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	12/19/2025

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 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. **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 (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

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	12/19/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 Supervisor, Employee E28, revealed on 12/15/2025 around 9:30 p.m. he/she was informed by the care nurse (identified as nurse aide, Employee E25) that Resident R223 was missing. Registered Nurse Supervisor, Employee E28, announced a code yellow and performed an in-house and outside perimeter search for the resident. Resident R223 was still unable to be located, and administration was made aware.Review of witness statement dated 12/16/2025 by Regional Registered Nurse, Employee E18, revealed per interview with the dispatcher, on 12/15/2025 an owner of a home in a nearby neighborhood (located approximately 1.5 miles away from the facility) called 911 (Emergency Medical Services) at 9:36 p.m. because Resident R223 was knocking on their door. The police called (EMS) at 9:42 p.m. to request assistance and EMS was dispatched at 9:43 p.m.Review of Resident R223's hospital records revealed the resident was admitted to the emergency department (ED) on December 15, 2025, at 10:13 p.m. for altered mental status. Resident R223 was found to be walking around knocking on doors in the cold. When Resident R223 was brought to the ED, he/she was found to be confused and had Hypothermia (a medical condition that occurs when the body temperature drops below 95 degrees Fahrenheit, leading to potentially life-threatening consequences) for which he/she was put on Bair Hugger (warming unit). The average temperature on December 15, 2025, ranged from 19 degrees Fahrenheit to 28 degrees Fahrenheit.Further interview with the Nursing Home Administrator, Employee E1, on December 17, 2025, at 9:00 a.m. revealed she was notified by the police on 12/16/2025 around 7:00 a.m. that Resident R223 was located at a near-by hospital. The Nursing Home Administrator, Employee E1, promptly went to the hospital on [DATE] to positively identify Resident R223. Per the Nursing Home Administrator, Employee E1, when the police arrived at the scene on 12/15/2025 Resident R223 was not able to identify him/herself, so he/she was taken to the hospital as an unknown patient. Nursing Home Administrator, Employee E1, stated that the hospital obtained fingerprints and that is how they identified Resident R223 and informed the facility of his/her whereabouts.Nursing Home Administrator, Employee E1, reportedly reviewed security camera footage for the front door and back door cameras with no success in identifying when/how Resident R223 left the building.Subsequently, surveyors requested review of security camera footage to determine how and what time Resident R223 left the building.Review of security camera footage was conducted on December 17, 2025, at 10:15 a.m. with the Nursing Home Administrator, Employee E1, and Assistant Nursing Home Administrator, Employee E2. Per security camera footage, on 12/15/2025 at 5:37 p.m. an individual wearing a dark colored crewneck sweatshirt, dark colored sweatpants, and dark colored house slippers was seen exiting the building via the ground floor, out the back rear door (loading dock). The individual was observed to effortlessly push open the back door without resistance.The (continued on next page)

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	12/19/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	individual was subsequently identified as Resident R223 by the Nursing Home Administrator, Employee E1, and Assistant Nursing Home Administrator, Employee E2. Interview on December 17, 2025, at 11:30 a.m. with Regional Registered Nurse, Employee E18, and Regional of Operations, Employee E14, revealed the elevators or stair wells do not have a wander guard sensor. Therefore, no alarms were triggered when Resident R223 left the 2nd floor nursing unit.Further interview and observation on December 17, 2025, at 11:30 a.m. with Regional Registered Nurse, Employee E18, and Regional of Operations, Employee E14, revealed the back doors in which Resident R223 exited the building can only unlocked/opened via a code on the key pad located next to the door or via a button used by the receptionist at the front desk.Observations and interview with Regional Registered Nurse, Employee E18, on 12/19/2025 revealed there are four wander guard sensors and alarms, and are only located on the ground floor. When a wander guard alarm is triggered, it sounds an alarm and also sends a notification to the front desk. The wander guard alarm can be turned off via a button at the front desk or by entering a code into the keypad of the alarm triggered.Interview on December 17, 2025, at 1:22 p.m. with Unit Manager, Employee E17, revealed this employee last saw Resident R223 on 12/15/2025 walking around the nurses station at approximately dinner time.Review of facility documentation Food Truck Delivery Log dated 12/15/2025 revealed dinner trays were delivered to the 2nd floor nursing unit between 4:45 p.m. and 5:00 p.m.Continued interview on December 17, 2025, at 1:22 p.m. with Unit Manager, Employee E17, revealed this employee applied a wander guard to Resident R223's left ankle on December 12, 2025. The Unit Manager, Employee E17, reported to have checked the functionality of the wander guard at the front door entrance before applying it to Resident R223's ankle. Front desk receptionist, Employee E15, was informed Resident R223 was an elopement risk, and his/her picture was put in the elopement risk binder at the front desk. Further interview with Unit Manager, Employee E17, revealed Resident R223 would often independently, ambulate the hallways and try to get on the elevator. Unit manager, Employee E17, was unaware that the elevators or stairwells did not have wander guard sensors/alarms. Unit manager, Employee E17, reported Resident R223 did not have an order for frequent checks. Interview on December 17, 2025, at 4:08 p.m. with Licensed Nurse, Employee E24, (identified as Resident R223's 3:00 p.m. to 11:00 p.m. assigned nurse) revealed Resident R223 was known to wander the unit and try to go up to doors. Licensed nurse, Employee E24, reported seeing the resident at the start of his/her shift and confirmed the placement of Resident R223's wander guard. When questioned, Licensed Nurse, Employee E24, reported not knowing how to check the functionality of the wander guard.Licensed Nurse, Employee E24, revealed he/she could not remember the last time Resident R223 was seen on the unit after the start of his/her shift. Licensed Nurse, Employee E24, was informed by nurse aide [identified as Employee E25] that the resident refused dinner.Interview on December 17, 2025, at 4:15 p.m. with Nurse Aide, Employee E25, revealed, he/she saw Resident R223 walking around on 2-South nursing unit around 3:30 p.m. Nurse Aide, Employee E25, reported Resident R223 refused to eat dinner. Nurse aide, Employee E25, reportedly found Resident R223's meal tray untouched in the dining room and assumed the resident was wandering back on 2-South.Continued interview on December 17, 2025, at 4:15 p.m. with Nurse Aide, Employee E25, revealed after returning from his/her 30-minute break and tending to other residents for bathing/bedtime, Resident R223 could not be located. After searching the 2nd, 1st, and ground floors the nurse aide, Employee E25, informed the nursing supervisor Resident R223 was missing. Nurse aide, Employee E25, could not recall specific times.Interview on December 18, 2025, at 10:05 a.m. with the Director of Nursing, Employee E2, and Regional Registered Nurse, Employee E18, revealed often the front desk receptionist will see staff members on the security cameras at the back door and assist by unlocking the back door by buzzing them out. Front desk receptionist (2nd shift, 3:00 to 11:00 p.m.), Employee E19, reportedly could not remember if he/she buzzed anyone out the back door on 12/15/2025 around 5:30 p.m.Continued interview on December 18, 2025, at 10:05 a.m. with the Director of Nursing, Employee E2, and Regional Registered Nurse, Employee E18, reportedly that there was nothing noted to be wrong with the door that would (continued on next page)

