

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>43277</p> <p>Based on review of facility policy, review of clinical records, and staff and family interviews, it was determined that the facility failed to ensure resident representatives had the opportunity to participate in the care planning process for one of 35 residents reviewed (Resident R31).</p> <p>Findings Include:</p> <p>Review of facility policy Care Conference revised June 20, 2023, revealed the purpose of the policy is to provide interdisciplinary communication with the resident and/or legal representative for purposes of the development of an individualized comprehensive plan of care. The resident and/or their representative will receive communication in advance of the scheduled care conference.</p> <p>Review of Resident R31's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 15, 2025, revealed the resident had diagnoses of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), anxiety (intense, excessive, persistent worry or fear), and depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things).</p> <p>Continued review of the MDS revealed Resident R31 scored a 7 on the Brief Interview for Mental Status (BIMS - used to assess cognitive function) assessment, reflecting severe cognitive impairment.</p> <p>Review of Resident R31's comprehensive care plan revised April 8, 2025, revealed Resident R31 was alert and oriented x 1 (oriented to person) and was totally dependent on staff to anticipate her needs for socialization and activities involvement related, but not limited, to dementia, physical limitation, and hearing impairment.</p> <p>Interview on April 29, 2025, at 1:30 p.m. with Resident R31's representative revealed this individual had concerns regarding social stimulation/activities for Resident R31. Further interview revealed Resident R31's representative was not invited to participate in the care planning process and was subsequently not provided with a copy of Resident R31's comprehensive care plan.</p> <p>Review of Resident R31's clinical record revealed a care plan note dated January 3, 2025, that a care review was completed for Resident R31. The care plan note indicated that Resident R31 refused to participate and that Resident R31's daughter had been in to visit on January 2, 2025.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident R31's care plan note dated January 3, 2025, revealed no documented evidence that Resident R31's representative was given advanced notice of the care plan meeting, was invited to participate, or was given a copy of Resident R31's care plan.</p> <p>Interview on May 1, 2025, at 9:35 a.m. with Social Services Director, Employee E26, confirmed there was no documented evidence that Resident R31's representative was invited to participate in the care plan meeting and further confirmed there was no documented evidence that Resident R31's representative was provided with a copy of the care plan.</p> <p>28 Pa. Code 211.10 (a) Resident care policies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>43277</p> <p>Based on observations and staff interview, it was determined that the facility failed to maintain a clean and homelike environment in resident care areas and dining experience for one of four nursing units observed (Main Unit).</p> <p>Findings Include:</p> <p>Observations on April 28, 2025, at 11:08 a.m. revealed Resident R95's breakfast tray, with leftover food on the tray, was left on the windowsill in the dining room on the Main Unit. Continued observations in the dining room on the Main Unit revealed the railing on the wall was broken.</p> <p>Further observations on April 28, 2025, at 12:35 p.m. as resident's gathered in the dining room to have lunch on the Main Unit revealed Resident R95's breakfast tray was still left on the windowsill. Observations were confirmed by Registered Nurse, Employee E6.</p> <p>Observations on April 28, 2025, at 12:45 p.m. revealed broken floor tiles in the shower room on the Main Unit.</p> <p>Observations on April 28, 2025, at 12:49 p.m. in Resident R16's room revealed the wallpaper behind the bed was peeling, the privacy curtain was stained, and there was a brown substance splattered in the corner behind the bed where the baseboard and wall meets.</p> <p>Observations on April 28, 2025, at 1:39 p.m. revealed Resident R4's headboard was broken off and propped on the floor next to the resident's bed.</p> <p>Observations on April 29, 2025, at 12:42 p.m. revealed the first food truck with meal trays was delivered to the Main Unit. Observations revealed staff did not begin to set residents up for lunch (setting out place mats, applying clothing protectors) until 12:49 p.m. Continued observations revealed staff did not begin to pass lunch trays until 12:55 p.m., 13 minutes after lunch was delivered to the unit.</p> <p>Continued observations on April 29, 2025, at 12:55 p.m. revealed the floors were dirty with food items spilled from breakfast. Resident R150 was observed to be sitting barefoot in the dining room with scrambled eggs beneath her feet.</p> <p>Further observations on April 29, 2025, during the lunch time meal in the dining room on the Main Unit revealed residents were served individual milk cartons on the lunch trays. Nursing staff was observed to be pouring the contents of the milk cartons into small, plastic, disposable cups.</p> <p>Observations made during the lunch time meal service on April 29, 2025, were confirmed by Registered Nurse, Employee E6.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on review of facility policies, review of facility documentation, clinical record review and interviews with residents and staff, it was determined that the facility failed to ensure that residents were free from verbal abuse, for two of four residents reviewed for abuse (Residents R135 and R361).</p> <p>Findings include:</p> <p>Review of facility policy, Vulnerable Adult Abuse and Neglect Prevention dated revised February 25, 2025, revealed that abuse includes, Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following . use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, use of repeated or malicious oral, written, or derogatory, humiliating, harassing, or threatening language.</p> <p>Review of Resident R135's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated October 21, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), encephalopathy (damage or disease that affects the brain) and contractures (permanent shortening of a muscle or joint). Continued review revealed that the resident required substantial/maximal assistance with toileting hygiene, personal hygiene and rolling in bed. Further review revealed that the resident was occasionally incontinent of bowel and bladder.</p> <p>Interview on April 28, 2025, at 10:28 a.m. Resident R135 stated that he needs help with toileting and that staff used profanity towards him when he asked for help.</p> <p>Review of facility documentation submitted to the Pennsylvania Department of Health on December 16, 2024, revealed that a nurse aide went into Resident R135's room and that the resident and the staff member had a verbal altercation. The facility substantiated the verbal altercation as an allegation of abuse.</p> <p>Review of grievances revealed a grievance, filed by Resident R105, undated, which indicated that he witnessed that a staff member did not want to assist Resident R135 with continence care and that the staff member and Resident R135 used profanity towards each other.