STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395374	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Yeadon	Lansdowne and Lincoln Ave Yeadon, PA 19050

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, facility documentation, and staff interviews, it was determined the facility failed to ensure Resident R1 was free from abuse. Resident R1 was included in a social media post in which he was photographed from behind, partially exposing his buttocks and without a shirt. The image also contained profanity. A reasonable person in Resident R1's position would likely feel humiliated by having such a photograph taken and posted on social media without consent. Posting this image of a cognitively impaired Resident R1 caused harm. This deficiency was cited as past noncompliance. (Resident R1).Findings include:Review of the facility policy titled, Policy and Procedure Vulnerable Adult Abuse and Neglect Prevention revised 03/25/2025, revealed it is the policy of the facility to provide residents a safe environment that is free from harm. Further, it is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment or exploitation. Review of facility policy Policy and Procedure Social Media, revised 01/29/2025, revealed staff should Refrain from using social media while on work time or on equipment we provide unless it is work-related as authorized by your manager and consistent with the [Equipment/Computer Usage Policy]/ Further review of facility policy revealed staff should not use legal facility name email addresses to register on social networks, blogs or other online tools utilized for personal use.Observations conducted on 07/01/2026 at 11:38 a.m., revealed Resident R1 was pacing in his/her room without a shirt, and pants were partially down, exposing part of his/her buttocks, similar to what was depicted in the social media post. Nurse aide, Employee E9, was present in the room and asked Resident R1 to put on a shirt. Resident R1 took the shirt and walked into the hallway, placing it onto his/her body and continued pacing back and forth on the nursing unit. Resident R1 did not respond to the surveyor's greeting and continued to walk the hallway. Nurse aide, Employee E9 reported Resident R1 is nonverbal and exhibits behaviors such as removing his shirt, walking without clothing on upper body, and pants partially pulled down. Review of Resident R1's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Schizophrenia (mental health condition that may result in a mix of hallucinations, delusions, and disorganized thinking and behavior), Autistic Disorder (neurodevelopmental and repetitive behavior), Anxiety Disorder (intense, excessive, persistent worry or fear), personal history of other mental and behavioral disorder, unspecified symptoms and signs involving cognitive functions and awareness (confused), and Major Depressive Disorder (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things).Review of Resident R1's Comprehensive Minimum Data Set Assessment (MDS-periodic assessment of a resident's needs) dated 05/14/2026, revealed a Brief Interview for Mental Status (BIMS) not recorded indicating the resident was unable to participate in the assessment due to severe cognitive impairment., Review of the comprehensive care plan dated 11/30/2020, revealed Resident R1 had wandering/pacing related to change in environment, cognitive impairment-autism. The goal included encouraging Resident R1 to rest throughout the day and to wander only within certain boundaries, specifically down the hall to his room entrance and back into his room. The interventions were to attempt to minimize excess stimulation. Review of (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	facility documentation submitted April 6, 2026, revealed on April 5, 2026, at approximately 5:30 - 6:00 p.m. the facility was made aware an agency certified nurse aide (CNA), Employee E3, posted an image of a resident on social media earlier in the day. Nuse aide, Employee E3, was put on Do Not Return (DNR) status from the nursing agency and an investigation was initiated. Review of the facility investigation revealed on April 5, 2026, the alleged perpetrator, Nurse Aide, Employee E3, was scheduled to work the 7:00 a.m. to 3:00 p.m. shift. Nurse aide, Employee E3, had previously worked one other shift at the facility on January 2, 2026. Further review of facility investigation revealed on April 5, 2026, Nurse aide, Employee E4, was at home around 5:20 p.m. when a social media image post (posted by nurse aide, Employee E3) was brought to his/her attention. The image included profanity across the picture and showed Resident R1 in the main unit hallway, facing away, with his/her buttocks partially exposed and without a shirt. The social media post was time stamped 10:12 a.m. on Aoril 5, 2026, during Nurse aide, Employee E3's shift. Further review of documentation revealed, nurse aide, Employee E4, notified facility management of the social media post. Nurse aide, Employee E3, was placed on Do Not Return (DNR) status pending the outcome of the investigation. The facility notified the resident's physician, Resident's Representative, Department of Health (DOH), Department of State and police. Resident R1 was assessed; there were no negative outcomes, as Resident R1 was unaware the photo was taken and remained at his baseline. Education was initiated to nursing staff. Further review of facility investigation revealed the facility substantiated the allegation of abuse related to the social media posted photograph of Resident R1. Review of Employe E4, nurse aide's, written statement dated 04/06/2026 revealed around 5:20 p.m. as we were having dinner, family member told me look your job is going viral on social media with a resident held naked walking down the hallway. So when I proceeded to look at her phone I noticed [Resident R1] was recorded walking half naked down the hallway. I reported ASAP through phone to my unit manager. Review of written