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	12/19/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	have prevented it from being locked/latched.Review of witness statement by Human Resources (HR) Director, Employee E23, dated December 17, 2025, revealed on December 15, 2025, around 5:30 p.m. Resident R223 was seen walking past his/her office (located on the ground floor) headed toward the front desk. A few seconds later HR Director, Employee E23, saw the same resident walk past HR again but this time Resident R223 was headed toward the elevator. HR, Employee E23, reportedly didn't think anything of it because it was right before smoke break and no alarms were triggered.Review of witness statement by Director of Housekeeping, Employee E22, dated December 19, 2025, revealed on December 15, 2025, Employee E22 was sitting in the office of Human Resources Director, Employee E23. Resident R223 was seen walking by the office two times around 5:30 p.m. Director of Housekeeping, Employee E22, stated I just observed him/her coming by no conversation was held.Based on a review of facility documentation, observations, and staff interviews, it was determined that Resident R223 eloped from the facility at 5:37 p.m. on 12/15/2025. A code yellow - elopement protocol, was not implemented until 9:30 p.m. (four hours after the resident exited the building) Resident R223 was located by local law enforcements 1.5 miles away from the facility in sub-freezing temperatures and brought to the local hospital at approximately 10:15 p.m. where he/she was treated for hypothermia. Resident R223 had no identification and was unable to identify him/herself. Hospital staff needed to obtain fingerprints and subsequently notified the facility on 12/16/2025 at approximately 7:00 a.m. of Resident R223's whereabouts.An Immediate Jeopardy situation was identified to the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, on December 17, 2025, at 12:58 p.m. for the facility's failure to adequately supervise a resident with a diagnosis of Dementia and history of exit seeking behaviors. This failure resulted in Resident R223 exiting and eloping from the facility, traveling approximately 1.5 miles away in a busy [NAME] area.An Immediate Jeopardy template (document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, on December 17, 2025, at 1:05 p.m.The facility submitted a written plan of action on December 17, 2025, at approximately 4:28 p.m. and implemented the plan of action which included: On 12/15/2025 at 9:30 p.m. [Resident R223] was noted to be missing. On 12/25/2025, a Code Yellow-Responding to Elopement was called at around 9:30 p.m. by the nursing supervisor. On 12/15/2025, elopement protocol initiated and whole building and outside perimeter was searched. On 12/15/2025 all other residents were verified as being present through a whole house bed check, and the police/911 and physician were called between 9:30 p.m. and 9:50 p.m. There was no response from police or 911. Director of Nursing (DON) and Nursing Home Administrator (NHA) were notified at on 12/15/2025 at 10:24 p.m. that Resident R223 was missing. Ground level door audits and wander guard system audit was completed on 12/15/2025 by NHA to ensure proper function. On 12/16/2025 the police/911 was called again with response to the facility around 3:36 a.m. Police notified NHA on 12/16/2025 around 7:00 a.m. that Resident R223 was located at the local hospital. Subsequently, NHA and nurse aide verified Resident R223's identity at the local hospital. On 12/16/2025 it was determined that Resident R223 was picked up by Emergency Medical Services (EMS) about 1.2 miles from the facility and taken to the local hospital at approximately 10:13 p.m. on 12/15/2025. On 12/16/2025 and ad hoc QAPI (Quality Assurance and Performance Improvement) meeting was held with department heads. Whole house wander guard audit was completed to verify placement and function for resident's to have been assessed as needing one on 12/16/2025. Whole house elopement assessments completed on 12/16/2025 with no new residents identified as being at risk for elopement. Elopement binder reviewed and audited to ensure book is up to date and current with completion of new assessments on 12/16/2025. Every 1-hour loading dock door checks initiated on 12/16/2025 and are ongoing. Facility contacted wander guard service provider on 12/16/2025 to obtain quotes to add wander guard sensors to elevators, stairwells, and service hallways. On 12/17/2025 it was determined that the resident exited out of the loading dock doors. Frequency of loading dock door check increased to every 30-minutes. On (continued on next page)