</p> <p>Review of facility documentation related to the incident revealed a witness statement, written by Resident R105, undated, which stated, 11-7 shift aide came in to change [Resident R135]. She told resident he was not wet. Resident said he knows his body and he was wet. I know when I'm wet (he said again). Aide showed resident his brief. That he was not wet. That's when the argument started. They was cussing at each other going back and forth. She said she was going to get her husband. Resident was gonna get his people (somebody). Using profanity to each other mother***, kiss my ***, etc. The nurse came in afterwards. Said he wasn't wet. And resident got mad about that also. A lot of profanity going around. But staff member did use offensive words (cursing) at resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of facility documentation related to the incident revealed a written statement from Resident R135, undated, which stated, On Monday December 16, 2024, around 4am he asked [Employee E12, nurse aide] to change his brief, she responded that it has already been changed. They had a verbal altercation with curse words and she threatened to get her husband to come to the facility.</p> <p>Continued review of facility documentation related to the incident revealed an interview witness statement from Resident R135, dated December 16, 2024, which stated, Resident stated that around 4am during the 11pm-7am shift, he was involved in a verbal altercation with [Employee E12, nurse aide] the nurse aide assigned to his room. Resident stated the when the nurse aide came into his room, she said 'I've already changed you 3 or 4 times.' The resident then told her that he knows when he has urinated and has a bowel movement and he needed to be changed again. He also said that sometimes he sweats a lot and need to be changed head to toe for that reason. According to the resident, the nurse aide checked him and stated, 'you're not wet.' The resident said that he told the nurse aide that he was wet and needed to be changed. The nurse aide then responded with 'you peed in the bed.' The resident went on to tell her that he did not urinate in the bed because he has a urinal that he uses. The resident stated that at that point, that is when the nurse aide started cursing at him and told him, 'I'm from South Philly' and 'I will get my man to beat your a**.' The resident then said that he replied with 'I don't care where you're from, but I am from North Philly and I will beat you and your man the f*** up.' There was some more back and forth arguing and cursing from both parties and eventually the nurse aide left.</p> <p>Interview on April 30, 2025, at 11:22 a.m. Resident R105 stated that he remembered the incident that occurred on December 16, 2024. Resident R105 reviewed his grievance and written statement and confirmed these documents to be true as written. Resident R105 confirmed that he heard Employee E12, nurse aide, curse and threaten Resident R135.</p> <p>Interview on April 30, 2025, at 11:46 a.m. the Nursing Home Administrator confirmed that the allegation of verbal abuse by Employee E12, nurse aide, towards Resident R135, was substantiated based on Resident R105's statement and the resident is a credible witness. Continued interview revealed that Employee E12, nurse aide, was terminated from employment at the facility due to the substantiated allegation.</p> <p>Review of Resident R361's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated February 12, 2025, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including cerebrovascular accident( stroke, when blood flow to the brain is interrupted, leading to brain damage) heart failure (chronic condition when the heart does not pump enough blood to meet the body's needs) and depression (a mental health is what our characterized by persistently depressed mood or loss of interest and activities, causing significant impairment in daily life). Continued review revealed that the resident required minimal assistance with toileting hygiene, personal hygiene and rolling in bed. Further review revealed that the resident was occasionally incontinent of bowel. Resident R361 has a Bims (Brief interview of mental status) Score of 15 indicating intact cognition.</p> <p>Review of facility documentation submitted to the Pennsylvania Department of Health on April 25, 2025, revealed that a nurse aide went into Resident R361's, the resident asked the aide to help clean him, the aide refused with verbal altercation. The facility substantiated the verbal altercation as an allegation of abuse.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of facility documentation related to the incident revealed an interview witness statement from Resident R361, dated April 20, 2025, which stated, I had a bm (bowel movement) accident. I asked my aide to help clean me up. She replied, I'm not wiping you're a**. Another aide overheard the comment, and she came in and cleaned me out I also informed the nurse of what happened.</p> <p>Interview on April 30, 2025, at 11:46 a.m. the Nursing Home Administrator confirmed that the allegation of verbal abuse by Employee E21, nurse aide, towards Resident R361, was substantiated. Continued interview revealed that Employee E21, nurse aide, was terminated from employment at the facility due to the substantiated allegation.</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 201.29(a)(c) Resident rights</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(c) Nursing services</p> <p>28 Pa Code 211.12(d)(1)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</b></p> <p>Based on review of facility policy, review of clinical records, observations, and staff interview, it was determined that the facility failed to ensure residents were free from physical restraint for one of 34 residents reviewed (Resident R310).</p> <p>Findings Include:</p> <p>Review of facility policy Physical Restraints revealed physical restraints are only used when they are used appropriately to treat the resident's medical symptoms and to promote an optimal level of function for the resident. A restraint may never be used for the purpose of discipline or staff convenience. Per the facility policy, a physical restraint includes all devices and practices that restrict freedom of movement or normal access to one's body.</p> <p>Review of Resident R310's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated March 2, 2025, revealed the resident had severe cognitive impairment, had impairment in functional limitation in range of motion to the upper and lower extremities, and required substantial/maximal assistance with mobility to roll left and right.</p> <p>Further review of Resident R310's quarterly MDS dated [DATE], revealed the resident had diagnoses of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), hemiplegia (weakness) or hemiparesis (paralysis), and difficulty in walking.</p> <p>Review of Resident R310's comprehensive care plan revised September 11, 2024, revealed the resident was at high risk for falls related to confusion and gait dysfunction.</p> <p>Observations on April 28, 2025, at 11:15 a.m. revealed Resident R310 was in bed with a wedge positioned under the sheets on the resident's right side and the left side of the bed was pushed up against the wall.</p> <p>Observations of Resident R310's positioning was confirmed on April 28, 2025, at 11:23 a.m. by Registered Nurse, Employee E6.</p> <p>Interview on April 28, 2025, at 11:23 a.m. with Registered Nurse, Employee E6, revealed the wedge was used to help position the resident and offload pressure from the sacrum. Further interview with Registered Nurse, Employee E6, confirmed Resident R310's bed should not have been pushed against the wall as it can act as a restraint.</p> <p>Review of Resident R310's entire clinical record revealed no documented evidence the resident had a physical restraint assessment or an order by the physician to push Resident R310's bed against the wall.