's worked and 5.93 were required. 8/04/24 facility census of 88 residents 5.31 NA's worked and 5.87 were required. 8/05/24 facility census of 88 residents 4.75 NA's worked and 5.87 were required.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: 081102	725 PAUL STREET NEW CASTLE, PA 16101

(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
P 5520	Continued from page 4 8/06/24 facility census of 87 residents 5.38 NA's worked and 5.80 were required. 8/07/24 facility census of 90 residents 5.25 NA's worked and 8.70 were required. 11/10/24 facility census of 89 residents 5.50 NA's worked and 5.93 were required. 11/11/24 facility census of 88 residents 5.50 NA's worked and 5.87 were required. 11/12/24 facility census of 90 residents 5.75 NA's worked and 6.00 were required. 11/13/24 facility census of 90 residents 5.75 NA's worked and 6.00 were required. 11/14/24 facility census of 89 residents 5.75 NA's worked and 5.93 were required. 11/15/24 facility census of 88 residents 5.75 NA's worked and 5.87 were required. 12/06/24 facility census of 89 residents 5.31 NA's worked and 5.93 were required. 12/07/24 facility census of 89 residents 4.88 NA's worked and 5.93 were required. 12/08/24 facility census of 89 residents 4.75	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: 081102	725 PAUL STREET NEW CASTLE, PA 16101

(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
P 5520	Continued from page 5 NA's worked and 5.93 were required. 12/09/24 facility census of 90 residents 5.25 NA's worked and 6.00 were required. 12/10/24 facility census of 90 residents 5.25 NA's worked and 6.00 were required. 12/12/24 facility census of 90 residents 5.25 NA's worked and 6.00 were required. During an interview on 12/13/24, at approximately 10:30 a.m. the Nursing Home Administrator confirmed the accuracy of the facility provided staffing information and confirmed the facility failed to meet the minimum NA to resident ratio on the above dates and shift.	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:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET** **NEW CASTLE, PA 16101**

(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
P 5530	Continued from page 6 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	Facility Staffing Coordinator was reeducated on current LPN staffing ratios according to current census and shifts. Facility will attempt to utilize facility staff and temporary staffing agencies as needed. Facility weekly Schedule will be made in accordance with current Pennsylvania DOH Staffing guidelines and facility census. Nursing Supervisors to be in-serviced on staffing guidelines by 1/8/2025. For the shifts on the dates indicated all residents in the facility received the care that they required, and the facility received no complaints from residents, their responsible person(s) or employees. Schedule and census will be monitored daily per shift by RN Nursing Supervisor for call offs and changes in census. Adjustments will be made as needed by Director of Nursing, RN Nursing Supervisor or Staffing Coordinator. Facility will utilize facility staff and or temporary Staffing Agencies to fill in shifts as	Completion Date: **02/14/2025** Status: **APPROVED** Date: **01/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET NEW CASTLE, PA 16101**

(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
P 5530	Continued from page 7	P 5530	needed according to type of nursing service personal that is needed. Assistant Administrator or designee will monitor schedules at least weekly x 4 weeks and then every 2 weeks until deemed in compliance by facility QAPI Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET** **NEW CASTLE, PA 16101**

(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
P 5530	Continued from page 8 Based on review of facility staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one Licensed Practical Nurse (LPN) per 25 residents on the day shift for one of 21 days reviewed (12/07/24); and failed to meet the minimum ratio of one LPN per 40 residents on the overnight shift for eight of 21 days reviewed (8/05/24, 8/07/24 and from 12/06/24 through 12/12/24). Findings include: Review of 21 days of nursing staffing documents for the time periods from 8/01/24 to 8/07/24, 11/10/24 to 11/16/24, and 12/06/24 to 12/12/24 revealed the following LPN shortage for the day shift: 12/07/24 facility census of 89 residents 3.0 LPNs worked and 3.56 were required. Review of 21 days of nursing staffing documents for the time periods from 8/01/24 to 8/07/24, 11/10/24	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: 081102	725 PAUL STREET NEW CASTLE, PA 16101

