

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/21/2026
NAME OF PROVIDER OR SUPPLIER  Yardley Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1480 Oxford Valley Road Yardley, PA 19067	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff interview, and a review of facility documentation, it was determined that the facility failed to implement safety interventions to prevent falls for one of four sampled residents. (Resident 3) Findings include: Clinical record review revealed that Resident 3 had diagnoses that included left and right below the knee amputations. According to the Minimum Data Set assessment dated [DATE], Resident 3 required assistance for transferring from surface to surface (wheelchair to chair). On October 5, 2025, at 3:38 p.m., a nurse noted that Resident 3 was being transferred from his wheelchair to the weight chair by NA1 and NA2. The wheelchair rolled from under the resident and the resident was lowered to the floor. The nurse noted that the cause of the fall from her observation was that the bilateral wheelchair brakes were broken and did not fully engage prior to the transfer. Review of facility documentation dated October 5, 2025, regarding the fall revealed that the bilateral wheelchair brakes were broken. In an interview on January 21, 2026, at 5:00 p.m., the Director of Nursing confirmed that the staff should have ensured that the brakes on the resident's wheelchair were engaged and working and that the wheelchair was not going to roll when they attempted to transfer the resident. CFR 483.25(d) Accidents Previously cited 3/12/25 28 Pa. Code 211.12(d)(1)(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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 395817	If continuation sheet Page 1 of 2

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on resident and staff interviews, review of facility policy, and clinical record review, it was determined that the facility failed to provide adequate treatment and care for a peripherally inserted catheter (a thin plastic tube inserted into a vein using a needle) in accordance with professional standards of practice for one of two residents. (Resident 4) Findings include: According to the Association of Vascular Access, at a minimum, the clinician overseeing the care of the resident conducts a daily peripheral intravenous catheter (PIVC) assessment. Clinicians must routinely inspect the insertion site and assess the functionality of the PIVCs for signs of complications and document assessment results. Clinicians must perform a daily evaluation for the ongoing need of the PIVC. Healthcare teams must review a resident's vascular access needs as part of a comprehensive, interdisciplinary evaluation to ensure effective communication and appropriate care planning. Further, clinicians should notify the provider if the PIVC is not used for 24 hours or more and remove PIVCs when they are no longer required for the plan of care. Review of the facility policy entitled, Peripheral Intravenous (IV) Catheter Removal last reviewed January 20, 2026, indicated that staff were to evaluate the continued need for vascular access during provider visits and care planning. Staff were to remove the peripheral intravenous catheter if vascular access was no longer clinically indicated or it was not used for more than 24 hours. Staff were to document the date and time of procedure, and resident tolerance. Clinical record review revealed that on December 25, 2025, Resident 4 had nausea and vomiting. Review of the Minimum Data Set assessment dated [DATE], revealed that Resident 4 had no cognitive impairment and required supervision/touching assistance for most activities of daily living and transfers. During an interview, January 21, 2026, at 11:25 a.m., Resident 4 stated that she had an IV catheter placed on December 25, 2025, because she had nausea and vomiting, but that the IV was never used and wasn't removed until a couple days later. A physician's order dated December 25, 2025, directed staff to place a peripheral intravenous catheter for hydration. Another physician's order dated December 25, 2025, directed staff to provide sodium chloride solution 0.9% and to use 100 milliliters per hour intravenously every shift for rehydration for one day and to give one liter of normal saline solution. The order's start date was December 25, 2025, at 11:00 p.m. and the order's discontinue date was December 26, 2025, at 11:06 a.m. According to the Medication Administration Record for December 2025, the medication was never provided. A nurse practitioner's note dated December 26, 2025, revealed that the PIVC was available in case of need but was not currently being used. There were no further evaluations or assessments or notes found supporting the need to continue the PIVC. According to the resident and the investigation of the Assistant Director of Nursing, the PIVC line was not removed until December 29, 2025. Review of the clinical record revealed a lack of documentation to support that the resident's peripheral intravenous line was removed and that the condition of the catheter or the skin surrounding the intravenous site was assessed. During an interview January 21, 2026, at 5:30 p.m., the Assistant Director of Nursing confirmed that the peripheral intravenous line was not removed until December 29, 2025, and that the policy should have been followed. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		