</p> <p>28 Pa. Code 211.10 (d) Resident care policies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to develop a person-centered comprehensive care plan related to behaviors for one of 35 residents reviewed (Resident R135).</p> <p>Findings include:</p> <p>Review of facility policy, Care Plan - Baseline and Comprehensive dated revised June 20, 203, revealed that care plans will be developed to ensure that each resident receives care individualized to him or herself and that goals and approaches for care are communicated to all parties including caregivers, the resident, and the resident's representative.</p> <p>Review of Resident R135's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated October 21, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures) and encephalopathy (damage or disease that affects the brain).</p> <p>Review of progress notes for Resident R135 revealed a behavior note, dated January 23, 2025, at 3:02 p.m. which indicated that the resident began yelling, screaming and using foul language. The note continued that the resident acted like he wanted to jump out of bed.</p> <p>Continued review of progress notes for Resident R135 revealed a psychiatric (mental health) provider note, dated January 27, 2025, at 8:58 a.m. for follow up on mood and behavior. The resident was reported to have increased anxiety and agitation. The mental health provider recommended to start Hydroxyzine three times per day for anxiety/agitation and to monitor the resident for increased anxiety.</p> <p>Continued review of progress notes for Resident R135 revealed a mood/behavior note, dated January 28, 2025, at 12:49 p.m. which indicated that the resident got upset with staff was using foul language and threatening to get everyone fired. The note continued that the resident and staff remained safe during the situation.</p> <p>Continued review of progress notes for Resident R135 revealed a behavior monitoring note, dated February 7, 2025, at 6:48 p.m. which indicated that the resident had multiple behaviors noted and was observed yelling obscenities.</p> <p>Review of nurse aide documentation of behavior monitoring from April 1, 2024, through April 30, 2025, for Resident R135 revealed the that resident exhibited behaviors on five days, and included attention seeking, screaming at others and yelling out. The documentation revealed that the resident's behaviors interfered with providing care to the resident and created a disruptive environment. Continued review revealed that on one of the days with behaviors, staff implemented an intervention of redirection and that the resident's behavior was unchanged despite the intervention. On three of the days when the resident exhibited behaviors, interventions were not implemented and were documented as not applicable.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R135's care plan, dated April 17, 2025, revealed that no care plan was developed related the resident's behaviors and that no interventions for staff to use when the resident exhibits behaviors were developed.</p> <p>Interview on April 30, 2025, at 11:35 a.m. Employee E14, nurse aide, revealed that she frequently provides care to Resident R135 and that the resident cusses me out everyday. Employee E14, nurse aide, stated that she has to wait for the resident to calm down and reapproaches the resident at a later time to provide care.</p> <p>Interview on April 30, 2025, at 2:20 p.m. Employee E15, licensed nurse, confirmed that no care plan was developed for Resident R135 related to his behaviors. Continued interview confirmed that nurse aide documentation noted that the resident has ongoing behaviors and that no interventions in response to the resident's behaviors were implemented.</p> <p>28 Pa Code 211.10(d) Resident care policies</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>43277</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on review of facility policy, review of clinical records, observations, and staff interview, it was determined that the facility failed to timely provide feeding assistance for a dependent resident for one of 34 residents reviewed (Resident R78).</p> <p>Findings Include:</p> <p>Review of facility policy Activities of Daily Living (ADLs) revealed the facility will provide care and services for eating, assistance with feeding or preparation of meals. Based on the assessments, a personalized care plan is created and outlines the level of assistance needed for activities of daily living.</p> <p>Review of Resident R78's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated March 7, 2025, revealed the resident had severe cognitive impairment and required substantial/maximal (helper does more than half the effort) assistance with eating (the ability to bring food to mouth).</p> <p>Review of Resident R78's comprehensive care plan revised May 1, 2025, revealed the resident had an activities of daily living self-care performance deficit related to contractures to the left upper and lower extremities, communication deficit, and impaired mobility.</p> <p>Continued review of Resident R78's comprehensive care plan revised May 1, 2025, revealed the resident had potential for altered nutritional status related to need for assistance with eating.</p> <p>Observations on April 28, 2025, revealed food carts with the lunch trays were delivered from the kitchen to the Main Unit from 1:00 p.m. to 1:12 p.m.</p> <p>Interview on April 28, 2025, at 1:40 p.m. with nurse aide, Employee E30, confirmed Resident R78 required 1:1 feeding assistance and staff were just beginning to feed the resident at 1:40 p.m., 30-40 minutes after the lunch trays were delivered.</p> <p>Observations on April 29, 2025, revealed food carts with the lunch trays were delivered from the kitchen to the Main Unit from 12:45 p.m. to 1:00 p.m.</p> <p>Observations on April 29, 2025, at 1:34 p.m. revealed Resident R78 was in bed and the resident's lunch tray was placed on the tv stand across the room. Observations revealed the lunch tray was untouched at this time.</p> <p>Observations on April 29, 2025, at 1:50 p.m. revealed nursing staff just began to assist Resident R78 with eating, 50-60 minutes after the lunch trays were delivered.</p> <p>Observations on April 30, 2025, revealed food carts with the lunch trays were delivered from the kitchen to the Main Unit from 1:00 to 1:15 p.m.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on April 30, 2025, at 1:30 p.m. with nurse aide, Employee E30, revealed Resident R78 was still waiting to be fed.</p> <p>Further observations on April 30, 2025, at 1:57 p.m. revealed Resident R78 was in bed and was still waiting to be assisted with lunch.</p> <p>Interview on April 30, 2025, at 1:57 p.m. with Unit Manager, Employee E5, confirmed Resident R78 had still not yet been assisted with lunch.</p> <p>28 Pa. Code 211.10 (d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43277</p> <p>Based on review of facility documents, review of clinical records, observations, and staff interviews, it was determined that the facility failed to implement both group and individual activities to meet the needs of each resident for 15 of 39 residents on the Main Nursing Unit (Resident R31, R78, R51, R71, R21, R142, R88, R4, R111, R133, R125, R131, R117, R64, and R150).</p> <p>Findings Include:</p> <p>Review of the April 2025 Activities Calendar revealed on April 29, 2025, Coffee &amp; Chat was scheduled for 10:00 a.m. and Fun &amp; Fit Exercise was scheduled for 11:15 a.m. on the Main Nursing Unit.