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	12/19/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12/16/2025, education on Code Yellow-Responding to Elopement initiated at 12:35 a.m. with in-house nursing staff. Elopement policy reviewed on 12/17/2025. On 12/17/2025 education initiated with all facility staff on signs and symptoms of elopement and supervision of residents with dementia and history of exit seeking behaviors, how to identify residents and where wander guard sensors are located within the facility. This will be added to new hire orientation. 85% of facility staff will be educated by 12/18/2025. Facility is completing loading dock and font entrance door audits every 30 minutes daily for 30 days. Facility will review findings of audits during QAPI meeting. Resident R223 at hospital and will be re-assessed upon re-admission.Review of facility documentation confirmed all other residents were accounted for on 12/15/2025.Review of facility documentation confirmed loading dock and front door entrance audits were completed.Review of facility documentation confirmed audits were completed for residents with wander guards to ensure placement and functionality. Further, audits were completed to ensure all residents had accurate/up to date elopement assessments. No new residents were identified.Elopement binder maintained at the front desk was reviewed and confirmed to be accurate/up to date with residents at risk for elopement.Interviews were conducted with 26 staff members from all departments on December 18, 2025. Interviews confirmed staff were educated on signs and symptoms of elopement and supervision of residents with dementia and history of exit seeking behaviors, how to identify residents and where wander guard sensors are located within the facility. Further staff confirmed they were educated on a code yellow responding to an elopement.The Immediate Jeopardy was lifted on December 18, 2025, at 3:40 p.m.28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.10 (d) Resident care policies

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	12/19/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, observations, and staff interviews it was determined that the facility failed to provide a safe, clean, comfortable and homelike environment on two of two nursing units (2-North and 1-North) Findings include: Review of facility policy titled Resident Rights-Safe Clean Comfortable Homelike Environment dated April 1, 2022, revealed that the facility policy affirms residents' rights to a safe, clean, comfortable, and homelike environment. It specifically requires the facility to maintain comfortable and safe temperature levels as part of ensuring resident comfort and well-being. Maintaining appropriate room temperatures is a core responsibility of the facility's housekeeping and maintenance services and is essential to providing care and services safely while respecting resident rights. Failure to maintain comfortable temperatures would be inconsistent with the facility's obligation to provide a homelike environment as outlined in this policy and required under CMS standards. Observation during the initial tour of the facility on December 15, 2025, at 09:55 a.m. revealed, multiple resident rooms on the second-floor nursing unit were observed to feel cold and uncomfortable. Resident R125 was observed in the hallway wrapped in blankets. Continued observation with the Maintenance Director employee E11 at 10:52 AM revealed the following room temperature readings: room [ROOM NUMBER]: 68.9 degrees Feirenheight room [ROOM NUMBER]: 68.9 degrees Feirenheight room [ROOM NUMBER]: 64.6 degrees Feirenheight room [ROOM NUMBER]: 64 degrees Feirenheight room [ROOM NUMBER]: 65 degrees Feirenheight room [ROOM NUMBER]: 65.5 degrees Feirenheight Recreation Room: 66 degrees Feirenheight These temperatures were below the expected comfort range for resident living areas and were inconsistent with maintaining a comfortable, homelike environment. Interviews with the Maintenance Director Employee E11at the time of observation revealed that it was his first day of employment at the facility. He stated he was previously unaware of the temperature issues and believed the problem was related to malfunctioning P-Tech heating units in individual rooms. He stated he would immediately contact the HVAC company to address the issue. Interviews with residents on the nursing unit revealed no resident complaints related to room (continued on next page)

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	12/19/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature. Some residents stated they preferred cooler temperatures and described them as invigorating. However, despite the lack of resident complaints, temperatures remained below acceptable comfort standards. Interview with Maintenance director employee E 11 on December revealed the following corrective actions: Conducted an audit of all individual P-Tech heating units and the overall heating system, relocated residents from rooms with significantly low temperatures to ensure comfort, provided additional blankets to residents as needed, installed portable heating units in common areas, including activity rooms and dining rooms. Contracted an external HVAC company to assess and repair the heating system and malfunctioning P-Tech units and implemented daily temperature audits for resident rooms and common areas. Observation On December 16, 2025, at 09:10 a.m., of the first- and second-floor nursing units revealed that temperatures were within acceptable standards in all resident rooms, with the exception of two rooms. Residents from those rooms had already been relocated for comfort. Documentation of daily temperature audits was provided by the Maintenance Director, along with confirmation that the HVAC company evaluated the system and initiated necessary repairs. All residents interviewed during follow-up stated they felt the facility living spaces were comfortable and had no concerns regarding temperature. Observations on December 15, 2025, at 11:40 a.m. in the 2-North lounge revealed a large, white commercial refrigerator toward the back left side of the room. Up to 8 residents were observed sitting in the lounge, waiting for lunch to be delivered. Surveyor proceeded to open the refrigerator and observed an old, rotting supplement (intended to be refrigerated) shake. The box was rotting and discolored. A foul odor proceeded to take over the room. Interview on December 15, 2025, at 11:45 a.m. with Unit Manager, Employee E17, revealed the refrigerator in the 2-north lounge has been broken and was supposed to be removed from the room. Unit Manager, Employee E17, confirmed the rotting supplement left in the fridge and is not sure when it was from. Follow-up observations on December 15, 2025, at 12:45 p.m. in the 2-North lounge revealed the fridge was removed, however mouse droppings were left on the floor that was beneath the fridge. Up to 8 residents were observed sitting in the lounge having lunch. Unit Manager, Employee E17, confirmed mouse droppings in the 2-North lounge on December 15, 2025, at 12:45 p.m. Observations on December 15, 2025, at 11:50 a.m. revealed Resident R185's foot board (in room [ROOM NUMBER]-A) was missing on the bed. Resident R185 reported it fell off, and maintenance did not fix it correctly. Observations on December 16, 2025, at 12:20 p.m. in room [ROOM NUMBER] revealed the window was unable to be closed all the way, allowing a constant flow of cold air in from the outside. 28 Pa. Code 201.14 (a) Responsibility of licensee. (continued on next page)

