

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/23/2026
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on Observations, review of clinical record, and interview with staff and residents, it was determined that the facility did not ensure dignity and privacy was maintained for one resident who had an audiology consult in a public activities area for one of 36 residents (Resident R13). Findings include: Review of Resident R13's April 2026 physician orders included the following diagnosis: diabetes (a group of diseases that affect how the body uses blood sugar/glucose; depression; chronic kidney disease (a condition in which the kidneys are damaged and gradually lose their ability to function properly over time), and hypertension (high blood pressure). During an observation on April 22, 2026 at 11:00 a.m. the resident was observed sitting in the activity office on the 2nd floor. The resident was observed sitting in the room receiving an audiology assessment. The audiologist was also sitting next to the resident with her computer on the desk. Observed in the room with the resident and audiologist were two barbers/beauticians were talking and transporting residents in and out of the room for hair care services. In addition to the residents being brought in and out of the room for services, three employees were observed coming in and out of the room for work related purposes, and at a later time the three employees were observed standing in the doorway of the activity office, having a conversation. During a discussion with the Activity Director (Employee E17) at 11:10 a.m. on April 22, 2026, it was discussed that the audiologist was conducting the resident's hearing assessment in the activity's room. During a discussion with the Nursing Home Administrator (NHA) on April 22, 2026 at 11:15 a.m. the NHA and acknowledged that she was aware of the above-referenced incident regarding resident R1.		

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 04/23/2026
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review clinical record, review of facility documents, facility investigations, facility policy and interview with staff and residents, it was determined that the facility did not ensure that residents were free from misappropriation of resident property related to narcotic diversion for one of 36 residents (Resident R14). This deficiency was identified as Past Non-compliance. Findings include: Review of facility policy on Controlled Substance Management with most recent revision date of August 7 2024, revealed that under section Policy: to provide guidance for record keeping receipt handling storing and disposal of control substances in accordance with federal state DEA (Drug Enforcement Agency) and board of pharmacy regulations under section Storage and Inventory, #1 store medications listed in schedules II, III, IV and V under double lock separate from other medications. #2 when a controlled medication is administered, the details of the administration should be documented on the accountability record. #a. date/time of administration #b. amount of medication administered #c. amount of medication remaining in the container #d. signature of nurse administering the dose. #3 conduct an inventory of all controlled medications at each shift or when keys are surrendered to another license nurse. Review of event details reported by the facility through the Department of Health on December 23 2025 revealed that on December 20 2025, misappropriation of resident property occurred related to oxycodone hydrochloride factual description of the event detail revealed that facility was notified by staff LPN that during narcotic count she noticed a discrepancy for Resident R14 for his oxycodone 5 milligrams. Description of follow up action revealed that an investigation was conducted and the investigation concluded that a diversion was substantiated. Further review facility investigation documents revealed that a PB22 report form for investigation of alleged abuse neglect misappropriation of property was completed by the facility for misappropriation of resident property description of event revealed as follow: on Monday December 22, 2025, at approximately 4:00 PM the facility was notified about the discrepancy in the narcotic logbook on the 2nd floor cart. Licensed nurse Employee E15 identified the miscount and notify the supervisor on December 20 2025 and the agency nurse Employee E16 signed out three PRN (as needed) 5 milligram oxycodone for Resident R14 which was not signed out in PCC, The starting count was sixteen pills, three were signed out, one pill was administered leaving the count at thirteen with two pills unaccounted for. The incident was reported to the Department of State, The Department of Health, and the [NAME] police. Resident R14 was interviewed which revealed that resident was not in pain at the time of the incident and did not request for pain medication. The facility initiated a facility wide staff education conducted, a quality assurance performance improvement on medication administration policy, physician completed a complete review of all narcotic logs and review of all PRN and narcotics discontinued and narcotics not being used per administration policy. Interview with Director of Nursing Employee E2 conducted on May 22, 2026, at 8:54 AM revealed that the facility conducted a complete and thorough investigation on the incident. Further Employee E2 revealed that Resident R14 never requested for the Oxycodone and was not in pain. Further the director of nursing revealed that 29 of 30 full time licensed nurses and 11 of 11 agency licensed nurses were educated on controlled drugs accountability and medication administration policy, QAPI was conducted and is still on going. Further employee 2 revealed that the plan of correction was completed and fully implemented on December 29, 2026. 28 Pa. Code 201.18(b)(2) resident's personal property 28 Pa. Code 201.29(c) Resident's rights		

