STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395442	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York North Skilled Nursing and Rehabilitation Ctr	1770 Barley Road York, PA 17408

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based in review of facility policy, documentation provided by the facility, clinical record review, and staff interviews, it was determined that the facility failed to protect the resident's right to be free from involuntary seclusion by a staff member (Resident 1).Findings include: Review of the facility policy and procedure, titled Abuse Prohibition, revised October 24, 2022, read, in part, the Center prohibits abuse, mistreatment, involuntary seclusion. Involuntary seclusion is definition included confinement of a resident to their room against the resident's will. Anyone who witnesses an incident of suspected abuse is to tell the abuser to stop immediately and report the incident to her/her supervisor immediately, regardless of shift worked. The notified supervisor will report the suspected abuse immediately to the Administrator. The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. Initiate an investigation within 24-hours of an allegation of abuse that focuses on whether it occurred, clinical examination for signs of injuries, causative factors. Ensure that documentation of witnessed interviews was included. Review of Resident 1's clinical record revealed that the Resident was admitted on [DATE], with diagnoses that included dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking), anxiety (a feeling of worry, nervousness, or unease), and fracture of left clavicle. Review of Resident 1's care plan included a focus area for resistive to care related to difficulty adjusting to facility, cognitive loss/dementia, initiated July 22, 2025. Interventions included, if Resident becomes combative or resistive, postpone care/activity and allow time for her to regain composure, initiated July 22, 2025. Additional focus areas included Resident has impaired cognitive function or thought processes related to dementia, initiated July 16, 2025. Interventions included to explain all care and reason for performing the care before initiating; allow extra time after speaking for resident to process thoughts and respond; allow Resident to make daily decisions, break down tasks to support short-term memory deficits and provide cueing/assistance as needed, and re-direct using external cues as needed, initiated July 16, 2025. Resident is at risk for injury or complications related to the use of anticoagulant (blood thinner) therapy, initiated July 16, 2025. Review of the facility reported incident revealed an incident on July 22, 2025, at 1:30AM. Statements provided by Employees 1 (Nursing Assistant), 3 (Licensed Practical Nurse), and 4 (Licensed Practical Nurse) revealed they heard banging down the hall. Employee 1 went to investigate and found Employee 2 (Nursing Assistant) holding Resident 1's door to her room shut. Resident 1 was heard yelling to be let out of her room and banging on the door. Employee 2 admitted to holding the door closed and stated that the Resident was upset and Employee 2 was scared. Further review of staff interviews from Employees 1, 3, and 4 documented after the incident, revealed Resident 1 stated she was being held hostage in her own home. The facility's initial investigation failed to include documentation of an interview with Employee 5 (Registered Nurse [RN] Supervisor) who worked night shift on July 21st into 22nd, 2025. Further review of the facility investigation documented Employee 1 reported the allegation to Employee 6 (Registered Nurse Unit Manager) on the following day shift on July 22nd, 2025, at 8:00 AM. Surveyor interview with Employee 6 on July 28, 2025, at 7:00 AM, it was revealed that she worked day shift on July 22nd, 2025, and at the start of her shift Employee 1 was upset and informed her of an incident that occurred at 1:30 AM between Employee 2 and Resident 1. It was confirmed that Employee 5 did not initiate an investigation or do an assessment on Resident 1. Employee 6 completed a full body assessment on Resident 1 and no injuries or bruising were noted, and the Resident didn't recall the incident. It was further revealed that Resident 1 does sundown starting around 7 PM. She is confused and she may yell and be resistant to care, however, she can usually be redirected by speaking in a calm reassuring voice, and you must remind her repeatedly of things. Statement provided by Employee 5 on July 28, 2025, at 12:31 PM, via electronic message stated that Employee 1 reported that Resident 1 was sundowning becoming belligerent, threatening to call the police and stating that she was being held hostage and making other accusations, which is normal behavior for this Resident. Staff was managing the behaviors. Later in the shift, Employee 1 commented that Employee 2 was holding the door closed, he didn't specify which door was held closed. Employee 2 was at the unit's cafe doors when Employee 1 made the statement. Employee 5 sated that it wasn't reported to her that the Resident's room door was held shut, and she assumed Employee 2 was holding the door to the cafe closed to keep Resident 2 out. During an interview with the Director of Nursing on July 28, 2025, at 9:00 AM, it was revealed that Employees 1 and 3 should've informed Employee 5, and a