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	12/19/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18 (b)(3) Management 28 Pa. Code 204.19 Plumbing, Heating, Ventilation, Air-condition, and Electrical

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	12/19/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility documentation, review of clinical records, and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated transfers and discharges for two of six months reviewed (July and August).Findings Include: Review of documentation provided by the Nursing Home Administrator on December 16, 2025, at 10:35 a.m. revealed the Office of the State Long Term Care Ombudsman was not made aware of facility-initiated transfers during the months of June and July. The Nursing Home Administrator was able to provide documentation for the month of September, October, and November. Interview on December 17, 2025, at 10:15 a.m. with the Social Worker, Employee E7, confirmed the ombudsman was not made aware of the discharges. Employee E7 stated that she started working at the facility at the end of July. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(2) Management

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	12/19/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observations, clinical record review, and interviews it was determined that the facility did not ensure the comprehensive care plan was implemented for three of thirty-six residents reviewed (Resident R87, R156, and R56). Findings Include: Review of the facility policy titled, Baseline Care Plan, Comprehensive Care Plan and Ongoing Care Plan Updates with a revision date on October 1, 2024 states, Policy Statement-the facility will follow a uniform process for initiating the baseline care plan upon admission, the Comprehensive care plan upon CAA completion, and ensuring care plans are updated to reflect the resident's status. Review of Resident R87's clinical record revealed the resident was admitted to the facility on [DATE] with the following diagnosis: Dementia (severe decline in mental abilities, like memory, thinking, and reasoning), Anxiety (natural feeling of worry, tension, or fear about future events, often with physical symptoms like a rapid heart rate or sweating, acting as a stress response to potential threats), and Bi-polar Disorder (a serious mental illness causing extreme shifts in mood, energy, and activity levels, from high manic (elated, irritable, energetic) episodes to low depressive (sad, hopeless) episodes, significantly impacting daily function, sleep, and thinking). Review of Resident R87's current care plan with a date of August 28, 2025, there is no focus, goal, or interventions for the diagnosis of Anxiety or B Bipolar Disorder. Review of Resident R156's clinical record revealed the resident was admitted to the facility on [DATE] with the following diagnosis: Alcohol Abuse in remission, Cocaine Abuse in remission, Sedative Hypnotic or Anxiolytic Dependence in remission. Review of Resident R156's current care plan with a date of November 14, 2025, there is no focus, goal, or interventions for the diagnosis of Alcohol Abuse in remission, Cocaine Abuse in remission, Sedative Hypnotic or Anxiolytic Dependence in remission despite documented evidence in the care plan of the resident abusing the current smoking policy. The current care plan dated November 14, 2025 states, Focus-The resident has a behavior problem hoarding personal medication from outside facility, vaping devices. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(e)(1) Management 28 Pa Code 211.12(d)(1)(3)(5) Nursing services Review of Facility policy titled Baseline Care plan, Comprehensive Care Plan, and Ongoing Care Plan Updates last revised October 1st 2024 revealed that the facility policy requires the development of a baseline care plan within 48 hours of admission and a comprehensive, person-centered care plan within 7 days of the comprehensive assessment. Care plans must identify all medical, nursing, mental, and psychosocial needs, including measurable goals and interventions to maintain the resident's highest practicable well-being. The policy mandates that care plans be developed by an interdisciplinary team in consultation with the resident and/or representative and must reflect all diagnoses, treatments, and risks identified in the resident's assessments, physician orders, and PASARR recommendations. Care plans must include clear instructions for staff to monitor, manage, and respond to conditions, including acute or potentially life-threatening medical issues, and be updated promptly when a resident's condition or physician orders change. Failure to include specific (continued on next page)

