

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  02/04/2025
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)
<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36609</p> <p>Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that a resident's right to request or refuse medical treatments were accurately reflected in the resident's record for one of 35 residents reviewed (Resident R96).</p> <p>Findings include:</p> <p>Review of Resident R96's clinical record revealed that the resident was admitted to the facility on [DATE] with a diagnosis of dementia (progressive degenerative disease of the brain). On December 13, 2024 the resident was placed on hospice care. Further review of Resident R96 clinical record revealed the resident's advanced directive remained full code.</p> <p>On January 31, 2025 at 2:12 p.m., interview with Unit Manager Employee E14 confirmed and stated that Resident R96's POLTS (Physician Orders for Life-Sustaining Treatment- a medical form that outlines a patient's end-of-life care preferences) should have been discussed on December 13, 2024 when the resident went on hospice care and it was not discussed with the resident and/or responsible party related to the resident's advance directives.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</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
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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43923</p> <p>Based on observations and resident and staff interviews, it was determined the facility failed to provide services to maintain a clean and homelike environment for two of four nursing units. (First floor South and North Nursing Units).</p> <p>Findings include:</p> <p>The facility's policy titled Resident's Rights-Safe/Clean/Comfortable/Homelike Environment dated April 1, 2022, indicated It is the policy of the facility to provide a safe, clean, comfortable homelike environment such as manner to acknowledge and respect residents' rights.</p> <p>On January 28, 2025, at 11:33 a.m. observation in room [ROOM NUMBER] bed C revealed dirty privacy curtains with brown spots and black strikes on both sides of the curtain.</p> <p>On January 28, 2025, at 12:25 p.m., an observation was conducted with the Maintenance Director, Employee E18, in room [ROOM NUMBER]B. The inspection revealed a loose closet door with two hinge screws that were not secure, as well as cracks in the wall around the heater that were not sealed.</p> <p>On January 28, 2025, at 1:06 p.m., an observation was conducted with the Maintenance Director, Employee E18, in the shower room on the 1st South nursing unit.</p> <p>. The inspection revealed 12 ceiling tiles with water damage, including one tile that had a large hole.</p> <p>On January 28, 2025, at 1:20 p.m. observation with the Maintenance Director, Employee E18 room [ROOM NUMBER] dresser was broken, baseboard was detached, heater P-Tac unit cover box was loose. Holes in the wall near the baseboard on the right side of the room. Broken tray tables in the B bed.</p> <p>On January 29, 2025, at 9:14 a.m., an observation was conducted with the Maintenance Director, Employee E18, in the 1 North shower room. The room was cluttered with various items, including:</p> <ul style="list-style-type: none"> <li>-The first shower stall containing three large trash cans.</li> <li>-The second shower stall holding a large trash can and three tray tables.</li> <li>-A mechanical lift stored in the middle of the shower area.</li> <li>-No privacy curtain between the second and third shower stalls.</li> <li>-The fourth shower stall containing three mechanical lifts.</li> <li>-A regular resident's chair placed near the sink.</li> </ul> <p>28 Pa. Code 201.18 (e)(1)(2.1) Management.</p> <p>(continued on next page)</p>		

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F 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 201.29 (a) Resident rights.

