

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Yorkview Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 970 Colonial Avenue York, PA 17403	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on facility policy, investigation reports, clinical records, and staff interviews, it was determined the facility failed to ensure residents are treated with respect and dignity for one of three residents reviewed (Resident 1). Findings include: Review of facility policy, titled Quality of life -Dignity, with revision date of August 2009, indicated; Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Review of the clinical record for Resident 1 revealed diagnoses that included dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement) with behavioral disturbance and adult failure to thrive (a syndrome characterized by unexplained weight loss, muscle wasting, and functional decline). Review of Resident 1 Quarterly MDS (periodic assessment of resident health, functional status, and needs) dated July 16, 2025, revealed the Resident had a brief interview of mental status (BIMS) and scored a 10, indicating moderately impaired cognitive status. Review of Resident 1's care plan had a focus area that stated the Resident had the potential to demonstrate verbally abusive behaviors related to dementia with behaviors and paranoia (an unrealistic trust of others or a feeling of being persecuted). A review of the facility reported event dated August 26, 2025, revealed Employee 1 went into Resident 1's room to provide incontinence care. Employee 3 was not present in the room, but could hear Resident 1 yelling at Employee 1 and requested Employee 2 to assist Employee 1. Employee 2 (Nurse Aide) provided a written statement to Administration stating that when he entered Resident 1's room, the Resident was scratching and hitting Employee 1. Employee 2 added that Employee 1 (Nurse Aide) had her hand raised above her head as if to strike Resident 1. Employee 2 added that Employee 1 lowered her hand when he entered the room. Employee 2 also added in the written statement that Resident 1 said to Employee 1 go ahead and hit me. Employee 2 stated that he assisted Employee 1 to secure Resident 1's brief and both staff left Resident 1's room. Employee 2 reported the event to Administration on August 26, 2025, immediately upon leaving Resident 1's room. The Registered Nurse assessed Resident 1, no new skin issues were identified. Employee 4 also notified the Resident Representative and physician. The facility did report the event to the appropriate agencies. Employee 1 was terminated from the facility due to being within her 90 days of hire and during interview with Nursing Home Administrator (NHA) was not receptive of reapproaching a resident later who is combative. Resident 1 was unable to be interviewed by NHA regarding the event due to periods of confusion and a cognitive communication deficit. The surveyor attempted to interview Resident 1 on September 4, 2025, at 11:30 AM, regarding the event but Resident 1 just stared and then closed her eyes. A response from the Director of Nursing on September 4, 2025, was there was no physical abuse. The said employee did not actually hit the resident; there was no mental anguish or anything. During an interview with the NHA on September 5, 2025, at 2:00 PM, the NHA agreed that when Resident 1 became combative during care, Employee 1 should have left the room and reapproached at a later time. 28 Pa Code 211.12(d)(1) Nursing services</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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