

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/24/2026
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)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on facility policy review, clinical record review, review of facility investigation documentation, review of hospital documentation, and resident and staff interviews, it was determined that the facility displayed past non-compliance in its failure to ensure each resident the right to be free from neglect for one of four residents reviewed (Resident 2), which resulted in actual harm for Resident 2 as evidenced by a fall with a femur fracture. Findings Include: Review of the facility's policy, titled Abuse, read, in part, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. The policy continued, Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The policy also defined serious physical injury as an injury that causes a person severe pain, significantly impairs a person's physical functioning, either temporarily or permanently. Review of the nurse aid job description revealed the purpose of the position was, to provide each of your assigned residents with daily nursing care and service in accordance with the resident's assessment and care plan . Duties and Responsibilities of a nurse aid included, Perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors. Review of Resident 2's clinical record revealed diagnoses that included hypertension (elevated blood pressure), difficulty walking, and contracture of the left and right knees. Review of Resident 2's interdisciplinary plan of care revealed a problem area that read risk of ADL self-care performance deficit. ADL's (Activities of Daily Living) described as self-care tasks an individual does daily that includes eating, bathing, dressing, getting out of bed or a chair. The plan of care continued, Bed Mobility- Max Assist x 2. Max Assist of 2 is described as when a patient needs maximal physical help from 2 people in order to complete a task. Review of Resident 2's Kardex (a concise patient care summary detailing a patient's daily care plan), read Bed Mobility-Max Assist of 2. Review of the facility's incident report, dated July 7, 2026, read [Resident 2] rolled out of his bed onto the floor while [Nurse Aide-Employee 2] was giving him care. The incident report continued, [Resident 2] complained of pain in his right ankle, R[ight] knee and his R[ight] hip area. After assessment it was determined that the resident needed to be sent to hospital for further assessment. Review of Employee 2's statement regarding Resident 2's fall revealed I was giving care to resident, and he was lying on his side. The resident rolled out of the bed he stated the bed was inflating and that his body could not adjust to the bed inflating [in] the inflation caused him to fall from his bed. Review of Resident 2's statement, post fall, read She came to change me and rolled me away from her. Her mistake was not bringing in 2 people. Review of Resident 2's hospital clinical record information revealed an assessment with diagnoses that included closed right distal femur fracture. The assessment also read Patient was seen and evaluated at the Emergency Department. Sustained (continued on next page)		

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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F 0600 Level of Harm - Actual harm Residents Affected - Few	a closed right distal femur fracture after fall off his bed earlier today. Additional review of the hospital clinical record revealed Resident 2 required surgical intervention while hospitalized to repair the fracture. An interview with the Nursing Home Administrator (NHA) on July 21, 2026, at 8:54 AM, revealed Employee 2 did not follow Resident 2's plan of care and should have had another staff person to help with providing care to Resident 2. The interview confirmed Employee 2 was not eligible to return to work at the facility at that time. The interview with the NHA also revealed Employee 2 stated that she did not know why she didn't get help with assisting Resident 2 in his bed. Prior to the abbreviated survey, the facility failed to ensure each resident the right to be free from neglect, resulting in harm for Resident 2 as evidenced by a closed distal right femur fracture. During the onsite visit on July 21, 2026, at 9:00 AM, the NHA confirmed the facility initiated and provided the facility's plan of correction that was put into place as a result of the facility's investigation into the fall, with a completion date of July 10, 2026. Review of the facility's document, titled Past Non-Compliance read, Resident to be provided with 2 assists during care, as per Care Plan. Review of current resident will be completed to ensure resident with air mattresses who require 2 assist are receiving 2 assist during care as per plan of care. Nursing staff will utilize the resident Kardex to identify plan of care and resident needs. Education will be provided to nursing staff to ensure use of Kardex and the plan of care is being followed. Observations of residents with air mattresses requiring 2 assist will be completed to ensure 2 assist are provided daily for 5 days, weekly for 2 weeks, monthly for two months. Facility documentation also revealed: Facility-wide staff training, beginning on July 8, 2026, with the topic 2 assist with care. Facility-wide auditing by Administration and monitoring of residents observed with 2 assist audits, beginning July 9, 2026. The facility's plan of correction was reviewed during the survey. Review of facility documentation revealed that on July 8- 9, 2026, the facility had initiated education for staff and audits to ensure compliance by July 10, 2026. During the abbreviated survey on July 21, 2026, staff interviews, resident interviews, resident record review, and observations revealed no concerns with neglect. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, review of facility investigation documentation, review of hospital documentation, and resident and staff interviews, it was determined that the facility displayed past non-compliance in its failure to ensure that each resident receives adequate supervision and assistance to prevent falls based on individual needs for one of four resident's reviewed (Resident 2), which resulted in actual harm for Resident 2 as evidenced by a fall with a femur fracture. Findings Include: Review of Resident 2's clinical record revealed diagnoses that included hypertension (elevated blood pressure), difficulty walking and contracture of the left and right knees. Review of Resident 2's interdisciplinary plan of care revealed a problem area that read risk of ADL self-care performance deficit. ADL's (Activities of Daily Living) described as self-care tasks an individual does daily that include eating, bathing, dressing, getting out of bed or a chair. The plan of care continued, Bed Mobility- Max Assist x 2. Max Assist of 2 is described as when a patient needs maximal physical help from 2 people in order to complete a task. Review of Resident 2's Kardex (a concise patient care summary detailing a patient's daily care plan), read Bed Mobility-Max Assist of 2. Review of the facility's incident report, dated July 7, 2026, read [Resident 2] rolled out of his bed onto the floor while [Nurse Aide-Employee 2] was giving him care. The incident report continued, [Resident 2] complained of pain in his right ankle, R[ight] knee and his R[ight] hip area. After assessment it was determined that the resident needed to be sent o hospital for further assessment. Review of Employee 2's statement regarding Resident 2's fall revealed I was giving care to resident, and he was lying on his side. The resident rolled out of the bed he stated the bed was inflating and that his body could not adjust to the bed inflating [in] the inflation caused him to fall from his bed. Review of Resident 2's statement, post fall, read She came to change me and rolled me away from her. Her mistake was not bringing in 2 people. Review of Resident 2's hospital clinical record information revealed an assessment with diagnoses that included closed right distal femur fracture. The assessment also read Patient was seen and evaluated at the Emergency Department. Sustained a closed right distal femur fracture after fall off his bed earlier today. Additional review of the hospital clinical record revealed Resident 2 required surgical intervention while hospitalized to repair the fracture. An interview with the Nursing Home Administrator (NHA) on July 21, 2026, at 8:54 AM, revealed Employee 2 did not follow Resident 2's plan of care and should have had another staff person to help with providing care to Resident 2. The interview confirmed Employee 2 was not eligible to return to work at the facility at that time. The interview with the NHA also revealed Employee 2 stated that she did not know why she didn't get help with assisting Resident 2 in his bed. During the onsite visit on July 21, 2026, at 9:00 AM, the NHA confirmed the facility initiated and provided the facility's plan of correction that was put into place as a result of the facility's investigation into the fall, with a completion date of July 10, 2026. Review of the facility's document, titled Past Non-Compliance read, Resident to be provided with 2 assists during care, as per Care Plan. Review of current resident will be completed to ensure resident with air mattresses who require 2 assist are receiving 2 assist during care as per plan of care. Nursing staff will utilize the resident Kardex to identify plan of care and resident needs. Education will be provided to nursing staff to ensure use of Kardex and the plan of care is being followed. Observations of residents with air mattresses requiring 2 assist will be completed to ensure 2 assist are provided daily for 5 days, weekly for 2 weeks, monthly for two months. Facility documentation also revealed: Facility-wide staff training, beginning on July 8, 2026, with the topic 2 assist with care. Facility-wide auditing by Administration and (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	monitoring of residents observed with 2 assist audits, beginning July 9, 2026. Prior to the abbreviated survey, the facility failed to ensure that each resident receives adequate supervision and assistance to prevent falls based on individual needs, resulting in harm for Resident 2 as evidenced by a closed distal right femur fracture. The facility's plan of correction was reviewed during the survey. Review of facility documentation revealed that on July 8- 9, 2026, the facility had initiated education for staff and audits to ensure compliance by July 10, 2026, During the abbreviated survey on July 21, 2026, staff interviews, resident interviews, resident record review, and observations revealed no concerns with adequate supervision and assistance to prevent falls. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)(e)(1) Management		