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>43923</p> <p>Based on facility policy review, personnel file review, and staff interview, it was determined that the facility failed to perform criminal history background checks prior to hire for one of five personnel files reviewed (Employees 2).</p> <p>Findings Include:</p> <p>The facility policy titled Employment Screenings for Potential Hires: Pennsylvania dated, April 2, 2022, revealed under Procedure B. section Criminal records check: i. in accordance with Act 13 and the Older adults Protective Services Act, the Facility will conduct a Criminal History Check as a condition of employment within the first 30 days of hire. This includes clearance through the Pennsylvania State Police.</p> <p>Review of the personnel file for Director of Nursing, Employee 2 revealed hiring date on November 11, 2024. Further review indicated that a Pennsylvania State Police background check was completed on January 29, 2025.</p> <p>An interview was conducted with the Nursing Home Administrator, Employee E1, on December 31, 2025, at 11:48 a.m. Employee E1 stated that the Human Services Director, Employee E9 had conducted a criminal background check at the time of hiring; however, it was not saved, and a more recent copy is unavailable. Additionally, documentation confirmed that the Director of Nursing, Employee E2, did not undergo a criminal background check until January 29, 2025.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management</p> <p>28 Pa. Code 201.19(8) Personnel policies and procedures</p>		

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<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> 43923</p> <p>Based on review of facility policies and clinical records, and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of two residents reviewed regarding a smoking (Resident R192)</p> <p>Findings include:</p> <p>Facility policy entitled, Base Care plan, Comprehensive Care Plan and Ongoing care Plan Updates Revised October 1, 2024, revealed The facility will follow a uniform process for initiating the baseline care plan upon admission, the comprehensive care plan upon CCA (Care Area Assessment) completion, and ensuring care plan updated to reflect the resident's status.</p> <p>Resident R192's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of dementia (progressive degenerative disease of the brain), mild cognitive impairment of uncertain or unknown etiology, adjustment disorder with mixed anxiety and depressed mood, and memory deficit following a nontraumatic intracranial hemorrhage. Additionally, the resident was identified as a smoker, and a smoking assessment was completed on October 30, 2024.</p> <p>Review of Resident R192's Minimum Data Set (MDS - a periodic assessment of care needs) upon admitted d November 5 , 2024, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated that the resident was cognitively intact.</p> <p>On January 30, 2025, at 9:46 a.m. Resident R192 was observed smoking during the normal routine time.</p> <p>A review of the current care plan, dated October 30, 2024, found no evidence of a comprehensive, person-centered plan of care addressing smoking interventions.</p> <p>During an interview on February 4, 2025, at 9:45 a.m., the Director of Nursing, Employee E2, confirmed that Resident R192 was a smoker and acknowledged that no comprehensive care plan had been developed to address safe smoking interventions.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38735</p> <p>Based on clinical record review, observations, resident and staff interviews, it was determined that the facility failed to maintain adequate personal hygiene and grooming of residents dependent on staff for assistance with these activities of daily living for two of 35 residents reviewed (Resident R114, and R60).</p> <p>Findings include:</p> <p>On January 28, 2025, at 12:34 p.m. Resident R114 was observed to have long and dirty nails on his hands. Resident R114 reported that he prefers his nails to be cut short.</p> <p>Review of Resident R114's most recent annual Minimum Data Set (MDS) dated [DATE], revealed him as totally dependent on one staff physical assistance for his activities of daily living.</p> <p>The resident's (BIMS - Brief Interview for Mental Status - a screen used to assist with identifying a resident's current cognition) indicated Resident R114 has intact cognition.</p> <p>A review of the comprehensive care plan for Resident R114 dated September 22, 2022, indicated Resident R114 has potential for impairment to skin integrity r/t decreased mobility incontinence. Under interventions it further revealed Keep fingernails short.</p> <p>On January 29, 2025, at 1:14 p.m. Resident R114 continued to have long nails.</p> <p>On January 30, 2025, at 11:00 a.m. the unit manager, Employee E22 confirmed the observations that Resident R114 nails were long and dirty and it was the responsibility of the nursing assistant to get them cut.</p> <p>On January 29, 2025, at 8:58 a.m. an interview and observation revealed Resident R60 had very long, dirty fingernails, when asked if this was his preference Resident R60 said no, I can't cut them myself, the nurse said she would cut them for me but has not yet.</p> <p>Review of Resident R60's most recent quarterly Minimum Data Set (MDS) dated [DATE], revealed him as independent; however, requires setup or clean-up assistance with personal hygiene</p> <p>The resident's (BIMS - Brief Interview for Mental Status - a screen used to assist with identifying a resident's current cognition) indicated Resident R60 has intact cognition.</p> <p>On January 30, 2025, at 11:20 a.m. interview with license nurse, Employee E23 revealed that the resident refuses care, will only let certain caregivers to help him.</p> <p>On January 30, 2025, at 2:36 p.m. an interview with Resident R60 revealed that license nurse, Employee E24 did cut his nails.</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>(continued on next page)</p>		

