

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/16/2024
NAME OF PROVIDER OR SUPPLIER  Brookview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 Northfield Drive Chambersburg, PA 17201	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31760</p> <p>Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from physical and mental abuse for one of five residents reviewed (Resident 2), resulting in Immediate Jeopardy to the resident's physical, mental health, and safety. This deficiency was cited as past non-compliance.</p> <p>Findings include:</p> <p>The facility's abuse policy, dated April 13, 2023, revealed that it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 2, dated November 16, 2023, revealed that the resident was understood, could understand, and had diagnoses that included Parkinson's disease, anxiety, and depression.</p> <p>A statement completed by Licensed Practical Nurse 1, dated January 29, 2024, at 2:00 p.m., revealed that on January 29, 2024, at 7:30 a.m. she was assisting Nurse Aide 2 with Resident 2. They were getting the resident out of bed by Hoyer lift (a mobile floor lift system that rolls on wheels and is intended to help lift, suspend, and transfer a medically-dependent person) and placing her in her wheelchair for breakfast. After the resident was safely placed in her wheelchair, Nurse Aide 2 put the footrests on the wheelchair and attempted to place the resident's feet onto the footrests. The resident then removed her feet, and in response to this Nurse Aide 2 grabbed hold of the resident's ankles to place them back onto the footrests. Every time Nurse Aide 2 grabbed hold of the resident's ankles, the resident would holler out and place her feet back on the ground. Based on these actions the nurse knew that the resident did not want her feet on the footrests. Nurse Aide 2 attempted to place her feet on the footrests again. When Nurse Aide 2 was bent over grabbing hold of the resident's ankles again, the resident hit Nurse Aide 2 with her open hand on Nurse Aide 2's back. Nurse Aide 2 then stood up straight and opened handed slapped the resident on her left hand and then told the resident, You are being an ass. Nurse Aide 2 then took the Hoyer lift out of the room and Licensed Practical Nurse 1 stayed in the room with the resident. Nurse Aide 2 returned back to the room to comb the resident's hair and stated to the resident, I hope that did hurt, then walked back out of the room.</p> <p>(continued on next page)</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: 395012
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An undated statement completed by Student Practical Nurse 3 indicated that on the morning of January 29, 2024, the student nurse heard Nurse Aide 2 raise her voice with a resident. Student Practical Nurse 3 was sitting in the nurses' station working on school paperwork when Licensed Practical Nurse 1 went to Resident 2's room to assist Nurse Aide 2 with the Hoyer lift. Shortly after she left, Student Practical Nurse 3 heard Nurse Aide 2 raise her voice to Resident 2. Student Practical Nurse 3 did not hear all that was said but remembered her saying this is ridiculous, do not hit me, and some comment about Resident 2 sliding in her wheelchair. Student Practical Nurse 3 was able to hear her comments clearly from the nurses' station.</p> <p>A social worker's interview with Resident 2, dated January 29, 2024, revealed that she spoke with Resident 2 regarding how she was treated that morning. The resident advised her that her caregiver this morning chose clothes that she did not want. The caregiver, whose name she could not remember, was cussing at her and even hit her, indicating her left wrist area, and stated fresh this morning. Resident 2 said, I hit her back.</p> <p>A statement completed by the Director of Nursing revealed that on January 29, 2024, at 7:45 a.m., upon arriving on the [NAME] House unit, she was updated that Licensed Practical Nurse 1 had witnessed an occurrence between Nurse Aide 2 and Resident 2. Licensed Practical Nurse 1 reported that while performing care for the resident Nurse Aide 2 open handed slapped the resident's left hand and she called the resident an ass. Nurse Aide 2 also said to the resident, I hope that hurt.</p> <p>Interview with Licensed Practical Nurse 1 on February 15, 2024, at 2:55 p.m. revealed that she went in to help Nurse Aide 2 with the Hoyer lift because Resident 2 was a Hoyer lift. She indicated that when she went into the room, she could tell that the resident was shaken up. They got the resident into her wheelchair and Nurse Aide 2 was insistent to place the resident's feet on the wheelchair footrests. She knew that the resident did not want her feet on the footrests. Nurse Aide 2 was bent over, and the resident slapped her on the back. Nurse Aide 2 then stood up and slapped the resident and called her an asshole. Nurse Aide 2 then took the Hoyer lift out of the room. She then returned to comb the resident's hair and stated, I hope that did hurt. She indicated that she remembered saying to Nurse Aide 2 that she can transfer herself and thought to herself that the resident slapped Nurse Aide 2 because it must have hurt. She indicated that she and the resident were near the resident's bed when Nurse Aide 2 came back in by the bathroom door and stated I hope that did hurt, and after making the comment she turned around leaving the resident's room.