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	12/19/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses, such as pulmonary embolisms or tachycardia, and corresponding interventions, monitoring parameters, and notification instructions constitutes noncompliance with this policy. Review of Resident R56's Minimum Data Set (MDS), a federally mandated assessment tool, revealed a quarterly assessment dated [DATE], which indicated the resident was admitted to the facility on [DATE] with diagnoses including cardiac arrest, (defined as the sudden cessation of effective heart function resulting in loss of blood flow to vital organs); respiratory failure(inability of the lungs to adequately exchange oxygen and carbon dioxide); anoxic brain injury (brain damage caused by a complete lack of oxygen resulting in cognitive and functional impairment); and dysphasia (a communication disorder characterized by impaired ability to understand or express speech). The MDS further documented a Brief Interview for Mental Status (BIMS) score of seven (7), indicating severe cognitive impairment. Review of the resident's clinical record revealed hospital documentation indicating the resident was evaluated in the emergency department for tachycardia, defined as an abnormally elevated heart rate, with documented heart rates ranging from 140 to 150 beats per minute, and was diagnosed with multiple pulmonary embolisms, defined as blood clots that obstruct blood flow in one or more pulmonary arteries and can be life-threatening. Hospital records further indicated the resident was started on medications including metoprolol, a beta-blocker used to control heart rate and blood pressure; clonidine, an antihypertensive medication used to reduce blood pressure and heart rate; and Lovenox (enoxaparin), an anticoagulant medication used to prevent and treat blood clots, for management of these conditions. Review of the resident 56s care plan revealed no identified problem statements, goals, or interventions addressing the diagnoses of pulmonary embolisms or tachycardia, including no instructions for monitoring heart rate or blood pressure, identifying signs and symptoms of complications, medication-related precautions, or guidance regarding when and whom staff should notify of changes in condition. The care plan also failed to include interventions related to the resident's increased risk for cardiopulmonary compromise. The facility's failure to incorporate these significant diagnoses and treatments into the resident's care plan placed the resident at risk for delayed recognition and treatment of potentially life-threatening conditions. An interview with director of nursing employee E 2 On December 19, 2025, at approximately 9:15 a.m. confirmed that Resident R56's care plan has not been properly updated according to facility policy and standards

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	12/19/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility documents, review of facility records, review of facility policy and interview with staff, it was determined that the facility failed to ensure that controlled substances are accounted for in order to identify diversion and lost narcotics in a timely manner for one of thirty-six residents reviewed (Resident R89). Review of facility policy on Controlled Substance Log dated April 24, 2023Revised: November 2025 revealed that under section POLICY The facility shall comply with all laws, regulations, and other requirements related to receiving, handling, storage, disposal, and documentation of Schedule II and other controlled substances. Under section GUIDELINES: Storage and Maintenance of Controlled Drugs: 1. Two licensed nursing staff are required to immediately log the received medication into the Controlled Substances Book Index Page, assign an Inventory Page number, and log or place pharmacy label onto assigned Inventory Page. One licensed nursing staff will log the required information for each entry and sign the entry. The second licensed nursing staff will witness the documentation and sign the entry.4. On first line of Inventory Page, enter: Date drug received; Total quantity received by Center; Signature of both receiving licensed nursing staff6. If a discrepancy is found after the controlled drug has been accepted: Notify pharmacy. Give drug to DON or designee for disposition according to federal and state regulations. NOTE: A controlled drug cannot be returned to the pharmacy once it has been accepted by the Center. Review of facility reported incident revealed that on November 4, 2025, the facility received narcotics for ten residents. The RN Supervisor Employee E31 signed for the delivery. He then proceeded to dispense the narcotics to the appropriate unit, gave his report, and signed off of his shift. Upon, audit of the delivery, it was determined that Resident R89's Suboxone was signed for, but not in the appropriate cart. The nursing team initiated an investigation, and interview conducted with Employee E31, and he stated that he reported signing for Resident R89's medication but didn't see it, and that he may have inadvertently thrown it away with the pharmacy bags from that delivery, eventhough he signed for it. Interview with DON (Director of Nursing) Employee E2 conducted on December 18, 2025, at 1:26PM revealed that when pharmacy delivers the narcotics, the supervisor on duty signs off the narcotics as received. The supervisor then delivers the narcotics to the respective units. The nurse on duty in the respective units then documents the number of narcotics received. Further Employee E2 revealed that the nurses on the respective units are only accountable for the controlled substances they received from the supervisor. Further interview with the Employee E2 confirmed that there is no process in place that ensures that all controlled substances received by the supervisor from the pharmacy are accounted for before they are delivered to the unit and that there is no system in place to identify missing narcotics after the supervisor receives the narcotics from the pharmacy. 28 Pa. Code 211.5(d) Drug accountability

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	12/19/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews with staff, and a review of facility documentation, 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 (Main Kitchen and 1-South Pantry). Findings include: An initial tour of the Food Service Department was conducted on December 15, 2025, at 10:00 a.m. with Employee E14, Food Service Director (FSD), which revealed the following: Observation in the kitchen near the hand sink revealed paint peeling and wall uneven near baseboard. Observation of the wall behind the reach-in refrigerators revealed paint peeling and dirty walls. Observation in the kitchen production area revealed a double convection oven with a heavy build-up of dark brown and black burned on food spatters on the outside of the oven and on the interior surfaces of the lower oven. Observation of the steam table in the tray-line area revealed a heavy build-up of dark burned on food spillage on the hot wells and water pans. Observation in the dish room revealed a low temperature, chemical sanitizing dish machine. When the rinse water was tested there was no reading indicating that there was no chlorine present. Interview with the FSD on December 15, 2025, at 10:30 a.m. confirmed the above observations and could not say how long the machine was not pumping sanitizer. Interview with the Administrator on December 15, 2025, at 10:45 a.m. confirmed that the dish machine was not sanitizing the dishes and that the facility would switch to disposable paperware and plasticware until the machine was repaired. Observations in the kitchen during a follow-up visit on December 17, 2025, at 12:05 p.m. revealed the following: Observation in the kitchen prep area and near the doorway revealed 50-gallon trash can with the lids off with trash inside open to the air. Observation in the prep area near the can-opener revealed a heavy black build-up of sticky black substance on baseboard under the wall plug. Observation of the coffee urn in the kitchen area revealed corrosion and burned on black coffee-colored stains and buildup of black substance on the top of the coffee urn. Interview with the FSD on December 15, 2025, at 10:30 a.m. confirmed the above observations. Observations on December 15, 2025, at 10:50 a.m. revealed a kitchenette on 1-south equipped with an ice machine, refrigerator, sink, and cabinets. Interview with Licensed Nurse, Employee E29, revealed the refrigerator is used to store resident food items (whether it be leftover takeout or pre-made (continued on next page)