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F 0677  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43923</p> <p>Based on facility policy review, clinical records review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that the resident environment was free of accident hazards for one of 35 residents reviewed (Resident 35).</p> <p>Findings include:</p> <p>The facility's policy titled Resident's Rights-Safe/Clean/Comfortable/Homelike Environment dated April 1, 2022, indicated It is the policy of the facility to provide a safe, clean, comfortable homelike environment such as manner to acknowledge and respect residents' rights.</p> <p>On January 28, 2025, at 12:21 p.m., an observation in Resident R35's room revealed a long electrical extension cord with five outlets plugged into a wall outlet behind the resident's bed. The cord extended across the room to power a television placed on a dresser. During an interview, Resident R35 stated that they had purchased the extension cord for their television and video player, with the facility's permission.</p> <p>On January 28, 2025, at 12:25 p.m., an observation was confirmed by the Maintenance Director, Employee E18, who reported that facility does not allow the electrical extension cords to be used in residents room as it is a hazardous item.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18 (e)(1)(3) Management.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</b></p> <p>Based on review of facility policy, review of clinical records, and staff interviews, it was determined that the facility failed to identify, implement, monitor, and modify interventions consistent with the residents needs and current professional standards of practice, to maintain acceptable parameters of nutritional status for one of eight residents reviewed. (Resident R67)</p> <p>Findings:</p> <p>Review of facility policy titled Weight Assessment and Intervention dated February 2022 revealed the nursing staff and dietician will communicate to prevent, monitor, and intervene for undesirable weight loss for the residents. The dietician will review monthly weights and determine if significant weight loss has occurred. Significant weight loss is defined as more or less 5% one month, and more or less 10% within 6 months. The dietician with the interdisciplinary team will make recommendations and care plan interventions.</p> <p>Review of Resident R67's annual Minimum Data Set (MDS- a federal mandated assessment for residents) dated November 7, 2024, revealed this resident was admitted to this facility on January 28, 2022 with diagnoses of coronary artery disease (blockage of arteries), hepatitis (inflammation of the liver), and dementia (group of symptoms that include problems with memory, thinking or language). Resident is 65 inches, and 160 lbs. currently prescribed a therapeutic diet with no indication of any swallowing disorder or impairment.</p> <p>Review of resident R 67's care plan initiated January 31, 2022, and revised on August 13 2024, revealed that this resident has a nutritional problem or potential nutritional problems related to a diagnosis of anemia (low levels of red blood cells), history of nasal cancer, bipolar (disorder that cause intense shifts in moods), depression, hypertension(high blood pressure), GERD (gastroesophageal reflux disease-stomach acid rising into the esophagus, also called heartburn), obesity, and history of significant weight changes. The goals listed include: maintain adequate nutritional status as evidenced by no significant weight changes, have no signs or symptoms of malnutrition, have no signs or symptoms of dehydration and or fluid overload and maintain skin integrity. Interventions include monitor, document, and report any signs of symptoms of dysphasia, pocketing, choking, coughing, drooling, and holding. Obtain and monitor lab diagnostic work and weight is ordered revised on April 1st, 2024</p> <p>Review of resident 67's Nutrition assessment dated [DATE], revealed the resident did trigger for significant weight loss times six months. The resident was assessed as consuming 1800-2160 calories daily. The summary of findings revealed the resident was eating 50 to a 100 percent of his meals. The resident also was ordered a house shake twice a day with good acceptance. Weight is stable since initial weight loss.</p> <p>Review of Resident r67's weight history revealed documented weights on August 9, 2024, of 205.0 lbs. and September 11, 2024, of 163.4 lbs. and a confirmed weight on September 26, 2024, of 163.2 lbs. representing a weight loss of 20.29% (41.6lbs.).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R67's clinical record, and physician orders dated September 25, 2024, revealed an order for weekly weights for the time span of four weeks. Review of the Resident R67's clinical record revealed no documented evidence that weights were obtained four weeks as ordered by the physician.</p> <p>Continued Review of resident r67's clinical record physician orders dated January 13, 2025, revealed resident is ordered a four-ounce house shake three times a day for weight maintenance.