</p> <p>Following the incident on January 29, 2024, the facility's corrective actions included:</p> <p>Nurse Aide 2 was suspended of her duties, and after the investigation her employment with the facility was terminated.</p> <p>An audit of residents was performed.</p> <p>Licensed Practical Nurse 1 was re-educated regarding abuse.</p> <p>Re-education regarding abuse to staff was started.</p> <p>Daily random audits of residents were being completed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On February 15, 2024, at 5:10 p.m. the Nursing Home Administrator and Director of Nursing were given the required Immediate Jeopardy Template and informed that the physical/mental health and safety of Resident 2 had been placed in Immediate Jeopardy due to the failure of the facility to ensure that Resident 2 was not subjected to physical/mental abuse by Nurse Aide 2, who physically/mentally abused the resident.</p> <p>On February 15, 2024, at 8:00 p.m. the facility submitted an immediate action plan that included:</p> <p>The nurse aide was suspended at the time of the reported abuse and is no longer employed at the facility.</p> <p>An in-house audit was performed on residents at the time of the incident, and assessments were completed along with interviews to confirm no other residents were identified.</p> <p>In-house re-education was provided to staff on abuse and reporting of abuse. The facility will not allow an employee to work unless this education has been completed prior to returning to work.</p> <p>Daily random audits of care and interviews continue to ensure that no residents have been affected. The audits are going to be reviewed at Quality Assurance Performance Improvement (QAPI) meetings.</p> <p>Facility staff were interviewed on February 16, 2024, and were knowledgeable of the facility's policy on abuse.</p> <p>The facility alleged compliance on January 31, 2024.</p> <p>The Immediate Jeopardy was lifted on February 16, 2024, at 12:03 p.m. when it was confirmed that the corrective action plans developed on January 29, 2024, were completed by January 31, 2024, and that Resident 2 and any other current residents were not physically/mentally abused since January 31, 2024.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.29(j) Resident Rights.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>31760</p> <p>Based on review of policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that staff reported physical abuse in a timely manner, which allowed the staff member to return to the resident to be mentally abused for one of five residents reviewed (Resident 2) putting all of the residents in danger of being abused, resulting in Immediate Jeopardy to their physical and mental safety. This deficiency was cited as past non-compliance.</p> <p>Findings include:</p> <p>The facility's abuse policy, dated April 13, 2023, revealed that it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Training topics will include prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property. Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown cause. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to responding immediately to protect the alleged victim and integrity of the investigation.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 2, dated November 16, 2023, revealed that the resident was understood, understands, and had a diagnosis which included Parkinson's disease, anxiety, and depression.</p> <p>A statement completed by Licensed Practical Nurse 1, dated January 29, 2024, at 2:00 p.m., revealed that on January 29, 2024, at 7:30 a.m. she was assisting Nurse Aide 2 with Resident 2. They were getting the resident out of bed by Hoyer lift (a mobile floor lift system that rolls on wheels and is intended to help lift, suspend, and transfer a medically-dependent person) and placing her in her wheelchair for breakfast. After the resident was safely placed in her wheelchair, Nurse Aide 2 put the footrests on the wheelchair and attempted to place the resident's feet onto the footrests. The resident then removed her feet, and in response to Nurse Aide 2 grabbed hold of the resident's ankles to place them back onto the footrests. Every time Nurse Aide 2 grabbed hold of the resident's ankles, the resident would holler out and place her feet back on the ground. Based on these actions the nurse knew that the resident did not want her feet on the footrests. Nurse Aide 2 attempted to place her feet on the footrests again. When Nurse Aide 2 was bent over grabbing hold of the resident's ankles again, the resident hit Nurse Aide 2 with her open hand on Nurse Aide 2's back. Nurse Aide 2 then stood up straight and opened handed slapped the resident on her left hand and then told the resident, You are being an ass. Nurse Aide 2 then took the Hoyer lift out of the room and Licensed Practical Nurse 1 stayed in the room with the resident. Nurse Aide 2 returned back to the room to comb the resident's hair and stated to the resident, I hope that did hurt, then walked back out of the room.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>There was no evidence to indicate that Resident 2's initial physical and verbal abuse (that included grabbing her ankles and repeatedly placing them back on the footrests of the wheelchair, slapping the resident or calling her an asshole) by Nurse Aide 2 was immediately reported when it happened.</p> <p>A statement completed by the Nursing Home Administrator (NHA), dated February 9, 2024, revealed that on January 29, 2024, she reviewed with Licensed Practical Nurse 1 her written statement regarding the incident with Resident 2. She reviewed with Licensed Practical Nurse 1 that Nurse Aide 2 should have been immediately sent off the unit to the staff lounge until the Director of Nursing or NHA could speak with her. The NHA also stated that Nurse Aide 2 should not have been allowed to come back into the resident's room to comb her hair.</p> <p>Following the incident on January 29, 2024, the facility's corrective actions included:</p> <p>Nurse Aide 2 was suspended of her duties, and after the investigation her employment with the facility was terminated.</p> <p>An audit of residents was performed.</p> <p>Licensed Practical Nurse 1 was re-educated regarding abuse.</p> <p>Re-education regarding abuse to staff was started.</p> <p>Daily random audits of residents were being completed.</p> <p>On February 15, 2024, at 5:10 p.m. the Nursing Home Administrator and Director of Nursing were given the required Immediate Jeopardy Template due to the failure of the facility to ensure that Licensed Practical Nurse 1 immediately reported the witnessed abuse of Resident 2 by Nurse Aide 2, and to protect the resident by allowing Nurse Aide 2 to return to the resident's room.</p> <p>On February 15, 2024, at 8:00 p.m. the facility submitted an immediate action plan that included:</p> <p>The nurse aide was suspended at the time of the reported abuse and is no longer employed at the facility.</p> <p>An in-house audit was performed on residents at the time of the incident, and assessments were completed along with interviews to confirm no other residents were identified.</p> <p>In-house re-education was provided to staff on abuse and reporting of abuse. The facility will not allow an employee to work unless education has been completed prior to returning to work.</p> <p>Daily random audits of care and interviews continue to ensure that no residents have been affected. The audits are going to be reviewed at Quality Assurance Performance Improvement (QAPI) meetings.</p> <p>Facility staff were interviewed on February 16, 2024, and were knowledgeable of the facility's policy on abuse.</p> <p>The facility alleged compliance on January 31, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Immediate Jeopardy was lifted on February 16, 2024, at 12:03 p.m. when it was confirmed that the corrective action plans developed on January 29, 2024, were completed by January 31, 2024, and that Resident 2 and any other current residents were not physically/mentally abused since January 31, 2024.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>19102</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a baseline care plan included instructions regarding behaviors and the use of psychotropic medications for one of five residents reviewed (Resident 5) who was admitted after February 9, 2024.</p> <p>Findings include:</p> <p>A nursing note, dated February 9, 2024, at 11:14 a.m., revealed that the resident was admitted to the facility on this date. Physician's orders, dated February 9, 2024, included orders for 12.5 mg of Seroquel in the morning and 25 mg of Seroquel(antipsychotic) at bedtime for dementia with behaviors, 0.25 milliliters (mL) of lorazepam (anti-anxiety) three times a day for anxiety, and 10 mg of escitalopram (anti-depressant) in the morning for major depression.</p> <p>A Certified Registered Nurse Practitioner (CRNP, a registered nurse who has advanced education and clinical training in a health care specialty area) note, dated February 9, 2024, revealed that the resident was agitated and anxious, refused to have her dressing changed, refused to have a skin evaluation, and refused her medications. New orders were received for 2.5 milligrams (mg) of Haldol (antipsychotic) one time, 0.5 mg of Ativan (anti-psychotic) three times a day for three days, and she was to continue her as-needed Ativan and 12.5 mg of Seroquel in the morning.</p> <p>A nursing note, dated February 9, 2024, at 2:21 p.m., revealed that the resident's daughter informed the facility that Resident 5 had behaviors of hitting, spitting, kicking, and throwing objects if she was mad and did not want anything or did not like something. She refused to allow the nurse to assist her with the removal of her coat and accepted sips of water and gingerale at lunch time, then threw her cup of gingerale. She was offered a cup of hot tea, and the resident picked up the cup and threw it at the nurse. Staff attempted to do her admission assessment and allowed staff to assess her feet and left arm, but then she began to hit, kick and spit at the nurse, and was unable to be redirected even with the daughter's assistance.</p> <p>Nursing notes for Resident 5, dated February 10, at 3:54 p.m., revealed that the resident was combative with morning medications, and on February 11, 2024, at 11:06 a.m. the resident was highly combative and hitting and spitting at staff.</p> <p>A baseline care plan for Resident 5, dated February 9, 2024, did not include instructions regarding Resident 5's behaviors or use of psychotropic medications.</p> <p>Interview with the Nursing Home Administrator on February 16, 2024, at 12:44 p.m. confirmed that Resident 5 had behaviors and used psychotropic medications, and the resident's baseline care plan should have included this information.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>31760</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized interventions to address resident care needs for one of five residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>The facility's policy regarding behaviors, dated April 13, 2023, revealed that facility staff will attempt to implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological interventions.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 2, dated November 16, 2023, revealed that the resident was understood, understands, and had a diagnosis which included Parkinson's disease, anxiety, and depression.</p> <p>A nursing note for Resident 2, dated January 18, 2024, revealed that the nurse and the nurse aide attempted to get the resident into the bath multiple times. The resident refused and became combative and kept stating she will tomorrow, or she will let them know when she wants a shower.</p> <p>A nursing note for Resident 2, dated January 21, 2024, revealed that the resident was hitting, pinching, and cursing at staff with morning care. Even with attempts of calming talk and redirecting, she was attempting to get out of bed by herself and did not want staff to assist her.</p> <p>A statement completed by Licensed Practical Nurse 1, dated January 29, 2024, at 2:00 p.m., revealed that on January 29, 2024, at 7:30 a.m. she was assisting Nurse Aide 2 with Resident 2. They were getting the resident out of bed by Hoyer lift (a mobile floor lift system that rolls on wheels and is intended to help lift, suspend, and transfer a medically-dependent person) and placing her in her wheelchair for breakfast. After the resident was safely placed in her wheelchair, Nurse Aide 2 put the footrests on the wheelchair and attempted to place the resident's feet onto the footrests. The resident then removed her feet and in response to this Nurse Aide 2 grabbed hold of the resident's ankles to place them back onto the footrests. Every time Nurse Aide 2 continued to grab hold of the resident's ankles, the resident would holler out and place her feet back on the ground. Based on these actions the nurse knew that the resident did not want her feet on the footrests. Nurse Aide 2 attempted to place her feet on the footrests again. When Nurse Aide 2 was bent over grabbing hold of the resident's ankles again, the resident hit Nurse Aide 2 with her open hand on Nurse Aide 2's back.</p> <p>A statement completed by Nurse Aide 2, undated, (referring to the incident of January 29, 2024, at 7:30 a.m.) revealed that while doing care on Resident 2, she started hitting me. I told her to stop it. I put my hand in front of hers to stop her from hitting me. She then started to yell at me. She was yelling and hitting me while the nurse was just standing there. The resident then started kicking and would not keep her feet on the wheelchair footrests.</p> <p>There was no documented evidence that a comprehensive care plan that included specific and individualized interventions was developed for Resident 2 regarding her behaviors until February 15, 2024.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Nursing Home Administrator on February 16, 2024, at 9:35 a.m. revealed that they felt Resident 2 did not have any behaviors, so a care plan was not developed regarding behaviors until February 15, 2024.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0743</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a resident does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless unavoidable.</p> <p>31760</p> <p>Based on review of policies, clinical records, and personnel files, as well as staff interviews, it was determined that the facility failed to properly address a resident's behavior of repeatedly taking her feet off the wheelchair footrests and placing them on the ground for one of five residents reviewed (Resident 2), resulting in Immediate Jeopardy when the nurse aide continued to grab hold of the resident's ankles, causing her to yell out and place her feet back on the ground, which resulted in the resident hitting the nurse aide while the nurse aide was bent over to once again grab the resident's ankles to place the her feet back on the wheelchair footrests. In response, the nurse aide slapped the resident's hand and called the resident an asshole.</p> <p>Findings include:</p> <p>The facility's policy regarding behaviors, dated April 13, 2023, revealed that facility staff will attempt to implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological interventions, to help meet behavioral health needs and may include, but are not limited to offering hydration and nutrition; exercise; pain relief; individualizing sleep and dining routines; considerations for restroom use, incontinence; adjusting the environment to be more individually preferred or homelike; consistent staffing to optimize familiarity; supporting the resident through meaningful activities that match his/her individualized abilities, interests and needs; assisting the resident with outdoors activity weather permitting; providing access to pets or animals for the resident who enjoys pets; assisting the resident to participate in activities that support their spiritual needs; focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident's experience is real to her/him; utilizing techniques such as music, art, electronics/computer technology systems, reminiscing, and providing redirection.</p> <p>A review of the personnel file for Nurse Aide 2 revealed that she was hired by the facility on October 13, 2003, received customer service training on January 23, 2023; received elder abuse training on May 2, 2023; received resident rights training on April 5, 2023; received hand-and-hand dementia module 1 training on June 5, 2023; hand-and-hand dementia module 2 training on July 5, 2023; received abuse, prevention, reporting and elder justice act training on August 29, 2023; and received behavioral health training on August 29, 2023. On December 10, 2017, she received disciplinary action regarding concerns that they had received multiple complaints about her poor attitude, being rude to other nurse aides, and speaking harshly and disrespectfully to residents.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 2, dated November 16, 2023, revealed that the resident was understood and could understand others, and had diagnoses that included Parkinson's disease, anxiety, and depression.</p> <p>A nursing note for Resident 2, dated January 18, 2024, revealed that the nurse and the nurse aide attempted to get the resident into the bath multiple times. The resident refused and became combative and kept stating she will tomorrow, or she will let them know when she wants a shower.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/16/2024
NAME OF PROVIDER OR SUPPLIER  Brookview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 Northfield Drive Chambersburg, PA 17201	
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 0743</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A nursing note for Resident 2, dated January 21, 2024, revealed that the resident was hitting, pinching, and cursing at staff with morning care. Even with attempts of calming talk and redirecting, she was attempting to get out of bed by herself and did not want staff to assist her.</p> <p>A statement completed by Licensed Practical Nurse 1, dated January 29, 2024, at 2:00 p.m., revealed that on January 29, 2024, at 7:30 a.m. she was assisting Nurse Aide 2 with Resident 2. They were getting the resident out of bed by Hoyer lift (a mobile floor lift system that rolls on wheels and is intended to help lift, suspend, and transfer a medically-dependent person) and placing her in her wheelchair for breakfast. After the resident was safely placed in her wheelchair, Nurse Aide 2 put the footrests on the wheelchair and attempted to place the resident's feet onto the footrests. The resident then removed her feet, and in response to this Nurse Aide 2 grabbed hold of the resident's ankles to place them back onto the footrests. Every time Nurse Aide 2 grabbed hold of the resident's ankles, the resident would holler out and place her feet back on the ground. Based on these actions the nurse knew that the resident did not want her feet on the footrests. Nurse Aide 2 attempted to place her feet on the footrests again. When Nurse Aide 2 was bent over grabbing hold of the resident's ankles again, the resident hit Nurse Aide 2 with her open hand on Nurse Aide 2's back. Nurse Aide 2 then stood up straight and opened handed slapped the resident on her left hand and then told the resident, You are being an ass. Nurse Aide 2 then took the Hoyer lift out of the room and the nurse stayed in the room with the resident. Nurse Aide 2 returned back to the room to comb the resident's hair and stated to the resident, I hope that did hurt, then walked back out of the room.</p> <p>A statement completed by Nurse Aide 2, undated, revealed that while doing care on Resident 2, she started hitting me. I told her to stop it. I put my hand in front of hers to stop her from hitting me. She then started to yell at me. She was yelling and hitting me while the nurse was just standing there. The resident then started kicking and would not keep her feet on the wheelchair footrests.</p> <p>There was no documented evidence in Resident 2's clinical record to indicate that Nurse Aide 2 attempted a different approach with the resident or other interventions to prevent her behavior from escalating to the point of hitting Nurse Aide 2.</p> <p>On February 15, 2024, at 5:10 p.m. the Nursing Home Administrator and Director of Nursing were given the Immediate Jeopardy Template due to the failure of the facility to properly address a resident's behavior of repeatedly taking her feet off the wheelchair footrests and placing them on the ground. The nurse aide continued to grab hold of the resident's ankles, causing her to yell out and place her feet back on the ground, which resulted in the resident hitting the nurse aide while the nurse aide was bent over to once again grab her ankles to place the her feet back on the wheelchair footrests. In response, the nurse aide slapped the resident's hand and called the resident an asshole.</p> <p>On February 15, 2024, at 9:31 p.m. the facility submitted an immediate action plan that included:</p> <p>The nurse aide was suspended at the time of the reported abuse and is no longer employed at the facility.</p> <p>Licensed Practical Nurse 1 was re-educated regarding abuse.</p> <p>Resident 2's care plan was updated to identify the resident's behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0743</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Care plans will be established for residents that exhibit behaviors with individualized interventions.</p> <p>In-house re-education was provided to staff on the facility's behavioral policy and how to manage behaviors. The facility will not allow an employee to work unless education has been completed prior to returning to work.</p> <p>Daily random audits of care and interviews continue to ensure that no residents have been affected. The audits are going to be reviewed at Quality Assurance Performance Improvement (QAPI) meetings.</p> <p>Interview with the Nursing Home Administrator on February 16, 2024, at 9:35 a.m. revealed that they felt Resident 2 did not have any behaviors for them to address at the time of the incident.</p> <p>The facility acknowledged compliance on February 16, 2024.</p> <p>The Immediate Jeopardy was lifted on February 16, 2024, at 12:03 p.m. when it was confirmed that the corrective action plans developed on February 15, 2024, were implemented. It was confirmed that Resident 2 and any other current residents did not exhibit any behaviors. The majority of staff were educated, and a plan for remaining staff to receive the education prior to the start of their next work shift was developed and implemented.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>31760</p> <p>Based on review of job descriptions and the deficiencies cited during the current survey, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to assume responsibility for effective management of the facility to ensure that the residents' environment remained free from abuse, for ensuring that staff reported abuse and protected the resident from further abuse, and for ensuring that staff properly address a resident's behavior.</p> <p>Findings include:</p> <p>The job description for the NHA, dated January 17, 2023, indicated that the primary function of this position was to</p> <p>provide general oversight and direction to all services provided by the Brookview Health Care Center. Maintains compliance with the Department of Health, Welfare, Medicare, and Educational regulatory requirements. Supervision and coordination of services to include overseeing budget and corporate policies and procedures related to the care of all residents.</p> <p>The job description for the DON, dated October 15, 2020, indicated that the primary function of this position was to organize, administrate, and supervise the total nursing service program in compliance with the regulatory process and operational guidelines, and modifies nursing care policies and/or procedures to maintain the highest practicable well-being of each resident.</p> <p>The deficiencies cited under the Code of Federal Regulatory Groups for Long-Term Care, 483.12 Freedom from Abuse, Neglect, and Exploitation (F600), revealed that the NHA and DON failed to fulfill their essential job duties for ensuring that the residents' environment remained free from abuse.</p> <p>The deficiencies cited under the Code of Federal Regulatory Groups for Long-Term Care, 483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property and 483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act (F607), revealed that the NHA and DON failed to fulfill their essential job duties for ensuring that staff timely reported abuse and allowing staff to return to the resident.</p> <p>The deficiencies cited under the Code of Federal Regulatory Groups for Long-Term Care, 483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable (F743), revealed that the NHA and DON failed to fulfill their essential job duties for ensuring that staff properly address a resident's behavior.</p> <p>Refer to F600, F607 and F743.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		