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	12/19/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sandwiches from the kitchen). Observations inside the refrigerator revealed multiple undated food items without labels/dates such as turkey sandwich in bag open to air, cake on Styrofoam plate wrapped in plastic wrap, roll in bag, and unknown food item in Ziplock bag. Further observations revealed an opened container of thickened, lemon water that had an expiration date of November 5, 2025, and three unlabeled Tupperware containers with leftover food. Observations were confirmed on December 15, 2025, at 10:50 a.m. by Licensed Nurse, Employee E29. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management

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	12/19/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations, and interviews with staff, it was determined that the facility failed to promptly notify a residents representative of a change in condition related to an elopement for one of 36 residents reviewed (Resident R223).Findings Include:Review of undated facility policy Resident Elopement Protocol revealed the unit manager/supervisor would be responsible to notify the resident representative of the elopement.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.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.Further interview with the Nursing Home Administrator, Employee E1, on December 17, 2025, at 9:00 a.m. revealed she was notified by the police on 12/16/2025 around 7:00 a.m. that Resident R223 was located at a near-by hospital. The Nursing Home Administrator, Employee E1, promptly went to the hospital on [DATE] to positively identify Resident R223. Further interview on December 17, 2025, with Nursing Home Administrator, Employee E1, revealed Resident R223's representative was not notified that Resident R223 eloped from the building on 12/15/2025, and was subsequently missing overnight in freezing temperatures, until after the resident was found and identified at the hospital on [DATE]. 28 Pa. Code 201.14 (a) Responsibility of licensee.

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	12/19/2025

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records and staff interviews, it was determined that the facility failed to ensure pre-admission screening and resident review, (PASRR Level I screenings(a program that ensures Individuals with a serious mental illness or intellectual development developmental disabilities aren't unnecessary place in nursing homes and if they are they receive specialized services.) were accurately completed for two (2) residents. Specifically, the facility did not correctly identify or document indicators of serious mental illness and/or intellectual disability on the PASRR Level I screens, resulting in inaccurate PASRR determinations for these residents. (resident R 79 and R184) Review of the facility's PASRR policy titled Preadmissions screening and Resident Review PASRR Program dated April 1, 2022, and reviewed December 2025, requires that all residents admitted to the facility receive a complete and accurate Pre-admission Screening and Resident Review (PASRR) in compliance with State and Federal regulations. The policy requires the facility to fully coordinate with the PASRR program and ensure that PASRR Level I and Level II determinations, evaluations, and recommendations are accurately identified, documented, and incorporated into the resident's assessment, care plan, and transitions of care, including correct identification of serious mental illness, intellectual disability, or related conditions. The policy further requires referral for a Level II PASRR review when a resident has a known or suspected mental illness or intellectual disability or experiences a significant change in condition that may indicate such diagnoses. In addition, the policy prohibits admission of individuals with mental illness or intellectual disability without a prior State determination confirming the need for nursing facility level of care and whether specialized services are required, and mandates timely notification to the State authority when significant changes occur. Failure to accurately and completely complete PASRR screenings, initiate required Level II reviews, or incorporate PASRR findings into resident assessments results in incomplete and inaccurate PASRR determinations and is inconsistent with facility policy and CMS PASRR requirements.Review of Resident #12's Minimum Data Set (MDS- a federally mandated assessment tool required for all residents), revealed that a quarterly assessment dated [DATE], indicated the resident was admitted to the facility on [DATE]. The assessment documented a Brief Interview for Mental Status (BIMS) score of zero (0), indicating severe cognitive impairment and the need for maximum assistance with functional abilities. The MDS further identified Resident #12 with diagnoses of dementia (defined as a progressive neurocognitive disorder characterized by memory loss, impaired reasoning, and diminished ability to perform daily activities); anxiety(a mental health condition involving excessive fear or worry that interferes with functioning); depression(a mood disorder characterized by persistent sadness, loss of interest, and impaired daily functioning); and bipolar disorder(a serious mental illness characterized by episodes of depression and mania or hypomania that significantly affect mood, behavior, and functional capacity).Review of Resident #12's PASRR dated September 12, 2023, revealed the resident was inaccurately identified as not having any mental health condition that may lead to a chronic disability, despite documented mental health diagnoses in the resident record.Review of Resident R184's PASRR dated January 27, 2021, revealed the resident had a documented diagnosis of schizophrenia. Further review of this document indicated the resident was treated by a psychiatrist and participated in an outpatient mental health program. However, continued review of the same PASRR reflected contradictory information, stating the resident had not been treated in an outside psychiatric setting and had not participated in a partial psychiatric program or received mental health services. The facility failed to ensure accurate identification of serious mental illness and failed to ensure the PASRR information was complete and accurate. 28 Pa. Code 211.5 (f)(xi)(i) Medical Records28 Pa. Code 211.10 (a) Resident Care Policies