</p> <p>Interview with dietitian employee E5 on February 4, 2025, at 10:47 a.m. revealed that it is his professional practice when assessing residents for weight loss to notify their disciplinary team of any significant weight loss and to include interventions such as speech therapy, speak to resident's physician, review any therapeutic diet, observe meals and interview residents. Employee E5 confirmed that he was aware of resident's weight loss and acknowledged the resident's weight has been trending downward this month. When alerted to resident's initial significant weight loss in September, 2024, he believed it to be caused by the scale malfunction. Employee E5 confirmed not testing the scale or practicing the above protocols for resident's weight loss.</p> <p>Interview with Employee E20, medical doctor on February 4, 2025, at 11:38 a.m. confirmed that Resident R67 was his patient and had significant weight loss in one month and this employee was made aware of it at that time. Employee E20 confirmed he saw resident October 21, 2024, and his documentation did not address the weight loss and did not provide any new orders relating to the weight loss. Employee E20 acknowledged that more interventions are warranted.</p> <p>28 Pa. Code 211.5 (f) Clinical records</p> <p>28 Pa. Code 211.12 (c)(5) Nursing services</p>

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<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> 36609</p> <p>Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for three of 35 residents reviewed (R31, R88, R163).</p> <p>Findings include:</p> <p>Review of the Facility Policy and Guidelines for Implementation of Oxygen Administration, dated June 2016, indicated that the nurse should review and follow the physician's orders while administering Oxygen via nasal canula.</p> <p>Review of Resident R163's clinical record revealed; the resident was initially admitted to the facility on [DATE]; diagnosed with Acute Respiratory Failure with Hypoxia (a condition where the lungs are unable to adequately exchange oxygen, leading to low blood oxygen levels {hypoxia}, which can occur suddenly (acute) or develop over time (chronic, causing significant breathing difficulties and potential complications depending on the severity and duration of the issue; essentially, it means the body isn't getting enough oxygen due to impaired lung function, either rapidly or gradually); Malignant Neoplasm of Upper Lobe, Left Bronchus of Lung (a cancerous tumor located in the upper lobe of the left lung).</p> <p>Review of clinical record indicated that Resident R163 was ordered of April 15, 2024, oxygen at 2 Liters/Min (minute0, via Nasal Cannula, continuously, every shift for supplementary Oxygen.</p> <p>Observation conducted on January 28, 2025, at 10:33 a.m., revealed that R163 was administered oxygen at 4 liters/Min, via nasal canula., and not 2 liters/min, as ordered by the physician; and the same was confirmed with a Director of Nursing, Employee E2 at the time of the finding.</p> <p>A review of the clinical record of Resident R88 revealed an admitted [DATE], with a diagnosis of dependence on supplemental oxygen.</p> <p>Review of clinical record indicated that Resident R88 was ordered on January 2, 2023, oxygen at 2 liters/min, via Nasal Cannula, continuously, every shift for supplementary oxygen.</p> <p>On January 28, 2025 at 11:28 a.m. observation of Resident R88's oxygen level was confirmed to be at 3 liter by the License nurse, Employee E10.</p> <p>Review of Resident R31's clinical record revealed a diagnosis of chronic obstructive pulmonary disease (lung disease) with physician orders for 3 liters of continuous supplemental oxygen.</p> <p>On January 28,2025 at 2:30 p.m. Resident R31 was observed using the oxygen on the incorrect setting of 4 liters and the concentrator was covered in dust. Immediately after, the Unit Manager Employee E14 confirmed the order was for 3 liters and the concentrator was not clean.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>(continued on next page)</p>		

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<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p>43923</p> <p>Based on a review of facility's job descriptions and personnel files, as well as staff interviews, it was determined that the facility failed to check the annotation list which becomes available on quarterly bases to verify the nurse aide certification to be valid to allow individuals to work as a nurse aide for one of three nurse aides reviewed (Employee E8).</p> <p>Findings include:</p> <p>The facility policy titled Employment Screenings for Potential Hires: Pennsylvania dated, April 2, 2022, revealed Prior to an offer of employment, the hiring manager should ensure all candidates for employment are properly interviewed and the following screens are completed: a. Attempt for two former employee references: i Ideally verification should include: 1. Dates of employment 2. Position held 3. Salary or hourly wage rate; i. When there is no prior employment, references can be obtained from schools, churches, or personal associations. a. Verification of license or certification if applicable The facility's job description for Nurse Aide, undated, revealed that a nurse aide certification was necessary to perform functions of the position.