</p> <p>Observations on April 29, 2025, at 9:45 a.m. revealed Resident R21, R88, R125, R64, and R131 were sitting in the dining room with no music and no television. These residents were observed to be sitting quietly with no stimulation.</p> <p>Follow up observations on April 29, 2025, at 11:45 a.m. revealed Residents R51, R71, R21, R142, R88, R4, R111, R133, R125, R131, R117, R64, and R150 were sitting in the dining room with only the television on and no stimulating/engaging activities.</p> <p>Interview on April 29, 2025, at 12:11 p.m. with nurse aide, Employee E31, revealed the Coffee &amp; Chat activity scheduled for 10:00 a.m. consisted of just passing coffee out to the residents and leaving the room. Continued interview revealed the Fun &amp; Fit Exercise was not held at 11:15 a.m. as scheduled on the activities calendar.</p> <p>Review of Resident R31's quarterly activities assessment dated [DATE], revealed the resident was totally dependent on staff to anticipate her needs for socialization and activities involvement related to dementia and physical limitations. Further review of the activities assessment revealed Resident R31 would benefit in having one to one beside activity for sensory stimulation.</p> <p>Review of Resident R78's quarterly activities assessment dated [DATE], revealed the resident was totally dependent on staff to anticipate all his needs related to dementia and physical limitations. Further review of the activities assessment revealed Resident R78 would benefit in having one to one bedside visit 2 times per week with staff from the activity department for 20-30 minutes, or as tolerated by the resident.</p> <p>Interview on May 1, 2025, at 12:26 p.m. with Activities Director, Employee E32, confirmed Resident R31 and R78 required one to one bedside visits for activity and sensory stimulation as the resident's are mostly bed bound and do not attend group activities.</p> <p>Review of one-to-one activity documentation provided by the Activities Director, Employee E32, revealed Resident R78 only had three documented one- to one bedside activity documented for the month of April 2024. There was no documented evidence that one- to- one beside activities were completed prior to April 2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of one-to-one activity documentation provided by the Activities Director, Employee E32, revealed no documented one-to-one bedside activity for Resident R31 prior to March 2025.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43277</p> <p>Based on review of facility policy, review of clinical records, observations, and staff interviews, it was determined that the facility failed to obtain, follow, and clarify physician orders related to medications and skin checks for two of 34 residents reviewed (Resident R84 and R64).</p> <p>Findings Include:</p> <p>Review of facility document titled Administering Medications revised January 22, 2024, revealed medications shall be administered per providers written or verbal orders upon verification of the right medication, dose, root, time and positive verification of resident's identity. Medications may only be administered to the individual in which the medication was prescribed.</p> <p>Review of facility policy titled Physician Orders last revised November 13, 2024, revealed the policy is to provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards. Clear and complete orders will be transcribed to the appropriate administration record medication administration record (MAR).</p> <p>Review of Resident 84's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated February 5, 2025, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including cerebrovascular accident (stroke, when blood flow to the brain is interrupted, leading to brain damage) heart failure (chronic condition when the heart does not pump enough blood to meet the body's needs), hypertension (high blood pressure, medical condition where the pressure in the blood vessels is too high) and depression (a mental health is what our characterized by persistently depressed mood or loss of interest and activities, causing significant impairment in daily life).</p> <p>Review of Resident R84's physician orders revealed an order dated January 10, 2025, for the medication MIDODRINE HCL (medication used to treat low blood pressure) oral tablet 2.5 milligrams with directions to give one tablet by mouth every eight hours for hypotension hold for SBP (systolic blood pressure, the force of blood pushing against your artery walls during the hearts contraction. A normal systolic blood pressure is generally considered to be less than 120 mm hg.) greater than 90.</p> <p>Review of Resident R84's medication administration record and nursing notes revealed that although the order specifically instructed to hold for blood pressure greater then 90, the medication administration record revealed that the medication was administered with documented blood pressure recorded as over 90 SBP (systolic blood pressure).</p> <p>Review of residen'ts MAR for the month of March 2025 revealed the medication order for Midodrine HCL 2.5 to be given every eight hours HOLD for SBP (systolic blood pressure) greater then 90, revealed the following recorded dates that the blood pressures were record above 90 SBP and the medication was administered, not following physician orders.</p> <p>March 11, 2025, Residents 84's blood pressure was recorded at 1:00 a.m. as 120/64, at 9:00 a.m. as 120/64 and at 5:00 p.m. as 110/68; the medication Midodrine was administered at all three times.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>March 14, 2025, Resident R 84's blood pressure was recorded at 1:00 a.m. as 112/64; the medication Midodrine was administered.</p> <p>March 15, 2025, Resident R84's blood pressure was recorded at 1:00 a.m. as 111/62 and at 9:00 a.m. 110/81 the medication Midodrine was administered at both times.</p> <p>March 16, 2025, Resident R 84's blood pressure was recorded at 9:00 am as 118/94 and the medication Midodrine was administered.</p> <p>March 17, 2025, Resident R84's blood pressure was recorded at 9:00 a.m. as 102/59 and at 5:00 pm as 105/69; the medication Midodrine was administered both times.</p> <p>March 18, 2025, Resident R84's blood pressure was recorded as 110/68, the medication Midodrine was administered.</p> <p>March 19, 2025, Resident R84's blood pressure was recorded at 1:00 am as 127/69 and at 9:00 a.m. as 122/94. The medication Midodrine was administered both times.</p> <p>March 24, 2025, Resident R84's blood pressure was recorded as 112/68 the medication Midodrine was administered.</p> <p>Review of residents MAR for the month of April 2025 revealed the medication order for Midodrine HCL 2.5 to be given every eight hours HOLD for SBP (systolic blood pressure) greater then 90, reveal the following recorded dated that the blood pressures were record above 90 SBP and the medication was administered, not following physician orders</p> <p>April 5, 2025, Resident R84's blood pressure was recorded at 9:00 am as 104/90 and at 5:00pm as 130/81 the medication Midodrine was administered both times.</p> <p>April 6, 2025, Resident R84's blood pressure was recorded at 9:00 am as 125/74 the medication Midodrine was administered.</p> <p>April 7, 2025, Resident R84's blood pressure was recorded at 9:00 am as 104/90, the medication Midodrine was administered.</p> <p>April 12, 2025 Resident R84's blood pressure was recorded at 1:00 am as 112/67and at 09:00 am as 104/90, the medication Midodrine was administered both times.</p> <p>April 14, 2025, Resident R84's blood pressure was recorded at 9:00 am as 122/66, the medication Midodrine was administered.