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	12/19/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, observations, and staff interviews it was determined that the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice for one of 36 residents reviewed (Resident R135).Findings Include:Review of Resident R135's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated October 3, 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), muscle weakness, and muscle wasting.Further review of Resident R135's comprehensive MDS dated [DATE], revealed the resident had severe cognitive impairments.Review of Resident R135's hospital discharge instructions dated October 21, 2024, revealed Resident R135 was found to have a fracture in the vertebral column that was further assessed by the orthopedic team. Recommendations from the orthopedic team included a thoracic lumbar sacral orthosis (TSLO) clamshell brace (a hard plastic brace worn around the entire trunk of the body) for Resident R135 to wear when out of bed.Review of Resident R135's physician order summary revealed an order dated October 23, 2025, for TSLO clamshell brace to be worn when out of bed to wheelchair due to fracture of spine.Observations on December 16, 2025, at 11:00 a.m. revealed Resident R135 was in the dining room, sitting in his/her wheelchair, wearing the TSLO clamshell brace.Review of Resident R135's report of consultation for orthopedics dated October 28, 2024, revealed recommendations included an MRI (imaging) of the spine, and to refer to endocrinology for osteoporosis (weak and fragile bones).Continued review of Resident R135's clinical record revealed the facility did not get an MRI done for Resident R135 until March 4, 2025. Review of Resident R135's clinical record revealed no documented evidence a follow-up was scheduled with orthopedics regarding the follow-up results of the MRI completed March 4, 2025.Further review of Resident R135's clinical record revealed no documented evidence the facility scheduled a consult with endocrinology per the recommendations from the orthopedic consult on October 28, 2025. 28 Pa. Code 211.12 (d)(5) Nursing services.

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	12/19/2025

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on review of facility documentation, review of clinical records, observations, and staff and resident interviews it was determined that the facility failed to ensure residents received proper treatment and care to maintain good foot health for one of 36 residents reviewed (Resident R44).Findings Include:Review of Resident R44's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated September 29, 2025, revealed the resident was cognitively intact and had diagnoses of cerebral palsy (neurological condition that affects movement and posture) and muscle wasting.Review of Resident R44's comprehensive care plan revised July 3, 2025, revealed the resident had an activity of daily living self-care performance deficit related to weakness and impaired mobility.Interview on December 15, 2025, at 11:30 a.m. Resident R44 expressed he/she has been requesting to see podiatry for months. Observations revealed Resident R44's had long toenails, up to 1/2 inch long. Further the bottom of Resident R44's feet were dry and peeling.Observations on December 18, 2025, at 11:15 a.m. with Unit Manager, Employee E17, confirmed the conditions of Resident R44's feet. Unit Manager, Employee E17, reported podiatry comes to the facility monthly, and as needed.Review of Resident R44's podiatry consult dated March 27, 2025, revealed the resident was seen for continued foot care and evaluation. Resident R44 was noted with long toenails and callus.Further review of Resident R44's podiatry consult dated March 27, 2025, revealed Resident R44 presented with mycotic nails. Professional debridement (removal of dead, damaged, or infected tissue) needed to manage infection and prevent complications. Recommendations included follow-up in nine to twelve weeks.Review of Resident R44's entire clinical record revealed no documented evidence Resident R44 had follow-up podiatry services.28 Pa. Code 211.12 (d)(5)

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	12/19/2025

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical records, and interviews with staff, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility to ensure that residents were properly supervised. This resulted in an Immediate Jeopardy situation for a resident, who had had a diagnosis of dementia and history of exit seeking behaviors, to exit and elope from the building.Findings Include:Review of the job description of the Nursing Home Administrator (NHA) revealed that, the employee assumes full-time administrative authority, responsibility and accountability for the operations of the nursing facility. The employee manages facility employees in the provision of care and services rendered in accordance with professional standards, and in compliance with state and federal laws and regulations. The employee implements operational and financial objectives of management and allocates resources in an efficient and economical manner to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident.Review of the job description of the Director of Nursing (DON) revealed that, the employee assumes full time administrative and clinical authority, responsibility, and accountability for the delivery of nursing services in the facility. The employee manages employees in the provision of care and services according to professional standards of nursing practice, consistent with facility philosophy of care and state and federal laws and regulations. In collaboration with the Nursing Home Administrator, allocates department resources in an efficient manner to enable each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The employee communicates and interprets policies and procedures to nursing staff and subsequently monitors practice for effective implementation.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).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, 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, (continued on next page)