</p> <p>Review of information submitted to the State Survey Office on October 24, 2024 , stated the facility became aware during a routine license audit that a Nursing assistant (NA), Employee E8 had her Nurse Aide certificate revoked on 7/15/2024 due to substantiated finding on file with the Pennsylvania Nurses Aide registry from a different facility.The employee was immediately suspended pending termination. The facility reviewed the employee file and noted that Employee E8 was hired on 12/14/2021 with a valid NA certification. The facility last verified her certificate on 7/13/2023 when the certificate was reviewed. The NA registration on file was current with an expiration date of 7/7/2025. The facility interviewed the Human Services (HR) Director, Employee E9 who reported that the facility was never made aware that Employee E8's NA license was revoked. The Employee E8 last shift worked was on 10/24/2024 from 7am-1:33p.m. Employee E8 was terminated on 10/24/2024.</p> <p>A personnel file for Nursing Aide, Employee E8 revealed that she/he was hired on 12/14/2021 with a valid NA certificate dated effective from 7/7/2017 - 7/7/2023, then NA certificate was renewed until 7/7/2025. On 10/24/2024 a screening was conducted for Employee E8 which revealed that the NA certification was revoked on 7/15/2024.</p> <p>Facility conducted an interview dated 10/24/2024 with the Human Service Director, employee E9 who revealed I was in the process of auditing staff licenses and discovered that Employee E8 license was revoked. I called Employee E8 to my office and she stated that she was aware that her license was revoked. She stated she renewed it in 2023. I asked her to log into credentials to download her current license. The website also showed that her license was revoked. Employee was send home suspended pending the outcome of the investigate.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  York Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7101 Old York Road Philadelphia, PA 19126	
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<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Nursing Home Administrator, Employee E1 on 01/30/2025, at 12:13 p.m. confirmed that Nurse Aide's certification for Employee E8 was revoked on 07/15/2024. Facility was conducting an audit and ran her certification license and discovered it was revoked. Employee E8 was suspended, and facility called the Department of Health field office to become aware why facility was not notified. Department of Health (DOH) notified the facility that every quarter there is a annotation list that comes out which would show if there is any certified aids' licenses were revoked due to a substantiated cases. Employee E1 was not aware of the annotation list to be available. Employee E1 obtained the annotation for 07/01/2024 and Employee E8 was not listed on the list. Then, 10/01/2024 annotation list was obtained and Employee E8 was listed as her license was revoked.</p> <p>On January 30, 2024, at 12:57 p.m. an interview was held with the HR director, Employee E9 who reported that she was doing an audit and discovered that Employee E8 had a revoked license. She interviewed the Employee E8 who did not disclose the revoke license and was asked to log into her credentials and the result revealed as a revoked license. Employee E8 was suspended and then terminated. Facility was not aware of the annotation list which would show a list of staff whose licenses have been revoked. Immediately, facility implemented a protocol to check the annotation list for their current staff and for any agency staff who are coming in to provide care for their residents.</p> <p>28 Pa. Code 201.29 (b) Personnel Policies and Procedures.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48347</p> <p>Based on review of facility policy, review of resident clinical records, interview with staff, it was determined that the facility failed to develop a comprehensive person-centered care plan relating to post traumatic stress disorder (PTSD) for two of two residents reviewed with this diagnosis of PTSD. (resident R 139, and R157)</p> <p>Findings include:</p> <p>Review of facility policy titled Trauma informed care dated October 24th, 2022, revealed that the facility ensures that residents who are trauma survivors receive culturally competent, trauma informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause traumatization of the resident. This includes training and assisting staff to create an environment where the resident feels safe. The facility will assess each resident to ensure they receive the appropriate treatment and services. The facility will ensure employees have education training or in service in caring for residents identified with mental and psychological disorders as well as residents with a history of Trauma and or post-traumatic stress this water. Appropriate staff will also be educated in implementing nonpharmacological interventions when appropriate. Trauma training will be part of our orientation program for all new employees and will be provided on an ongoing basis .Trauma specific interventions for a resident will be placed in our individualized person-centered care plan upon a mission and assessment. Care plans and interventions will be reviewed quarterly and more often is necessary, based on any change in residents physical and psychosocial well-being. As we evaluate our interventions, we will be sensitive to the need for professional referral to psychological mental health services and personnel as well as ways to communicate our plans with staff in order to enlist their support. The Social service department initially will identify any trauma and or PTSD by supplied questionnaire and gather trigger information through Medical records/ assessments, family members.