statement by Employee E2, Director of Nursing dated 04/06/2026, revealed On 04/05/2026 around 5:30-5:45 p.m. I was notified that a picture was posted of one of our residents on social media by an agency CNA that worked at the facility that morning. The picture did not show resident's face or any other resident's identifier. I immediately informed the NHA and notified the scheduler to DNR [do not return] the CNA on all agency platforms, when I went to look on the CNA's social media account so that I can report, the picture was already removed. Review of the written statement by the CNA, Employee E3, who was named as the alleged perpetrator, revealed the following: 'I am writing to formally address a matter that appears to involve a misunderstanding. I am not sure where the mix-up may have occurred; however, I want to make it absolutely clear that I would never treat any resident improperly or engage in any action that would compromise my professional responsibilities. I take my role and ethical obligations very seriously and would not put my career at risk under any circumstances. If there are specific concerns or details that need to be reviewed, I am more than willing to cooperate fully to help clarify the situation and resolve any confusion.' Interview conducted on 07/01/2026 at approximately 10:00 a.m. with Nursing Home Administrator (NHA), Employee E1, and Employee E2 (DON), who revealed on 04/06/2026 local police were notified and police report was filed regarding the investigation. In addition, Resident R1's representative, physician, Department of State, and adult protective services were all notified about the incident. Employee E1 (NHA), and Employee E2 (DON), revealed the post does not identify Resident R1 nor the facility. It was further stated the facility provided emotional support to Resident R1, but the resident did not exhibit any negative effects related to the incident. Interview on 07/01/2026 at 11:47 a.m., with the licensed nurse, Employee E10, reported Resident R1 is nonverbal, nonˆaggressive, and exhibits behaviors such as pacing and walking in his room or in the hallway. Resident R1 is able to follow directions but is unable to speak; Resident R1 has a low, soft voice and able to say yes or no. Resident R1 has a history of removing shirt, pants, socks, and other clothing, particularly when preparing to lie down in bed. Resident R1 is currently prescribed Lorazepam (anti-anxiety medication) 2 mg (milligram) every 8 hours and Risperidone (anti-psychotic medication) 2 mL (milliliter) twice daily at 9 a.m. and 5 p.m. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Telephone interview on 07/01/2026 at 1:45 p.m., with the facility's medical director, Employee E18, stated that Resident R1 did not experience any negative effects related to the incident, due to cognitive impairments. The facility stated that they were not able to fully identify Resident R1 as the individual in the social media post because the image showed only the resident's back, with no facial features or name visible. However, during the surveyor's observations, on all units, on July 1, 2026, no other residents were found with the same physical characteristics. When the surveyor arrived on Resident R1's unit, Resident R1 was observed walking without a shirt, pants partially pulled down, exposing part of his/her buttocks, consistent with the image in the post. The facility did not identify any other resident for comparison besides Resident R1. Review of the facility's action plan revealed the following information: The involved CNA, Employee E3, was immediately removed from resident care and placed on Do Not Return (DNR) status. The facility conducted an investigation immediately upon identification of the allegation. A review of the employee's social media activity was completed to determine the scope of the incident. No additional residents were identified as being affected. The facility completed a comprehensive review of the employee's social media activity and resident assignments. Nursing leadership reviewed resident interviews, observations, and clinical records as indicated. The investigation determined no additional residents were impacted by the deficient practice. The scheduler, nursing supervisor and all staff were reˆeducated on the facility's staffing procedures to ensure agency staff are no longer automatically scheduled by external staffing agencies. The nursing supervisor and scheduler received education on the social media policy and the abuse, neglect, and exploitation policy. The interdisciplinary team will complete audits of staff knowledge and compliance with the Abuse Prevention and Exploitation and social media policies. Audits will be conducted daily for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Audit results will be reviewed during the facility's QAPI (Quality Assurance Performance Improvement) meetings. Any identified concerns will result in immediate corrective action, reˆeducation, and additional monitoring until sustained compliance is achieved. Based on the completed corrective actions and monitoring, the deficient practice was determined to be past noncompliance effective as of April 10, 2026. Facility education records and subsequent audits were verified as complete. Staff were interviewed to confirm completion of education on the facility's policies regarding resident privacy, social media use, and protection of resident dignity. Additional staff interviews were conducted to verify compliance with the plan of correction. No continuing concerns were identified through record review, staff interviews, or observation.The facility failed to ensure Resident R1 was free from mental abuse when a staff member posted a partially naked photograph of the resident, including profanity, on a public social media platform, causing harm to Resident R1 as a reasonable person would not consent to such social media posts.28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management