</p> <p>April 18, 2025, 4/18 Resident R84's blood pressure was recorded at 1:00 am as 108/79 and at 9:00 am as 104/90 the medication Midodrine was administered both times.</p> <p>April 19, 2025 Resident R84's blood pressure was recorded at 1:00 am as 117/69 and at 9:00am as 104/90 and at 5:00 pm as 100/69 the medication Midodrine was administered all times.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>April 23, 2025, Resident R84's blood pressure was recorded at 1:00a.m. as 110/70, and at 9:00 am as 128/69 the medication Midodrine was administered both times.</p> <p>April 24, 2025, Resident R84's blood pressure was recorded at 1:00 am as 118/76, the medication Midodrine was administered.</p> <p>Interview with the Director of Nursing Employee E2, on April 30, 2025, confirmed that the medication was given incorrectly. Continued interview with Employee E2 revealed that the physician has been notified and has acknowledge that the order was entered incorrectly, the order should be HOLD for SBP (systolic blood pressure) greater then 130, greater then 130, reveal the following recorded dated that the blood pressures were record above 90 SBP and the medication was administered, not following physician orders.</p> <p>Review of Resident R64's comprehensive care plan revised April 17, 2025, revealed the resident was at risk for alteration in skin integrity.</p> <p>Further review of Resident R64's comprehensive care plan revised April 17, 2025, revealed the resident was an elopement risk with interventions to apply a wanderguard (safety device place at the ankle) and check per facility policy.</p> <p>Review of Resident R64's physician order summary revealed an order dated May 28, 2024, to check skin integrity of skin surrounding/under roam alert bracelet to ensure there was no breakdown every shift and to further document impairments in a progress note.</p> <p>Observations on April 30, 2025, at 1:30 p.m. revealed Resident R64 had a wanderguard applied to the right ankle. The wander guard appeared to be tight fitting around the resident 's ankle.</p> <p>Observations on April 30, 2025, at 1:45 p.m. with Licensed Nurse, Employee E28, revealed the wanderguard applied to Resident R64's left ankle was too tight to see the skin beneath the wanderguard. Licensed Nurse, Employee E28, needed to cut Resident R64's wander guard off to adequately assess the area under the wander guard.</p> <p>Review of Resident R64's treatment administration record revealed the order to check skin integrity of skin surrounding/under roam alert bracelet was signed out as completed by Licensed nurse, Employee E29.</p> <p>Interview on April 30, 2025, at 2:25 p.m. with Licensed Nurse, Employee E29, confirmed the employee signed out the skin check as completed but was unable to adequately assess the area under the wanderguard because the medical device was too tight due to swelling of Resident R64's ankle.</p> <p>28 Pa. Code 211.10 (d) Resident care policies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46508</p> <p>Based on observations, review of clinical records, review of facility policy and staff interview, it was determined that the facility failed to ensure residents with limited range of motion received treatment and services to maintain or improve range of motion/mobility for one of one resident reviewed with limited range of motion (Resident R101).</p> <p>Findings include:</p> <p>Review of the facility policy, Specialized Rehabilitative and Restorative Services, dated April 1, 2022 indicated that the facility will provide restorative services, such as, but no limited to walking, transfer training, bowel and/or bladder training, bed mobility, range of motion, splint and brace, eating and/or swallowing, amputation/prostheses care and communication, when necessary, as indicted by the assessment of the interdisciplinary team.</p> <p>Review of Resident R101's clinical record revealed that Resident R101 was most recently admitted to the facility on [DATE]. Resident R101's current diagnoses were but not limited to Rheumatoid arthritis, COPD, (Chronic Obstructive Pulmonary Disease), Generalized Muscle Weakness, Poly-osteoarthritis</p> <p>Review of Resident R101's Quarterly MDS (minimum data set- a federally required resident assessment completed at a specific interval) dated February 25, 2025, Section GG015 (Functional Limitation of Range of Motion) revealed that Resident RF101 was impaired in ROM (range of motion) on both sides of the upper extremity and on both sides of the lower extremity.</p> <p>Observation of Resident R101 conducted on April 28, 2025, at 10:44 a.m. during tour of the first floor unit of the facility revealed that Resident R101 was in bed. Further observation revealed that resident's both hands had limited movement.</p> <p>Interview with Resident R101 conducted at the time of the observation, confirmed that he was not able to fully use both of his hands, Further Resident R101 revealed that he is no longer on physical therapy and occupational therapy.</p> <p>Review of Physical Therapy discharge recommendation dated February 3, 2025, revealed a rehab recommendation for Restorative Nursing Program for Range of Motion.</p> <p>Further review of Resident R101's clinical record revealed no documented evidence that a Range of Motion was provided to Resident R101.</p> <p>Interview with Employee E21 Rehab Director revealed that the therapist who wrote the recommendation did not communicate the recommendation to the nursing department resulting in the recommendation not followed through by nursing.</p> <p>Further Employee E21 and Employee E2, DON (Director of Nursing) confirmed that Resident R101 did not receive services to prevent further deterioration of his limitations.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0688  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 211.12 (d)(3) Nursing services.  28 Pa. Code 211.12 (d)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46508</p> <p>Based on clinical record review and interviews with staff, it was determined that the facility failed to obtain orders for oxygen for one of three residents reviewed who was receiving oxygen therapy (Resident R410).</p> <p>Findings include:</p> <p>Review of Resident R410 clinical record revealed that Resident R410 was admitted to the facility on [DATE], with diagnoses of but not limited to Chronic Respiratory Failure with Hypoxia, Pleural Effusion</p> <p>Further review of Resident R410's clinical record revealed that Resident R410 was transferred to a local hospital on April 14, 2025, and was readmitted to the facility on [DATE].</p> <p>Review of Resident R410's physician order revealed an order for Oxygen humidification: O2 (oxygen) liters via trach collar at 4LPM (liters per minute) every shift related to Tracheostomy status. Order Date-03/18/2025 . Further, there was no order for O2(Oxygen) upon return on April 23, 2025.</p> <p>Review of Resident R410's April 2025 Treatment Administration Record (TAR) revealed that resident was on Oxygen humidification: O2 liters via trach collar at 4LPM (liters per minute) every shift Hold Date from 04/14/2025 to 04/15/2025 -D/C Date-04/15/2025.</p> <p>Further review of Resident R410's TAR revealed no documented evidence that Resident R410 received Oxygen upon his readmission to the facility on [DATE].</p> <p>Review of Resident R410's care plan revealed a care plan for oxygen therapy via trach r/t r(related to) espiratory failure with hypoxia, pleural effusion history and hyper secretions. Date Initiated: 12/26/2023.</p> <p>Observation of Resident R410 conducted on April 28, 2025, at 11:13 a.m. during the initial tour of the first-floor unit of the facility revealed that Resident R410 was in bed, on O2 (Oxygen) concentrator at 3.5 liters/minute. Follow-up observation conducted on April 30, 2025, at 8:44 a.m. revealed that Resident R410 was O2 concentrator at 3.5 liters/ minute.