</p> <p>Review of Resident R139's Quarterly Minimum Data Set(MDS) dated [DATE] revealed that Resident</p> <p>R139 was admitted in to facility October 12, 2022 with diagnosis including Bipolar (Bipolar disorder is a mental health condition that causes extreme mood swings between depression and mania or hypomania. Learn about the types, symptoms,) and PTSD (Post traumatic stress disorder is a mental health condition caused by a traumatic event that affects your ability to function normally.</p> <p>Review of resident R 139's clinical record psychology note dated December 7, 2023, revealed that resident R139 has a history of PTSD and bipolar disorders. The psychological notes indicated the resident suffered trauma as a child.</p> <p>Review of Resident 139's care plan noted PTSD associated with other concerns, however, did not develop any identification, plan of care, or goals for this disorder. Resident R139's care plan consists of identification of diagnosis and or health concerns including this resident has a history of shower refusal related to history of PTSD, with interventions including education of noncompliance, encourage participation, explain care activities, and paired care.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of resident R139's care plan revealed the focus of anti-anxiety medications usage related to PTSD with the goal of resident will be free from discover or adverse reactions related to anti-anxiety therapy. Interventions of this focus and goal include administer medications and monitor document report any adverse reactions</p> <p>The final notation of the diagnosis of PTSD in resident R 139's care plan can be detected under the focus of nutritional problem related to the diagnosis of diabetes two, anemia and PTSD, history of homelessness, morbid obesity, consumption of medication that may cause weight loss.</p> <p>The care plan reviewed contained the diagnosis of post traumatic stress disorder but lacks any goals, implementations, or outcomes directly relating to the diagnosis of PTSD.</p> <p>Review of Resident R157 quarterly minimum date set (MDS- a federal mandated assessment for all residents) dated November 4, 2024 revealed resident R157 was admitted into the facility on [DATE] diagnosis including schizophrenia (a mental disorder characterized by disruptions in thought process, perceptions, emotional responsiveness, and social interactions) , depression, and PTSD.</p> <p>Review of Resident R157's comprehensive care plan revealed no documented evidence that Resident R157's diagnosis of PTSD care planned and developed related to the treatment and services for PTSD.</p> <p>Interview with Employee E2 Director of Nursing on February 4, 2025 at 12:40 p.m .acknowledged that care plans are incomplete with goals, implementation, and evaluation for the specific diagnosis and care needs of post traumatic stress disorder.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>38735</p> <p>Based on observations, resident and staff interviews, and a review of facility documentation, it was determined that the facility failed to provide food and drink that was palatable and served at palatable temperatures for five of ten residents reviewed (Residents R112, R121, R60, R56 and R32).</p> <p>Findings include:</p> <p>Interview with Resident R112 on January 28, 2024, at 10:55 a.m. revealed that since the new people took over in the kitchen, they keep bringing me breakfast items with pork, like bacon. I cannot eat pork, they know I cannot have pork it makes me sick, why do they do this? I do not eat a lot of the food it just is not good, especially at night, and the nurse has to go down to the kitchen for two sandwiches every night either grilled cheese or turkey, why can't they just send me two sandwiches on my tray so that she does not have to go all the way down there every night?</p> <p>Interview with Resident R121 on January 28, 2024, at 11:00 a.m. revealed that food does not look right, I can't eat the platters, so I have to ask for sandwiches, I get 2 grilled cheese sandwiches for supper, the meals are always late.</p> <p>Interview with Resident R60 on January 28, 2024, at 11:03 a.m. revealed staff did not offer me breakfast the past few days, the food here sucks, it's really bad.</p> <p>Interview with Resident R56 on January 28, 2024, at 11:05 a.m. revealed that the food here is terrible, it is all mashed together, I haven't had a salad since these people took over, the trays are dripping wet-they used to have a place mats, now you get one napkin and it is wet, disgusting, they do not have hot dogs any more, they serve mashed potatoes all the time, no baked potato or any other kind, I send the food back all the time and end up ordering out a hoagie or Chinese food.</p> <p>Interview with Resident R32 on January 28, 2024, at 11:07 a.m. revealed that her ticket says cold cereal (her preference) and that last two days she has been given hot cereal (grits/cream of wheat) and that her food is not always warm.</p> <p>Observation on January 29, 2024, at 12:05 p.m in kitchen where starter is placing cold pellets out of the dish room right on the tray. Starter said the machine (pellet heater) was not working. The person serving the hot food was taking plates which were stacked well above the plate warmer and the plates were barely warm to the touch.</p> <p>On January 28, 2025, at 12:53 p.m. an interview was held with Resident R111 revealed that food is disgusting I can eat waffles, pancakes, toast are good, everything else is horrible. It's the taste, the look.