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 04/23/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interviews and the review of clinical records, it was determined that the facility failed to ensure that one resident with a diagnosis of congestive heart failure was properly assessed after a 27.4-pound weight gain in a two-month time period, for one out of 29 residents reviewed (Resident R3). Findings include: Review of the facility's Resident Height and Weight policy with a revision date of January 7, 2025 indicated that all residents will be weighed upon admission and subsequently as the policy directs to provide a baseline and ongoing record for monitoring stability of weight as an indicator of nutritional status and medical condition over a period of time. The policy also stated that any weight change of 5lbs or more will be retaken and if a reweight verifies a significant, unplanned weight change, this is communicated to the resident's physician, power of attorney, dietician, and any others deemed necessary by the disciplinary team. Continued review of the policy indicated that the weight change will be assessed and reviewed by the dietician in cooperation with the disciplinary team, and appropriate interventions will be implemented, reviewed and revised as needed. Review of the April 2026 physician orders for Resident R3 include the following diagnosis: Congestive Heart Failure (COPD-a progressive lung disease that makes it difficult to breath); diabetes (a condition defined by persistently high levels of sugar/glucose) in the blood); chronic pulmonary edema (a condition caused by too much fluid build-up in the lungs, making it difficult for an individual to breath, and oftentimes due to cardiogenic causes such as congestive heart failure), and congestive heart failure (occurs when the heart muscle doesn't pump blood as well as it should, causing fluid can build up in the lungs, and shortness of breath). Review of the resident's monthly weight from December documented the resident as weighing 186 pounds. Review of the resident's monthly weight for January 9, 2026 included a weight of 198 pounds, which is a significant weight gain of 12 pounds in a month, and a +6.5% significant weight gain for the resident with a diagnosis of congestive heart failure. Review of a clinical note written by the dietician (Employee E25) dated January 10, 2026, at 1:29 p.m. indicated that the resident's weight on January 9, 2026 was 198 pounds, with a 6.5% weight and 12 pounds weight gain since the previous month. The clinical note from the dietician stated that a reweight was requested. Review of the clinical record did not show evidence that a reweight was completed. Review of a physician's note dated January 27, 2026 at 11:22 p.m. documented that the resident was seen for a routine follow up. Resident's weight gain from January 9, 2026 was not acknowledged/addressed by the physician in the above referenced routine follow up. Continued review of the resident's weight record indicated that the resident's weight was documented as being 213.4 pounds on February 6, 2026, which is an additional 15.4 pound weight gain for the resident with a diagnosis of congestive heart failure, a total weight gain of 27.4 pounds since December 8, 2025, and a total significant weight gain of +15% for a resident with congestive heart failure. Review of a clinical note written by the dietician on February 7, 2026 at 11:08 a.m. indicated that the dietician acknowledged the above referenced weight gain. Review of a clinical note written by the dietician on February 7, 2026 at 11:20 a.m. documented that the dietician notified the physician and the nursing supervisor of the resident's weight change. Continued review of the clinical record did not show evidence of what the physicians response was regarding the additional weight gain for the resident with congestive heart failure, to ensure the weight gain was acknowledged, and any additional care and services, or interventions, if ordered, by the physician, were implemented for the resident. During a discussion with the facility's Medical Director on April 23, 2026 at 2:00 p.m. concerns regarding the physician not acknowledging/assessing the resident's weight gain in January and in February to determine whether any additional interventions were needed was discussed.		

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 04/23/2026
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, and interview with staff, it was determined that the facility did not ensure that residents receiving a tube feeding was placed in proper position to avoid aspiration for one resident (Resident R2).Review facility policy on two feeding Revealed that under section purpose to provide guidelines to ensure safe and effective administration of medications administered via Interlube under section procedure number 5 ensure head of bed is elevated unless contraindicated.Review of resident R2S clinical record revealed that resident R2 was admitted to the facility on [DATE], with diagnosis of but not limited to Dysphagia and get stressed and Gastrostomy Status.Review of Resident R2's MDS minimum data set significant change assessment dated [DATE], section K0520. Nutritional Approaches revealed that Resident R2 was on Feeding tube (PEG percutaneous Endoscopic Gastrostomy- A flexible tube Inserted through the abdomen into the stomach to deliver nutrition, fluids and medications directly).Review of Resident's R2's care plan revealed that Resident R2 requires tube feeding r/t (related to) dysphagia/tracheostomy, and vegetative state. Resident R2 needs the HOB (head of bed) elevated during and thirty minutes after tube feed.Observation of Resident R2 conducted on April 20, 2026, at 1:14 PM revealed that Resident R2 was in bed with tubing connected to feeding pump running at 60 milliliters/hour Further, the head of Resident R2's bed was not elevated, Resident R2 was lying flat on bed. Further observation revealed that Resident was coughing with gurgling sound. Resident R2's tracheostomy mask was on Resident R's right side of face.Further observation revealed yellowish-beige colored substance mixed with mucous was on Resident R2's chest and on lower part of Resident R2's tracheostomy dressing.Further observation revealed that specks of the yellowish beige substance were also on the inside surface of the tracheostomy mask and on the inside of corrugated tubing connected to the tracheostomy mask.Staff were alerted by surveyor, and licensed nurses Employees E5, E6 and E7 responded. Employee E7 stopped the feeding and proceeded to assess the resident, while Employee E5 elevated the head of Resident R2's bed.Interview with Employee E7 conducted at the time of the observation confirmed that a yellowish-beige colored substance mixed with mucous was on chest, below the tracheostomy site, inside of the tracheostomy mask and in the inside of the corrugated tubing. Further, Employee E7 stated she will order x-ray to rule out aspiration.Interview with Employee E5 conducted at the time of the observation confirmed that Resident R2 was receiving feeding via feeding tube while the head of bed of Resident R2's was not elevated and that Resident R2 was lying flat on bed.Further interview with Employee E5 revealed that the facility's policy was that the head of the bed should be elevated for all residents receiving tube feeding. Review of progress note dated April 20, 2026, time stamped15:00 revealed: This RN assessed this resident and noted with copious secretions, and coughing out with some undigested TF (tube feeding). Resident head kept elevated, TF (tube feeding) stopped as per protocol. Another nurse was called in the room to assist with trach care, suctioning and repositioning res. Stat CXR ordered by MD to r/o aspiration PNA (pneumonia). RP (responsible party) made aware. 28 Pa. Code 211.12(d)(1) Nursing services28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 201.18(b)(1) Management responsibility		