</p> <p>Review of medical record revealed no current orders for the administration of oxygen therapy.</p> <p>Interview with Unit Manager Employee E5 and Licensed Nurse Employee E22 conducted on April 30, 2025, at 8:35 a.m. confirmed that Resident R410 was receiving Oxygen at 3.5 liters/minute. Further, Employee E5 and Employee E22 confirmed that there was no physician's order for oxygen for Resident R410. Further, Employee E22 also confirmed that Resident R410 had an order for oxygen but was discontinue when he was transferred to the hospital.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to ensure professional practice standards related to pain management for one of 35 residents reviewed (Resident R260).</p> <p>Findings include:</p> <p>Review of facility policy, Pain Management and assessment dated revised April 27, 2022, revealed that the purpose of the policy is to develop a standardized method for assessing, monitoring, evaluating, managing and documenting pain. Continued review revealed that staff should, Assess and document pain including onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms. Further review revealed, Non-pharmacological interventions will be attempted prior to use of PRN [as needed] analgesics whenever appropriate. Use of interventions and effectiveness will be documented.</p> <p>Interview on April 28, 2025, at 12:44 p.m. Resident R260 stated that she frequently has pain.</p> <p>Review of Resident R260's care plan, dated April 23, 2025, revealed that the resident was admitted to the facility on [DATE], and has chronic back pain.</p> <p>Review of progress notes for Resident R260 revealed a physician's note, dated April 25, 2025, at 6:11 p.m. which indicated that the resident complains of 8/10 (pain scale of 0 to 10, where 0 is no pain and 10 is the worst pain imaginable) low back pain. The physician conducted a pain and opioid management evaluation and recommended to continue Percocet (opioid pain medication), Tylenol (pain medication) and to monitor for pain and effect on therapy progress. The physician also recommended medication weaning as tolerated and in accordance with current pain management guidelines</p> <p>Review of Resident R260's Medication Administration Records (MARs) for April 2025, revealed a physician's order, dated April 22, 2025, for Tylenol, give 650m.g every six hours as needed for generalized pain. The MAR indicated that no doses were administered.</p> <p>Further review of Resident R260's MARs for April 2025, revealed a physician's order, dated April 22, 2025, for Percocet, 5-325 m.g, give one tablet every six hours as needed for pain. The MAR indicated that the resident received ten doses between April 22 through 29, 2025.</p> <p>Review of eMAR (electronic MAR) notes for Resident R260 revealed that Percocet was administered on April 22, 2025, at 6:45 p.m. There was no indication of onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms, nor any indication of any non-pharmacological interventions attempted.</p> <p>Continued review of eMAR (electronic MAR) notes for Resident R260 revealed that Percocet was administered on April 23, 2025, at 3:53 p.m. There was no indication of onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms, nor any indication of any non-pharmacological interventions attempted.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Continued review of eMAR (electronic MAR) notes for Resident R260 revealed that Percocet was administered on April 24, 2025, at 12:39 p.m. and 6:41 p.m. There was no indication of onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms, nor any indication of any non-pharmacological interventions attempted.</p> <p>Continued review of eMAR (electronic MAR) notes for Resident R260 revealed that Percocet was administered on April 25, 2025, at 1:53 p.m. There was no indication of onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms, nor any indication of any non-pharmacological interventions attempted.</p> <p>Continued review of eMAR (electronic MAR) notes for Resident R260 revealed that Percocet was administered on April 26, 2025, at 7:32 p.m. There was no indication of onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms, nor any indication of any non-pharmacological interventions attempted.</p> <p>Continued review of eMAR (electronic MAR) notes for Resident R260 revealed that Percocet was administered on April 27, 2025, at 9:03 p.m. There was no indication of onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms, nor any indication of any non-pharmacological interventions attempted.</p> <p>Continued review of eMAR (electronic MAR) notes for Resident R260 revealed that Percocet was administered on April 28, 2025, at 6:24 p.m. There was no indication of onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms, nor any indication of any non-pharmacological interventions attempted.</p> <p>Further review of eMAR (electronic MAR) notes for Resident R260 revealed that Percocet was administered on April 29, 2025, at 5:55 p.m. There was no indication of onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms, nor any indication of any non-pharmacological interventions attempted.</p> <p>Interview on May 1, 2025, at 9:07 a.m. the Director of Nursing revealed that pain location as well as a pain scale for appropriate administration of medications, such as mild, moderate and severe pain with corresponding numeric values, should be included in the physician orders for pain medications and that physician orders should also include non-pharmacological interventions for pain. The Director of Nursing confirmed that Resident R260 orders for pain medications did not include any of the above pain medication standards of practice.</p> <p>28 Pa Code 211.2(9) Medical Director</p> <p>28 Pa Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12 (d)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</b></p> <p>Based on clinical record review and interviews with staff, it was determined that the facility failed to maintain effective communication with a dialysis provider for two of two resident reviewed. (Residents R138, and R38)</p> <p>Findings include:</p> <p>Review of facility policy titled Care of Hemodialysis Resident revised January 28, 2025, revealed the facility will provide an ongoing assessment of residents' condition and will monitor for complication before and after each dialysis treatment. Continued review of this policy revealed that the facility will have an ongoing communication and collaboration with the dialysis facility.</p> <p>Review of Resident R138's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated February 1, 2025, revealed that the resident reentered the facility on January 28, 2025, and had diagnoses' including kidney disease (nephropathy-the kidneys are damaged and cant filter waste, fluids, and toxins from the body), diabetes(chronic disease characterized by abnormal high levels of glucose), and malnutrition (the body does not receive enough nutrients to maintain health). Continued review revealed that the resident required medication insulin, antipsychotics diuretics. Resident 138 was dependent on dialysis (a life sustaining treatment used when the kidneys can no longer filter waste from the blood).</p> <p>On May 1, 2025, Resident R138's communication binder was requested, the binder that contains the resident's information and communication pages between the facility and the dialysis team. Facility staff was unable to be located the communication binder on the nursing unit.