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On January 29, 2025, at 10:30 a.m. a resident council meeting was held with 10 alert and oriented residents ( R130, R44, R17, R82, R146, R126, R86, R165, R136, R147) . It was reported that food remains an issue, with residents expressing that only one out of the three daily meals is satisfactory. Dinners are often served cold, while breakfast and lunch are frequently delayed. Additionally, meal delivery trucks from the kitchen arrive on schedule but remain on the unit for an extended period before nursing staff distribute the meals to residents.</p> <p>Observations during a test tray conducted on January 29, 2024, revealed that the tray cart left the kitchen at 12:17 p.m and the last tray was passed at 12:30 p.m. Temperatures were taken by the Food Service Director (FSD), Employee E4, revealed that the bread stuffing was only 125 degrees and the roast cauliflower was only 122 degrees, and the apple juice was 50 degrees and the diced pears were 50.5 degrees all outside the acceptable temperature range for palatability.</p> <p>An interview with the FSD, on January 29, 2024, at 12:35 p.m. confirmed that these food items were outside the acceptable temperature and therefore not palatable.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38735</p> <p>Based on observations and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>A tour of the Food Service Department was conducted on January 28, 2025, at 10:00 a.m. with Employee E3, Food Service Director (FSD), revealed the following concerns:</p> <p>Observation in the receiving dock revealed dozens of empty plastic 5 gallon chemical containers sitting outside the loading dock door.</p> <p>Observation in the walk-in freezer revealed a bag of frozen French fries with hole in bag, and a box of frozen peanut butter cookie dough open to the circulating air.</p> <p>Observation in the walk-in cooler revealed a yellow substance spilled on floor which had cracks in the steel plating with sharp rusty edges with food substances in the cracks. The broken flooring moved as weight was put on it causing a tripping hazard.</p> <p>Observation of the floor in the corner next to the prep sink revealed a thick black substance on the floor.</p> <p>Observation in the dry storage area revealed multiple boxes of napkins, cups and other disposable paperware on multiple shelves all stacked less than the required 18 from the ceiling or other fixtures.</p> <p>Observation of the convection oven revealed that the lower over has a heavy buildup of burned on food substances on doors, base and walls of the inside of the oven.</p> <p>Interview with the FSD on January 28, 2025, at 10:15 a.m. confirmed the above findings.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36609</p> <p>Based on review of clinical records , interview with staff and facility policy, it was determined that the facility failed to maintain complete and accurate records for one of 35 resident records reviewed (Resident R603).</p> <p>Findings include:</p> <p>Review of facility policy titled, Charting and Documentation, dated April 1, 2022 states, Observations, medications administered, services performed, etc., will be documented in the resident's clinical records.</p> <p>Resident R603 was admitted to the facility on [DATE] diagnosed with unspecified dementia with unspecified severity with agitation. Review of Resident R603 nursing progress note dated, January 20, 2025 indicated 500 milligrams (mg) of acetaminophen was given to Resident R603 when the resident complained of pain.</p> <p>Interview with Licensed Practical Nurse (LPN) Employee E17 confirmed the acetaminophen was given at approximately 2:00 p.m. with a positive effect and was sleeping at 3:30 p. m. before the nurse ended her shift.</p> <p>Further review of Resident R603 electronic administration record revealed the LPN failed to document the resident's acetaminophen was given for pain.</p> <p>Continue review of Resident R603's nursing progress note dated January 20, 2025 revealed Registered Nurse Employee E15 documented pain medication was given to Resident R603 with positive relief.</p> <p>Interview with Employee E15 on January 30, 2025 at 4:30 p.m. confirmed the nurse gave the pain medication.</p> <p>Further review of Resident R603 electronic administration record revealed Employee E15 failed to document that the resident's acetaminophen was given for pain.</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>

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<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** 48347</b></p> <p>Based on review of facility policy and procedures, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices related to the use of appropriate protective equipment for wound care of two of two residents observed. (resident R4 and R 171).