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 04/23/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews with staff, and review of clinical records, facility documentation, and policy it was determined that the facility did not implement an effective infection control program related to use of Personal Protective Equipment (PPE) and wound care for two of thirty-six residents observed (Resident R2 and Resident R5). Findings include: Review facility policy on Isolation Precaution with a most recent revision date of May 8, 2024, revealed that under section Purpose: To establish transmission-based precaution for residents who are suspected or confirmed to have communicable diseases/infections that can be transmitted to others. Under section Procedure: #1 Transmission based precaution will be used when transmission cannot reasonably be prevented by standard precaution alone. Under section Contact Precaution: #1 Implemented for residents suspected of or confirmed to be infected with a communicable disease that can be transmitted by direct contact with a resident or indirect contact with environment services/equipment in the resident's environment #3 prior to entering the isolation room the following steps are required: #a. perform hand hygiene and apply gloves and gown prior to entering room. #c. Remove gloves and perform hand hygiene before leaving room. Review of resident R2's clinical record revealed that Resident R2 was admitted to the facility on [DATE], with diagnosis of but not limited to Dysphagia and Gastrostomy Status. Review of Resident R2's MDS minimum data set significant change assessment dated [DATE], section K0520. Nutritional Approaches revealed that Resident R2 was on Feeding tube (PEG percutaneous Endoscopic Gastrostomy (A flexible tube Inserted through the abdomen into the stomach to deliver nutrition, fluids and medications directly). Review of Resident's R2's care plan revealed that Resident R2 requires tube feeding r/t (related to) dysphagia/tracheostomy, and vegetative state. Resident R2 needs the HOB (head of bed) elevated during and thirty minutes after tube feed. Observation conducted on April 20, 2026, at 1:12 PM revealed that Resident R2 for Enhance Barrier Precaution and Contact Precaution posted outside the resident's bedroom door. Observation of Resident R2 conducted on April 20, 2026, at 1:14 PM revealed that Resident R2 was in bed with tubing connected to feeding pump running at 60 milliliters/hour Further, the head of Resident R2's bed was not elevated, Resident R2 was lying flat on bed. Further observation revealed that Resident was coughing with gurgling sound. Resident R2's tracheostomy mask was on Resident R2's right side of face. Further observation revealed yellowish-beige colored substance mixed with mucous was on Resident R2's chest and on lower part of Resident R2's tracheostomy dressing. Employees E6 was notified by surveyor, Employee E6 then went to Resident's R2's room to check on Resident R2 without wearing PPE. Employee E6 then came out of the room, at the same time, surveyor also alerted Employee E7 of the situation and surveyor and Employee E7 donned PPE and entered Resident R2's room to check on Resident R2. Employee E6 also started to put on PPE and followed surveyor and Employee E7 to Resident R2's room. Employee E7 proceeded stop Resident R2's tube feeding and assesses Resident R2. Employee E5 then instructed Employee E6 to get a pulse oximeter. Employee E6 then left the room without removing her PPE and went to the medication cart located in the hallway around the corner from Resident R2's room. Interview with Employee E7 conducted at the time of the observation confirmed Resident R2 was on contact precaution. Further, Employee E7 also confirmed that Employee E6 left the room to retrieve a pulse oximeter from the medication cart located in the hallway around the corner from Resident R2's room without removing the PPE that she was wearing inside Resident R2's room. Further, Observation conducted on April 21, 2026, at 9:33 AM revealed that Resident R5's room had a signage for Enhance Barrier Precaution and Contact Precaution posted outside the door. Further PPE supplies were in a drawer outside of Resident R5's room. Further observation revealed that hospice nurse Employee E27 was going in and out of Resident R5's room without PPE. Interview with Employee E27 conducted at the time of the observation together with licensed nurse Employee E5 revealed that Employee E27 was the hospice aide Employee E5 who was in Resident R5's room (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/23/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview with Employee E27 revealed that she was not aware that she had to wear a PPE and thought that the contact precaution was only for bed A. Employee E5 informed Employee E27 that Employee E27 has to put on PPE before entering Resident R5's room. Interview with Employee E5 confirmed that Employee E28 was in Resident R2's and Resident R5's room without wearing PPE and confirmed that Employee E27 did not know that she had to wear PPE when entering their room. 28 Pa. Code 211.10 (a)(c) Resident care policies28 Pa. Code 211.12(d)(1)(5) Nursing services		