(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
P 5530	Continued from page 9 to 11/16/24, and 12/06/24 to 12/12/24 revealed the following LPN shortages for the overnight shift: 8/05/24 facility census of 88 residents 2.0 LPN worked and 2.20 were required. 8/07/24 facility census of 90 residents 2.0 LPN worked and 2.25 were required. 12/06/24 facility census of 89 residents 2.0 LPN worked and 2.23 were required. 12/07/24 facility census of 89 residents 2.0 LPN worked and 2.23 were required. 12/08/24 facility census of 89 residents 2.0 LPN worked and 2.23 were required. 12/09/24 facility census of 90 residents 2.0 LPN worked and 2.25 were required. 12/10/24 facility census of 90 residents 2.0 LPN worked and 2.25 were required. 12/12/24 facility census of 90 residents 2.0 LPN worked and 2.25 were required. During an interview on 12/13/24, at 10:30 a.m. the Nursing Home Administrator confirmed that the facility failed to meet the minimum LPN ratio	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: 081102	725 PAUL STREET NEW CASTLE, PA 16101

(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
P 5530	Continued from page 10 requirements on the above shifts and dates.	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:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET** **NEW CASTLE, PA 16101**

(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
P 5640	Continued from page 11 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	Facility Staffing Coordinator was reeducated on current nursing care hours provided according to current census and shifts. Facility will attempt to utilize facility staff and temporary staffing agencies as needed. Facility weekly Schedule will be made in accordance with current Pennsylvania DOH Staffing guidelines and facility census. Nursing Supervisors to be in-serviced on staffing guidelines by 1/8/2025. For the date indicated all residents in the facility received the care that they required, and the facility received no complaints from residents, their responsible person(s) or employees. Schedule and census will be monitored daily per shift by RN Nursing Supervisor for call offs and changes in census. Adjustments will be made as needed by Director of Nursing, RN Nursing Supervisor or Staffing Coordinator. Facility will utilize facility staff and or temporary	Completion Date: **02/14/2025** Status: **APPROVED** Date: **01/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: **081102**	**725 PAUL STREET NEW CASTLE, PA 16101**

(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
P 5640	Continued from page 12	P 5640	Staffing Agencies to fill in shifts as needed to comply with current nursing care hours in a 24-hour period. Assistant Administrator or designee will monitor schedules at least weekly x 4 weeks and then every 2 weeks until deemed in compliance by facility QAPI Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396106	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAVEN CONVALESCENT HOME INC STATE LICENSE NUMBER: 081102	725 PAUL STREET NEW CASTLE, PA 16101

(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
P 5640	Continued from page 13 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure the total number of nursing care hours provided in each 24-hour period met the required minimum of 3.2 hours of direct care per resident for one of 21 days reviewed (8/07/24). Findings include: Review of nursing staffing documents for the time periods from 8/01/24 to 8/07/24, 11/10/24 to 11/16/24, and 12/06/24 to 12/12/24 revealed the following per patient day (PPD) hours: 8/07/24 3.16 PPD During an interview on 12/13/24, at approximately 10:30 a.m. the Nursing Home Administrator confirmed the accuracy of the facility provided staffing information and confirmed the facility failed to meet the required hours of direct resident care on the above date.	P 5640		

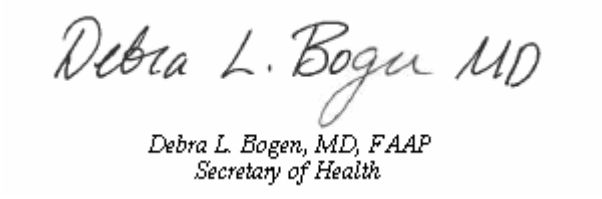
Certified End Page

HAVEN CONVALESCENT HOME INC

STATE LICENSE NUMBER: 081102

SURVEY EXIT DATE: 12/13/2024

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY