

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 03/12/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>43883</p> <p>Based on clinical record review and observation, it was determined that the facility failed to ensure that a call bell was accessible for one of 32 sampled residents. (Resident 3)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 3 had diagnoses that included anxiety, dysphagia, and osteoarthritis. Review of the care plan revealed that the resident had a self-care deficit due to physical limitations and the intervention was for staff to encourage her to use the call bell for assistance. On March 9, 2025, at 11:54 a.m. and 1:53 p.m., the resident was observed in bed. The call bell was inside of the drawer to her bedside stand which was positioned away from the bed, out of reach. On March 11, 2025, at 11:02 a. m., the resident was observed in bed; the call bell was again observed in the drawer of the bedside stand, out of reach.</p> <p>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
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>43883</p> <p>Based on clinical record review and resident and staff interviews, it was determined that the facility failed to provide services to improve activities of daily living (ADLs) for one of 32 sampled residents. (Resident 14)</p> <p>Findings include</p> <p>Clinical record review revealed that Resident 14 had diagnoses that included anxiety, osteoarthritis, and muscle weakness. Review of the care plan revealed that the resident had a self-care deficit and required a restorative nursing program (RNP) for ambulation (walking). The interventions were for staff to assist with ambulation and perform a restorative nursing program with the resident daily. In an interview on March 11, 2025, at 1:11 p.m., the resident stated that she was willing to walk with staff but that staff had not offered to assist her with ambulation regularly. Review of the nurse aide task record revealed no evidence to support that staff offered to assist the resident with the ambulation RNP on February 10, 12, 15, 16, 17, 19, 22, 26, and 27, 2025, and March 1, 2, 5, and 8, 2025. There were no documented refusals.</p> <p>In an interview on March 12, 2025, at 12:26 p.m., the Administrator confirmed that the RNP was to be performed daily and there was a lack of evidence that staff offered to ambulate the resident daily.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43883</p> <p>Based on clinical record review, observation, and resident interview, it was determined that the facility failed to implement interventions to prevent a decline in range of motion for one of 32 sampled residents. (Resident 103)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 103 had diagnoses that included left wrist contracture. Review of the care plan revealed that the resident required assistance from staff for activities of daily living (ADLs). A physician's order dated April 15, 2024, directed staff to apply a soft pro [NAME] resting hand splint due to a left-hand contracture. The resident was observed on March 9, 10, and 11, 2025, at 12:34 p.m., 1:05 p.m., and 11:06 a.m., respectively. The splint was not in place at any of those times. The resident stated that staff had not applied the hand splint in a while and he had not refused use of the splint. There was a lack of evidence to support that staff had applied the splint; there were no documented refusals.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48578</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent accidents for one of 32 sampled residents. (Resident 99)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 99 was admitted to the facility on [DATE], with diagnoses that included dementia, anxiety, and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident had moderate cognitive impairment, but could make her needs known. A review of the care plan revealed that the resident had a self-care deficit related to her cognitive disease process and required supervision with eating and drinking. The interventions were for staff to ensure the resident was upright prior to all oral intake, provide supervision of all meals, and have the resident out of bed and in the dining room for meals. On March 5, 2025, staff noted that Resident 99 experienced a choking episode that required mechanical assistance from staff. Review of a speech therapy evaluation dated March 6, 2025, indicated the resident would benefit from proper positioning and supervision with meals. On March 7, 2025, the nurse practitioner noted that Resident 99 was to sit in an upright position for meals and continue with speech therapy. Observations on March 9, 2025, from 12:10 p.m. to 12:35 p.m., and March 11, 2025, from 12:07 p.m. to 12:30 p.m., revealed that the resident was lying in her bed eating her meal with the head of the bed at less than a 45-degree angle; her head was just above the level of the meal tray on the bedside table. On March 12, 2025, from 12:05 p.m. to 12:15 p.m., the resident was again observed lying in her bed while eating her meal. Her chest and head were propped up on her left elbow; she was not sitting upright. Staff did not provide supervision during those meals.</p> <p>In an interview on March 12, 2025, at 1:05 p.m., the Director of Nursing confirmed the resident should have been supervised while eating.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14599</p> <p>Based on clinical record review and policy review, it was determined that the facility failed to assess residents who were incontinent of bladder to determine the cause of the incontinence or if normal bladder function could be restored for two of 32 sampled residents. (Residents 9 and 87)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Urinary Continence and Incontinence - Assessment and Management, last reviewed January 7, 2025, revealed that the facility was to assess residents who were incontinent of bladder, including determining the type of incontinence and any clinical factors contributing to the incontinence, so residents' normal bladder function could potentially be restored.</p> <p>Clinical record review revealed that Resident 9 was admitted to the facility on [DATE], and had diagnoses that included heart failure and muscle wasting. At the time of admission, the physician assessed the resident and noted that he had previously been continent of bladder. According to the Minimum Data Set (MDS) assessment, dated February 18, 2025, the resident had no cognitive impairment, was able to communicate needs, and was always incontinent of bladder. Nurse aide records since admission confirmed that the resident was completely incontinent of bladder. There was no documented evidence that the facility ever assessed the resident for the cause of their incontinence or evaluated to determine if normal bladder function could be restored.</p> <p>Clinical record review revealed that Resident 87 was admitted to the facility on [DATE], and had diagnoses that included a urinary tract infection and muscle wasting. According to a nursing assessment on the day of admission, the resident was continent of bladder. According to her MDS assessment, dated January 24, 2025, the resident was able to communicate her needs, required assistance from staff for mobility, and had become frequently incontinent of bladder. From February 14 through 26, 2025, the resident was hospitalized due to a change in condition. According to a nursing assessment when she was readmitted to the facility, the resident's continence again declined to being completely incontinent. This was confirmed by a review of the nurse aide records. There was no documented evidence that the facility ever assessed the resident for the cause of their incontinence or evaluated to determine if normal bladder function could be restored.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>48578</p> <p>Based on observation and staff interview, it was determined that the facility failed to post accurate and current nurse staffing information.</p> <p>Findings include:</p> <p>Observation on March 9, 2025, at 9:29 a.m., revealed that staffing information posted in the lobby was dated for March 6, 2025.</p> <p>In an interview on March 12, 2025, at 12:36 p.m., the Director of Nursing confirmed that the incorrect staffing information was posted.</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 - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43883</p> <p>Based on observation and staff interview it was determined that the facility failed to store food under sanitary conditions in the kitchen.</p> <p>Findings include:</p> <p>Observation of the kitchen on March 9, 2025, at 9:54 a.m., revealed the following:</p> <p>In the walk in refrigerator, there was a rolling storage rack that contained raw meat. There was a pan of raw chicken that was stored above a pan of cooked roast beef. The same rolling storage rack also held pans of raw turkey, cubed beef, whole beef tenderloins, and ground meat. The raw poultry (chicken and turkey) were stored above the raw beef, which required a lower internal cooking temperature than raw poultry.</p> <p>In an interview on March 12, 2025, at 9:33 a.m., the Administrator confirmed that the raw meat was not stored properly and raw poultry should not have been stored above cooked food or raw beef.</p> <p>28 Pa. Code 201.18(b)(3) Management.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>43883</p> <p>Based on observation, it was determined that the facility failed to dispose of trash and refuse properly.</p> <p>Findings include:</p> <p>Observation during an environmental tour on March 9, 2025, at 9:54 a.m., revealed the following:</p> <p>The trash compactor was overflowing with trash bags from the top and out of the back of the machine, onto the ground. The lid on top of the machine and the cover on the back of the machine were not able to be closed due to the overflow of trash.</p> <p>28 Pa. Code 201.18(b)(3) Management.</p>