STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395168	A. BLDG: 00 B. WING:	01/07/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORKVIEW NURSING AND REHABILITATION STATE LICENSE NUMBER: **033402**	**970 COLONIAL AVENUE** **YORK, PA 17403**

(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 Revisit Survey completed on January 7, 2025, it was determined that Yorkview Nursing and Rehabilitation did not correct all of the deficiencies cited during the survey of November 27, 2024, under the requirements of the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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.

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YORKVIEW NURSING AND REHABILITATION STATE LICENSE NUMBER: 033402	970 COLONIAL AVENUE YORK, PA 17403

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P 5640		P 5640		

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

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P 5640	Continued from page 1 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	Development and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth in the statement of deficiency. This plan of correction is prepared and/or executed by provision of Federal or State Law. 1. Residents received required care and there were no negative outcomes from the staffing level falling slightly below 3.2 ppd. 2. The facility has identified that all the residents have the potential to be affected by the average nursing care hours falling below 3.2 in a 24-hour period of direct resident care for each resident. 3. Facility will implement the critical staffing plan and will begin to utilize agency contracts to ensure the average nursing care hours are a minimum of 3.2 hours of direct resident care for each resident in a 24-hour period. Facility will ensure	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/17/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 2	P 5640	resident quality of care continues. 4. HR Director/Designee will conduct 3 random audits weekly for 1 month, and then 3 random audits monthly, to ensure that a minimum of 3.2 hours of direct resident care is provided for each resident in a 24-hr period. HR/Designee will report audit results monthly for Quality Assurance and Performance Improvement Committee to address any trends or patterns, need for further review, and or recommendations. 5. Date of compliance 2/3/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 3 Based on facility staffing documentation review and staff interview, it was determined that the facility failed to meet the minimum of 3.20 hours of direct resident care for each resident for four of six days reviewed (January 3, 4, 5, and 6, 2025). Findings include: A review of facility-submitted staffing information revealed the following dates had not met the minimum of 3.20 hours of direct resident care for each resident: January 3, 2025, the facility provided 3.16. January 4, 2025, the facility provided 3.09. January 5, 2025, the facility provided 3.02. January 6, 2025, the facility provided 2.70. An interview with the Director of Nursing on January 7, 2025, at 9:20 AM, confirmed that the facility would not meet the minimum requirement of 3.20 hours of direct resident care on those dates.	P 5640		

Certified End Page

YORKVIEW NURSING AND REHABILITATION

STATE LICENSE NUMBER: 033402

SURVEY EXIT DATE: 01/07/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY