| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395290 | A. Building<br>B. Wing | 12/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pleasant Acres Rehabilitation and Nursing Center | 118 Pleasant Acres Rd,rd7<br>York, PA 17402 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Based on facility policy review, clinical record review, review of facility investigation documentation, and resident and staff interviews, it was determined that the facility displayed past non-compliance in its failure to ensure each resident to be free from abuse, which resulted in mental anguish and actual harm as evidenced by multiple bruises and swelling to the right side of the resident's face, bilateral legs, and bilateral knuckle areas on his hands after an alleged staff to resident altercation for one of five residents reviewed (Resident 1).Findings Include:Review of facility policy, titled Abuse Policy- Prevention and Management, last revised September 8, 2022, read, in part, the facility prohibits the mistreatment, neglect, and abuse of residents by anyone including staff, family, friends, visitors, etc. Possible indicators of physical abuse include an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time. Examples of injuries that could indicate abuse include but are not limited to: bruises including those found in unusual locations such as the head, and facial bruising, bleeding or swelling. The facility assumes the responsibility of ensuring the safety and well-being of the residents.Review of Resident 1's clinical record revealed diagnoses that included tremors, insomnia, disorientation, Parkinsonism (neurological conditions causing similar movement problems, primarily slowness, rigidity, resting tremor and balance issues) and dementia. Review of Resident 1's physician orders included: 1:1 monitoring for fall prevention on 7-3 and 3-11 shifts, started June 17, 2025; 15-minute visual checks on 11-7 shift for fall prevention, started June 17, 2025. Review of Resident 1's care plan included focus areas for impaired cognitive function related to dementia and Parkinsonism, initiated November 14, 2024; potential to demonstrate physical behaviors related to dementia, initiated November 25, 2024; behavioral problem related to disrobing at times without known origin, hitting, kicking, placing himself on the floor, throwing water, and refusal of care at times, initiated December 16, 2024.Review of the facility investigation report, dated November 29, 2025, revealed that Resident 1 was noted to have bruising to his face and legs in the morning that, per staff, were not present the prior evening. The Resident was assessed by a Registered Nurse who noted red/purple bruises to the right side of Resident 1's face with swelling noted to the area. Bruising was also noted to bilateral legs and to bilateral knuckle areas on the Resident's hands. Per staff, bruises were not visible the evening prior.Further review revealed the Resident speaks Vietnamese and was unable to communicate the whole story of what happened with staff. At that time, the Power Of Attorney was at bedside, however, she speaks very little English herself and had difficulty with using the translation service line. Another visitor, who is multi-lingual, was able to translate and stated that the Resident told him that on November 28, 2025, at 11:00 PM, a large black female employee came into his room and told him to straighten out his legs. The Resident stated he did, but she then hit him in the legs with a shoehorn. He then said she hit him on the face with the shoehorn and then went to hit him again, and he put his hands up, which she then hit him on the hands and then on the right thigh with it. The Resident stated he did not yell at time of incident or attempt to report it. He stated that the employee worked there often and was wearing black scrubs and had shoulder length hair. The Registered Nurse (RN) Supervisor found a shoehorn in the Resident's room. The Nurse Aide (NA) (Employee 3) was an agency employee that was assigned to the Resident during alleged time of incident and matched the Resident's description.During interviews with staff, everyone concurred that the injuries were not present the prior evening and were not seen until the morning of November 29th, 2025.Resident 1 recanted the same story of events, that his injuries were obtained by a large black female, wearing dark scrubs on November 28, 2025, at approximately 11:00 PM. The description continued to match the night shift NA (Employee 3).On December 3, 2025, using a translation line service, Resident 1 was shown photos of two women, and when asked if either of them was the female that hurt him, he clearly pointed to Employee 3's picture and stated it was her. The facility substantiated abuse and Employee 3 was terminated.Review of the Resident's clinical records revealed a Nursing progress note dated November 29, 2025, at 5:26 PM, read, in part, Resident 1 made abuse allegations. Interviewed Resident with the assistance of an interpreter, Registered Nurse assessment completed, injuries noted (swelling to right side of face) was consistent with the allegation of being struck to the right side of his face. The Police responded and attempted to interview the Resident. The Resident became very tearful stating it was already taken care of and he didn't want to talk about it anymore.A Nursing progress note dated December 1, 2025, at 10:11 AM, read, in part, full body assessment completed on November 29, 2025, in-house acquired right zygomatic (check) bone region of the |