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	12/19/2025

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2025, by Registered Nurse Supervisor, Employee E28, revealed on 12/15/2025 around 9:30 p.m. he/she was informed by the care nurse (identified as nurse aide, Employee E25) that Resident R223 was missing. Registered Nurse Supervisor, Employee E28, announced a code yellow and performed an in-house and outside perimeter search for the resident. Resident R223 was still unable to be located, and administration was made aware.Review of witness statement dated 12/16/2025 by Regional Registered Nurse, Employee E18, revealed per interview with the dispatcher, on 12/15/2025 an owner of a home in a nearby neighborhood (located approximately 1.5 miles away from the facility) called 911 (Emergency Medical Services) at 9:36 p.m. because Resident R223 was knocking on their door. The police called (EMS) at 9:42 p.m. to request assistance and EMS was dispatched at 9:43 p.m.Review of Resident R223's hospital records revealed the resident was admitted to the emergency department (ED) on December 15, 2025, at 10:13 p.m. for altered mental status. Resident R223 was found to be walking around knocking on doors in the cold. When Resident R223 was brought to the ED, he/she was found to be confused and had Hypothermia (a medical condition that occurs when the body temperature drops below 95 degrees Fahrenheit, leading to potentially life-threatening consequences) for which he/she was put on Bair Hugger (warming unit). The average temperature on December 15, 2025, ranged from 19 degrees Fahrenheit to 28 degrees Fahrenheit.Further interview with the Nursing Home Administrator, Employee E1, on December 17, 2025, at 9:00 a.m. revealed she was notified by the police on 12/16/2025 around 7:00 a.m. that Resident R223 was located at a near-by hospital. The Nursing Home Administrator, Employee E1, promptly went to the hospital on [DATE] to positively identify Resident R223. Per the Nursing Home Administrator, Employee E1, when the police arrived at the scene on 12/15/2025 Resident R223 was not able to identify him/herself, so he/she was taken to the hospital as an unknown patient. Nursing Home Administrator, Employee E1, stated that the hospital obtained fingerprints and that is how they identified Resident R223 and informed the facility of his/her whereabouts.Nursing Home Administrator, Employee E1, reportedly reviewed security camera footage for the front door and back door cameras with no success in identifying when/how Resident R223 left the building.Subsequently, surveyors requested review of security camera footage to determine how and what time Resident R223 left the building.Review of security camera footage was conducted on December 17, 2025, at 10:15 a.m. with the Nursing Home Administrator, Employee E1, and Assistant Nursing Home Administrator, Employee E2. Per security camera footage, on 12/15/2025 at 5:37 p.m. an individual wearing a dark colored crewneck sweatshirt, dark colored sweatpants, and dark colored house slippers was seen exiting the building via the ground floor, out the back rear door (loading dock). The individual was observed to effortlessly push open the back door without resistance.The individual was subsequently identified as Resident R223 by the Nursing Home Administrator, Employee E1, and Assistant Nursing Home Administrator, Employee E2. Based on a review of facility documentation, observations, and staff interviews, it was determined that Resident R223 eloped from the facility at 5:37 p.m. on 12/15/2025. A code yellow - elopement protocol, was not implemented until 9:30 p.m. (four hours after the resident exited the building) Resident R223 was located by local law enforcements 1.5 miles away from the facility in sub-freezing temperatures and brought to the local hospital at approximately 10:15 p.m. where he/she was treated for hypothermia. Resident R223 had no identification and was unable to identify him/herself. Hospital staff needed to obtain fingerprints and subsequently notified the facility on 12/16/2025 at approximately 7:00 a.m. of Resident R223's whereabouts.Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to the Immediate Jeopardy situation.Refer to F689.28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 211.12 (c) Nursing services.

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	12/19/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined that the facility failed to maintain and implement infection control program related to handwashing for one of thirty-six residents observed (Resident R47). Observation on Resident R47 conducted on December 2, 2025, during mediation administration revealed that Employee E32 administered Artificial Tears to the resident's right and left eye.Further observation revealed that Employee E32 did not perform hand hygiene between administering eye drops to the right and left eyeFurther observation revealed that Employee E32 administered Oxymetazoline HCl 0.05% Nasal Spray to Resident R47 left and right nostrils. Further observation revealed that Employee E32 did not perform hand hygiene prior to administering the nasal spray and between administration to left and right nostrils.Interview with Employee E32 confirmed that she did not sanitize her hands during administration of artificial tears between the left and right eyes and that she did not sanitize her hands during administration of Oxymetazoline HCl 0.05% Nasal Spray between left and right nostrils.

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	12/19/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, employee interviews and a review of facility policies, it was determined that the facility failed to maintain the dish machine in a safe operating condition.Findings include: A review of the undated facility policy, Chlorine Sanitizer Test Procedure revealed that staff should verify that dish machine is operating properly and allow it to run one full cycle and if the test strip reveals a chlorine reading below 50 parts per million (ppm) to notify the supervisor, adjust the sanitizer feed and retest. Observations during the initial tour of the kitchen on December 15, 2025, at 10:00 a.m. with Employee E14, Food Service Director (FSD), which revealed that the dish machine final rinse gage was reading between 140 degrees. The FSD indicated that the dish machine was a chemical sanitizing low temperature machine. Testing of chemical sanitizing dish machine with chlorine test strips revealed that no sanitizer was present in the final rinse confirming that the machine was not sanitizing the dishes that were being run through. After several attempts to adjust the sanitizer, the FSD could not get the machine to pump the sanitizing chemical into the rinse water and the machine and could not get a reading on the test strips. Interview with the FSD on December 15, 2025, at 10:30 a.m. confirmed the above findings, and that he was not certain how long the machine was operating without sanitizer as no one had reported testing concerns to him. Interview with the Administrator on December 15, 2025, at 10:50 a.m. confirmed that the dish machine was not working, that the dishware could not be properly sanitized and that she instructed the FSD to serve on disposable paperware and plasticware. The facility failed to maintain the dish machine in proper working order. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa Code 201.18(b)(3) Management