</p> <p>Findings:</p> <p>Review of facility policy titled Isolation Steps; Categories of Transmission-Based Precautions revised September 26th, 2022, revealed standard precautions shall always be used when caring for residents regardless of suspected or confirmed infection status. Transmission based precaution shall be used when caring for residents who are documented or suspected to have communicable disease or infections that can be treated submitted to others. Enhanced barrier precautions expand the use of personal protective equipment (ppe) beyond situations in which exposure to blood and bodily fluids is anticipated and refers to the use of gowns and gloves during high contact resident care activities that provide opportunity for transfer of multi-drug-resistant organisms MDRO to staff hands and clothing. All residents with any of the following conditions should use enhanced barrier precautions: infection or colonization with a novel or targeted MDRO, open wounds, indwelling medical devices (central line, urinary catheter, feeding tube, and tracheostomy). For any of the above personal protective equipment (PPE) must include wear a gown and gloves for all in our actions that may involve contact with the resident or resident's environment for high contact activities such as dressing, bathing, transferring, providing hygiene, changing linens, therapy, changing briefs or assisting with toileting, to voice care, and wound care.</p> <p>Review of Residents R4's Minimum Data Set (MDS- federal mandated assessment for residents) admission assessment dated [DATE], revealed that the resident entered the facility November 27, 2024, with diagnosis including anemia (low levels of red blood cells), stroke (poor blood flow to the brain causing cell death), and hemiplegia (paralysis that effects on side of the body). Further review of the admission assessment revealed that Resident R4 has an open lesion listed under skin conditions.</p> <p>Observation on the first-floor nursing unit on January 28, 2025, at 9:48 a.m. of Licensed nurse, Employee E19, wound nurse, providing wound care to Resident R4. Employee E19 was observed as wearing (personal protective equipment (PPE) consisting only of gloves. Employee E19 was not wearing required enhanced barrier precaution of a gown.</p> <p>Review of Residents R171's quarterly Minimum Data Set (MDS)dated November 20, 2024, revealed that this resident entered the facility June 9, 2024, with a diagnosis of paraplegia (paralysis in both legs). This resident has been assessed of having an unhealed pressure ulcer stage 3.</p> <p>Review of resident 171 wound notes dated January 31, 2025, revealed Resident R171 was being treated for wound care of right lower extremity pressure ulcer and left ankle trauma wound.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Licensed nurse, Employee E19, wound nurse, and Licensed nurse Employee E 14 on January 28, 2025, at 10:30 a.m. providing wound care to Resident R171. Both licensed nurses Employee E 19 and Employee E 14 were observed only wearing gloves, neither employee wearing required enhanced barrier precaution PPE gowns.</p> <p>Interview with Employee E19 on January 28, 2025, at 10:48 a.m. verified that both residents R4 and R 171 were residents that require use of gowns and gloves.</p> <p>Interview with Employee E14 on January 28, 2025, and 11:00a.m. indicated that resident R171 was not on enhanced barrier precaution, the two wounds that were treated did not qualify as requiring PPE, that directly contradicted the facility policy .</p> <p>28 Pa. Code 211.12 (d)(1)(5) Nursing services</p> <p>28. Pa. Code 201.14(a) Responsibility licensee</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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> 43923</p> <p>Based on observations of the physical environment, interviews with staff and reviews of the pest control operators reports, it was determined that the facility was not maintaining an effective pest control program.</p> <p>Findings include:</p> <p>Based on observations of the physical environment interviews with staff and reviews of the pest control operators reports, it was determined that the facility was not maintaining an effective pest control program.</p> <p>A review of the facility policy titled Pest Control dated, April 1, 2022, revealed Bedrock Care shall maintain an effective pest control program.</p> <p>On January 28, 2025, at 10:49 a.m. observation of 2 flies were seen on the 1st floor South nursing unit.</p> <p>On January 28, 2025, at 11:32 a.m. interview with Resident R4 revealed an observation of a fly in the room. Resident R4 reported that flies are often present.</p> <p>On January 28, 2025, at 12:14 p.m., an observation of the lunch meal service on the second floor near room [ROOM NUMBER] revealed the presence of flies around the tray cart and on a wheelchair in the hallway outside the room.</p> <p>On January 29, 2025, at 10:30 a.m. on the first floor of activity room during the resident council meeting flies were observed flying in the room.</p> <p>A review of the pest control logbook on the 1st South Nursing unit revealed on :</p> <ul style="list-style-type: none"> <li>-January 7, 2025 - one mouse room [ROOM NUMBER]</li> <li>-January 15, 2025 - Nets location S Services</li> <li>-January 22, 2025- Mice in room [ROOM NUMBER]</li> </ul> <p>A review of the pest control invoices on January 30, 2025, indicated inspected and treated kitchen and baseboards throughout. Recommended better sanitation practices in kitchen. Observed heavy drain/fruit fly activity behind cooking area and water leaks throughout cooking area. Recommended leaks to be fixed.</p> <p>On January 31, 2025, an interview with the Administrative, Employee E1 confirmed that flies and nets are an issue in the facility. Facility has increased their pest control treatment from ones a week to two times a week.</p> <p>28 Pa. Code 201.18(a)(b)(1) Management</p> <p>(continued on next page)</p>		

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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 0925  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of licensee