</p> <p>Interview with licensed nurse, Employee E25 on May 1, 2025 at 08:24 a.m. revealed that the communication binder was not available, cannot be found on the unit. The communication binder is usually kept with the residents, Employee E25 confirmed that Resident R138's communication binder was not with Resident 138.</p> <p>Review of Resident R38's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated February 26, 2025, revealed that the resident was admitted to the facility on [DATE] , and had diagnoses including kidney failure (renal failure- when your kidneys no longer function), diabetes, and hypertension (high blood pressure). Continued review revealed that the resident required dialysis (a life sustaining treatment used when the kidneys can no longer filter waste from the blood).</p> <p>Review of Resident R38's communication binder on May 1, 2025, at 08:29 a.m. revealed that there was information that needed to be completed on every day of dialysis. The information needed is pretreatment, to be complete by facility nurse which includes resident vitals, medication, labs, any pertinent information signed and dated by facility unit nurse.</p> <p>Continued review revealed that the next part of the communication sheet was to be completed by the dialysis center nurse including any pertinent information, any labs, any medical concerns and to be signed and dated by the dialysis nurse.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of this document revealed the final part of communication to be completed by the facility unit nurse with information of post treatment vitals, and symptoms resident may be experiencing and to be signed and dated.</p> <p>Review of Resident 38's dialysis communication binder revealed that on the following days the pages were found to be incomplete, only the pre dialysis was completed with vitals and signature, the dialysis nurse did not complete the form, nor was the form completed after the resident returned to the facility of post dialysis evaluation on</p> <p>April 3, 2025; April 14, 2025; April 22, 2025; April 24, 2025 and April 29, 2025.</p> <p>Interview with Licensed nurse, Employee E25 confirmed the dialysis binder was incomplete with resident assessment information. Employee E25 described the protocol of a resident to leave for dialysis, the nurse will take vitals, document the dialysis communication binder and send the resident with the communication binder to transfer, when the resident returns, the nurse is then to assess the resident, take vitals and document the communication binder.</p> <p>28 Pa. Code 211.(5)(f) Clinical records</p> <p>28 Pa. Code code 211.12 (d)(1) Nursing services</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>39344</p> <p>Based on review of personnel files, review of facility documentation and interviews with staff, it was determined that the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs for two of five newly hired personnel files reviewed (Employees E16 and E17).</p> <p>Findings include:</p> <p>Review of the facility's job description for nurse aides, dated May 5, 2015, revealed that nurse aides provide care to residents including: bathing, dressing, grooming, toileting, feeding, incontinence care, transferring, ambulation, range of motion, turning, repositioning, obtaining vital signs, weights, applying creams and collecting specimens.</p> <p>Review of facility documentation revealed that Employees E16 and E17 were hired by the facility as nurse aides on March 25, 2025.</p> <p>Personnel files, including documentation of skills competencies evaluations, for Employees E16 and E17, nurse aides, were requested on April 29 and 30, 2025.</p> <p>Personnel files were provided for review on May 1, 2025. There was no evidence of any skills competencies evaluations conducted for Employees E16 and E17, nurse aides. Documentation of skills competencies evaluations of hands-on direct patient care skills was requested again on May 1, 2025 at 9:15 a.m.</p> <p>No skills competency evaluations of hand-on direct patient care skills for Employees E16 and E17, nurse aides, were provided for review at any time during the survey.</p> <p>28 Pa Code 201.19(6)(7) Personnel policies and procedures</p> <p>28 Pa Code 201.20(b)(d) Staff development</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>43277</p> <p>Based on observations and interviews with staff, it was determined that the facility did not ensure that that trash was properly disposed of in the receiving and dumpster area.</p> <p>Findings Include:</p> <p>A tour of the main kitchen was conducted on April 28, 2025, at 9:32 a.m. with the Food Service Director, Employee E13. The tour included observations of the outside area where food deliveries are accepted and where the dumpsters are stored.</p> <p>Observations in the receiving area outside revealed trash, food, and debris on the ground surrounding the dumpsters. On one dumpster, the door on the back was open, and trash was exposed.</p> <p>28 PA Code: 201.14(a) Responsibility of licensee.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>43277</p> <p>Based on review of personnel files, observations, and staff interview it was determined that the facility failed to ensure staff were qualified to provide feeding assistance for one of one employee reviewed (Employee E27).</p> <p>Findings Include:</p> <p>Review of Resident R124's comprehensive care plan revised December 30, 2024, revealed the resident exhibited dysphagia (swallowing difficulties) when consuming foods by mouth putting the resident at risk for aspiration (inhaling food or saliva into the airway or lungs) and weight loss.</p> <p>Continued review of Resident R124's comprehensive care plan revised June 30, 2023, revealed the resident had an activities of daily living self-care performance deficit and required supervision assistance with eating.</p> <p>Review of Resident R125's comprehensive care plan revised April 10, 2025, revealed the resident had an activities of daily living self-care performance deficit and required set-up/assistance with eating.</p> <p>Review of Resident R125's physician order summary revealed a diet order dated April 24, 2025, that the resident required a mechanically altered diet (texture modified diet for individuals who have difficulty chewing or swallowing).</p> <p>Review of Employee E27's personnel file revealed the employee was hired as a receptionist effective March 4, 2024. Further review of Employee E27's personnel file revealed the employee transferred departments and was hired as an activity aide effective February 17, 2025.</p> <p>Observations on April 30, 2025, at 1:30 p.m. revealed Activity Aide, Employee E27, was providing hands on feeding assistance during the lunch time meal for Residents R124 and R125.</p> <p>Observations on April 30, 2025, at 1:30 p.m. revealed Resident R124 and R125 were seated next to each other at a table in the dining room during lunch on the Main Unit. Activity Aide, Employee E27, was observed to be standing between Resident R124 and R125 and alternated between the two residents to feed/guide food into their mouths.</p> <p>Interview on April 30, 2025, at 2:45 p.m. with Employee E1, Nursing Home Administrator, revealed nursing staff are responsible for providing feeding assistance to residents who require help.</p> <p>Review of Activity Aide, Employee E27, job descriptions for receptionist and activity aide revealed no evidence it included the job duties of providing feeding assistance for residents. Further review of Activity Aide, Employee E27, personnel file revealed no evidence the employee had any training to provide hands on feeding assistance for residents.