

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER York Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documentation, resident clinical records, observations, and staff interviews, it was determined the facility failed to provide adequate supervision for one of three residents assessed as at risk for elopement (Resident R223). Resident R223 exited the second-floor nursing unit via elevator and walked out the back rear entrance of the facility. Resident R223 was located by local law enforcements approximately four hours after the resident exited the facility, approximately 1.5 miles away in a busy [NAME] area. This failure resulted in actual harm to Resident R223 who was admitted to the hospital with hypothermia and resulted in an Immediate Jeopardy situation. (Resident R233)Findings Include:Review of facility policy titled Elopement reviewed September 23, 2024, revealed an elopement is defined as when a resident leaves the premises or a safe area without authorization and or necessary supervision. Further review of facility policy revealed multi-faceted interventions for residents identified as at risk include, but are not limited to, Increase supervisor (checks). The facility should adjust staffing as indicated; particularly during times when the resident is agitated and/or making attempts to exit.Review of undated facility policy Resident Elopement Protocol revealed any staff person who determined a resident may be missing will immediately notify their unit manager/supervisor. If the resident cannot immediately be found, the Unit Manager/Supervisor will notify the Administration, Director of Nursing, and Security. The Administrator/Director of Nursing/Supervisor or Security staff will announce code yellow (responding to elopement) with the resident's name and room number to notify all staff of the need to perform the internal/external search.Review of facility policy Elopement Prevention/Wander-guard Assessment dated January 2021, revealed the unit manager/designee will perform an assessment of the resident's behaviors and history. Prevention measures may include, but are not limited to, interdisciplinary team meeting and care planning, staff monitoring plan, and family observations and ideas for prevention.Review of Resident R223's clinical record revealed the resident was admitted to the facility's 2nd Floor North Side nursing unit on December 11, 2025, and had diagnoses of Dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Apraxia (neurological disorder that affects motor planning and coordination), Diabetes Mellitus (ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose), and Hypertension (high blood pressure).Review of Resident R223's hospital documentation dated December 11, 2025, revealed Resident R223 was brought to the emergency department for inability to care for self and need for long-term placement. Resident R223 was noted to be living with a caregiver but due to patient's agitation and frequent elopements they were no longer able to care for Resident R223.Continued review of Resident R223's clinical record revealed a Brief Interview for Mental Status assessment conducted on December 12, 2025, determined that Resident R223 had severe cognitive impairment.Review of Resident R223's comprehensive care plan revised December 12, 2025, revealed the resident was an elopement risk/wanderer related to history of dementia and wandering. Wander guard applied to left ankle. Interventions dated December 12, 2025, included placing resident photograph at reception/exit and Resident R223 was on Center Watch Program (facility elopement binder maintained at front desk) for elopement risk.Review of Resident R223's physician order summary revealed an order dated December 12, 2025, for monitor wander guard/watchmate to left ankle/check placement and function every shift (morning, evening, and night shift). Review of Resident 223's nursing note dated December 12, 2025, at 5:41 a.m. noted that the resident was easily redirected back to his/her room several times as he/she attempted to enter other residents' rooms. Review of Resident R223's nursing note dated December 12, 2025, at 11:26 p.m. revealed that the resident was repeatedly walking the halls.Continued review of Resident R223's nursing notes dated December 13, and 14, 2025, revealed that Resident R223 ambulated the unit.On December 17, 2025, at 9:00 a.m., the Director of Nursing, Employee E2, informed Department of Health surveyors that a resident [identified as Resident R223] eloped from the facility in the evening of December 15, 2025.Interview on December 17, 2025, at 9:00 a.m. with the Nursing Home Administrator, Employee E1, confirmed that revealed that she, as well as the Director of Nursing, Employee E2, were informed Resident R223 was missing on 12/15/2025 at approximately 10:30 p.m. Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, both arrived at the building by approximately 11:30 p.m. to conduct a search of the building and perimeter with no luck in locating the resident Review of statement dated December 15, 2025, by Registered Nurse</p>		