STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395687	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York Nursing and Rehabilitation Center	7101 Old York Road Philadelphia, PA 19126

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47973 Based on interviews with staff, review of clinical records, facility policies and facility documentation, it was determined the facility failed to implement interventions to assure one resident (Resident R3) was free from physical abuse resulting in actual harm to Resident R3 who was struck by Resident R4 in the face with a leg rest, and sustained a chipped tooth for one of 10 resident records reviewed. (Resident R3 and Resident R4) Findings include: Review of facility policy titled, Abuse revised December 13, 2024, revealed, each resident will be free from abuse including verbal, mental, sexual, or physical abuse. Further review indicated, residents will be protected from abuse, neglect, and harm while they are residing at the facility and facility will educate staff in techniques to protect all parties. Review of Resident R3's clinical record revealed the resident was admitted on [DATE], with diagnoses including Cervical Disc Disorder, muscle weakness, difficulty walking, cognitive communication deficit, Atherosclerosis (coronary artery bypass graft), and Arterial Fibrillation (irregular rapid heart rate). Review of Resident R3's admission Minimum Data Set (MDS is an assessment of resident's care needs) dated January 28, 2025, revealed Resident R3 was cognitively intact, required maximal assistance with lower body dressing, and used a manual wheelchair for mobility. Review of Resident R3's care plan, initiated on January 22, 2025, revealed Resident R3 has an ADL (activity of daily living) self-care performance deficit related to muscle weakness, difficulty walking, and muscle wasting and atrophy (reduce muscle mass). Further review of Resident R3's care plan revealed the resident had oral/dental problems and was a smoker. Review of Resident R4's clinical record revealed Resident R4 was admitted to the facility on [DATE], with diagnoses including cognitive communication deficit, muscle weakness, Rhabdomyolysis (breakdown of skeletal muscle), Bipolar Disorder (condition in which a person has periods of depression of being extremely happy), and Depression (major loss of interest in pleasurable activities). Review of Resident R4's quarterly MDS assessment dated [DATE], revealed Resident R4 was cognitively intact and used a manual wheelchair for mobility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R4's care plan initiated on August 16, 2024, revealed Resident R4 had a behavior problem related to insomnia, depression, anxiety. Continued review of Resident R4's care plan revealed a single intervention, administer medications as ordered. Monitor for side effects and effectiveness. Review of Resident R3's clinical records including a Social Services note, dated March 24, 2025 revealed, a violent incident occurred outside in the smoking area. Resident was hit with leg rest from a wheelchair by another resident and Resident R3 was struck resulting in the loss of one tooth. Review of facility documentation titled, Injury Report, dated March 24, 2025, revealed Resident R3 had a chipped tooth inside of mouth. Interview conducted on April 2, 2025, at 9:55 a.m., with the Activity Aides, Employee E6, and Employee E5, who were supervising residents during the smoke break on March 24, 2025, approximately 1:30 p.m. revealed Employee E5 and Employee E6 announced to the residents, the facility staff would no longer provide cigarettes to the residents. Resident R4 responded with verbal aggression using foul language toward Employee E5 and Employee E6. Continued interview revealed when Resident R3 intervened in an effort to stop Resident R4 expressing foul language towards the activity aides, [Resident R4] got up with the leg rest in [his/her] hand and started chasing me (Employee E5), attempting to hit me. When [Resident R3] stood up from (his/her) wheelchair to defend (himself/herself), [Resident R4] swung at [Resident R3] in the face with the leg rest. Continued interview revealed Resident R3 dropped back into the wheelchair after the hit and Resident R4 tackled Resident R3 in [his/her] wheelchair and continued to punch (him/her) for approximately 15 seconds. During the interview, Activity Aides, Employee E5 and E6, revealed Resident R4 portrayed verbal aggression in the past with profanity towards staff during smoke breaks. During the Interview with Nurse Aide, Employee E11, conducted on April 2, 2025, Employee E11 stated, Resident R3 threatened to beat up [his/her] roommate because [his/her] television was loud, and now [his/her] roommate won't watch TV anymore. Interview with Nurse Aide, Employee E10, conducted on April 2, 2025, at 11:22 a.m. revealed that last month she heard Resident R4 shout at the roommate, I will beat you up. The facility failed to implement interventions to assure Resident R3 was free from physical abuse resulting in actual harm to Resident R3 who was struck in the face with a leg rest and sustained a chipped tooth. 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47973 Based on observations, resident and staff interviews, it was determined that the facility failed to provide food and drink that was palatable and served at palatable temperatures for three of 10 residents reviewed. (Resident R3, Resident R6, Resident R7) Findings include: Review of facility policy titled, Food Temperatures, dated January 17, 2019, revealed, All hot food items must be cooked to appropriate internal temperatures, held and served from steam table at temperature of at least 135 F. Take temperatures often to monitor for safe temperature ranges of at or below 41 F for cold foods and at or above 135 F (Fahrenheit) for hot foods. Continued review revealed, Hot food items may not fall below 135 F after cooking and all cold food items must be maintained and served at a temperature of 41 F or below. Interview with Resident R6 on April 1, 2025 at 10:00 a.m. revealed some food does not have flavor. Interview with Resident R7 on April 1, 2025, at 10:10 a.m. revealed the food is warm, not hot. Interview with Resident R3 on April 1, 2025, at 1:30 p.m. revealed, they never get my food right. Observations during a test tray conducted with the Foodservice Director, Employee E12, on April 1, 2025, at 12:26 p.m. revealed chicken registered 118 degrees Fahrenheit (F); [NAME] registered 118 degrees F; Steamed Broccoli 106.7 degrees F; and cold pears registered 46.2 degrees F. Follow-up interview with the Food Service Director, on April 1, 2025 at 12:32 p.m. revealed that that foods should be at at least 120 degrees F and confirmed that these food items were outside the acceptable temperature range and therefore not palatable. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management