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.10 (d) Resident care policies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>39344</p> <p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>Based on review of facility documentation, clinical record reviews and interviews with staff, it was determined that the facility failed to maintain accurate documentation of arbitration agreements for five of six arbitration agreements reviewed (Residents R37, R122, R48, R136 and R410).</p> <p>Findings include:</p> <p>Binding Arbitration Agreements are agreements by which the parties agree to submit to arbitration (private process where disputing parties agree that another individual can make a decision about the dispute after receiving evidence and hearing arguments) to resolve disputes between them within a defined legal relationship. The decision is final and can be enforced by court.</p> <p>Review of facility documentation dated March 20, 2025, revealed a list of Residents who are currently residing in the facility that have entered into a binding arbitration agreement on or after 9/16/2019: Residents R150, R37, R122, R48, R136 and R410 were selected for review from the list.</p> <p>On May 1, 2025, at 10:30 a.m. arbitration agreements for Residents R150, R37, R122 and R410 were provided for review. The Nursing Home Administrator revealed that arbitration agreements for Residents R48 and R136 were not available because those residents did not have signed arbitration agreements.</p> <p>Review of arbitration agreements for Residents R37, R122 and R410 revealed that none of the agreements were dated and that all three had initials from the residents' family members in the signatures section of the agreement. The rest of the forms for Residents R37, R122 and R410 were blank/incomplete.</p> <p>Interview on May 1, 2025, at 10:20 a.m. Employee E3, assistant administrator, stated that the arbitration agreements for Residents R37, R122 and R410 were completed by her in person with the resident's family members present. Employee E3, assistant administrator, stated that Residents R37, R122 and R410's family members all agreed to the arbitration agreements. Employee E3, assistant administrator, confirmed that there were no dates or signatures on the forms and was unable to explain why the forms were not filled out properly.</p> <p>Interview on May 1, 2025, at 10:48 a.m. the Nursing Home Administrator stated that Residents R37, R122 and R410 did not have binding arbitration agreements with the facility. The Nursing Home Administrator stated that the provided list of residents who have entered into binding arbitration agreements with the facility was incorrect, that the facility's tracking system was wrong and that she needed to create a new list. Employee E3, assistant administrator, stated that she misspoke during her earlier interview and was unable to explain why she stated that she reviewed the arbitration agreements in person with Residents R37, R122 and R410's family members, that she said they agreed to the arbitration agreements and that now she did not know if they agreed to the arbitration agreements. The Nursing Home Administrator confirmed that it was unclear if the arbitration agreements for Residents R37, R122 and R410 were agreed to or not and that the forms were incomplete.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46508</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement enhanced barrier precautions for one of five residents on enhance barrier precaution observed (Residents R410).</p> <p>Findings Include:</p> <p>Review of facility Policy on Enhanced Barrier Precaution with an issue date of March 26, 2024 revealed that under section Policy, It is the Policy of this facility that Enhanced barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high0contact resident activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as residents with Chronic wounds requiring a dressing, indwelling medical device or residents with infection or colonization with an MDRO. Under section Definition, Enhanced Barrier Precaution (EBP) refer to an infect ion control intervention designed to reduce transmission of multidrug-resistant organism that employs targeted gown and glove use during high contact resident care activities. High contact resident care activities include Dressing, Bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, decide care or use: Central line, urinary catheter, feeding tube, tracheostomy, wound care (any skin opening that requires dressing).</p> <p>Review of Resident R410's clinical record revealed that Resident R410 was admitted to the facility on [DATE] with diagnoses of but not limited to Intracranial injury, Respiratory Failure, Left Basilar Infiltrate, Aspiration Pneumonia</p> <p>Review of Resident R410's physician's orders revealed an order for Meropenem Intravenous Solution Reconstituted 1 GM (Meropenem) Use 1 gram intravenously every 8 hours 10 Days-Order Date-04/24/2025</p> <p>Observation conducted on April 28, 2025, at 11:13AM revealed that Resident R410 was in bed. Further observation revealed that Resident R410 had an IV (intravenous-through the vein) line to his right arm, partially covered with his blanket.</p> <p>Further observation revealed that Licensed nurse, Employee E20 came into the room with a vial and a 50cc IV bag in her hand. Further, Licensed nurse, Employee E20 put on a pair of gloves, but did not wear any other PPE required for EBP. Licensed nurse, Employee E20 then initiated the IV set up using the same gloved hand and primed the IV tubing using the same gloved hand.</p> <p>Further observation revealed that Licensed nurse, Employee E20 proceeded to administer the IV medication without washing her hands or changing gloves.</p> <p>Licensed nurse, Employee E20 did not respond to interview and left the room.</p> <p>28 Pa. Code 211.10 (d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Yeadon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46508</p> <p>Based on observations of the physical environment, interviews with staff and residents, it was determined that the facility failed to maintain an effective pest control program.</p> <p>Findings include:</p> <p>Review of Resident R37's clinical record revealed that resident was admitted to the facility on [DATE], with diagnoses of but not limited to cardiovascular disease, and gastrostomy status.</p> <p>Observation conducted on April 28, 2025, at 11:13 a.m. during the tour of the first-floor unit revealed that Resident R37 was in bed asleep. Further observation revealed that Resident R37 was on tube feeding with feeding bag of Jevity 100 cc hanging on a pole, the tubing was primed (feeding formula was in the tubing) but not connected to the pump.</p> <p>Further observation revealed a fly on Resident R'37's sheet. Further, three other flies were observed flying about Resident R37.</p> <p>Further observation of Resident R37's bedroom revealed that the screen on one of the windows in her room had a hole.</p> <p>Interview with unit manager Employee E5 conducted on April 28, 2025, at 11:13 a.m., confirmed that there were flies in the room and that the screen on one of the windows had a hole in it. Employee E5 stated that she will immediately get someone to replace the screen.</p> <p>Interview with Resident R37's roommate Resident R52, conducted on April 28, 2025 at 11:30 a.m. confirmed that that there were flies in their room. Further Resident R52 revealed that she observed the flies since a few days ago. Further Resident R52 revealed that she doesn't know where flies came from.</p> <p>Further interview with Resident R52 also revealed that she opens the window of the room sometimes.</p> <p>28 Pa Code 201.18(a)(b)(1) Management</p>		