STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395227	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Healthcare & Rehabilitation Center	2630 Woodland Road Roslyn, PA 19001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43883 Based on observation, clinical record review, and resident interview, it was determined that the facility failed to ensure that a call bell was accessible for one of 33 sampled residents. (Resident 51) Findings include: Clinical record review revealed that Resident 51 had diagnoses that included parkinsonism (neurological disorders that cause movement problems), depression, and muscle weakness. Review of the care plan revealed that the resident was at risk for falls and had limited physical mobility. The interventions were for staff to ensure that the call bell was within reach and encourage her to use it to call for assistance. On October 30, 2024, at 9:41 a.m., Resident 51 was in her room in bed. Registered Nurse (RN) 1 assisted the resident and left the room. The call bell was observed on the floor, at the head of the bed, out of reach. The resident stated she was not aware of the location of her call bell. At 11:00 a.m., the resident was again observed in her room in bed. The call bell was in the same position and remained out of the resident's reach. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39422 Based on clinical record review and policy review, it was determined that the facility failed to ensure that the baseline care plan summary was provided to the resident or representative for two of 33 sampled residents. (Residents 17, 104) Findings include: Review of the facility's policy entitled, Care Plans-Baseline, dated September 9, 2024, revealed that a baseline plan of care was to be developed within 48 hours of admission. The baseline care plan was to include instructions needed to provide person-centered care of the resident that meets professional standard of quality care and must include initial goals based on admission orders and discussion with the resident and/or representative, physician orders, dietary orders, therapy orders, social services, and pre-admission screening resident review, if applicable. The baseline care plan was to be updated as needed to meet the resident's needs until the comprehension care plan was developed. The resident and/or representative were to be provided a written summary of the baseline care plan in a language that the resident and/or representative could understand. Clinical record review revealed that Resident 17 was admitted to the facility on [DATE]. On October 8, 2024, the baseline care plan was developed. There was a lack of evidence to support that the facility provided the resident and/or representative with a summary of the baseline care plan that included all the required components. Clinical record review revealed that Resident 104 was admitted to the facility on [DATE]. On September 23, 2024, the baseline care plan was developed. There was a lack of evidence to support that the facility provided the resident and/or representative with a summary of the baseline care plan that included all the required components. In an interview conducted on November 1, 2024, at 9:48 a.m., the Administrator confirmed there were no evidence the baseline care plan summary was provided to Residents 17 and 104. 28 Pa. Code 201.18 (1) Management.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39422 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to develop or implement a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for three of 33 sampled residents. (Resident's 11, 12, 21) Findings include: Clinical record review revealed that Resident 11 had diagnoses that included muscle weakness and depression. Review of a nutrition assessment dated [DATE], revealed that the resident was underweight for his age and he reported a desire to gain weight. The nutrition intervention was fortified foods once daily and snacks twice daily for weight support, and the dietitian was to develop a dietary plan of care. Review of the care plan revealed that the resident was at risk for altered nutrition status and was to receive fortified mashed potatoes with lunch. On October 29, 2024, at 12:41 p.m., and October 31, 2024, at 1:20 p.m., the resident was observed in his room with his lunch tray. The tray ticket indicated that the resident should have received fortified mashed potatoes. There were no fortified mashed potatoes observed on the resident's tray. In an interview on November 1, 2024, at 11:50 a.m., the Administrator confirmed that the kitchen staff had not prepared fortified mashed potatoes on those dates and they were not provided to the resident, per the plan of care. Clinical record review revealed that Resident 12 was admitted to the facility on [DATE], and had diagnoses that included dementia and heart failure. The Minimum Data Set (MDS) Care Area Assessment (CAA) summary dated July 2, 2024, noted that the resident's psychotropic medication was to be addressed in the care plan. There was no evidence that interventions to address Resident's 12's psychotropic medication were included in the current care plan. Clinical record review revealed that Resident 21 had diagnoses that included cerebral infarction (sudden loss of blood flow to the brain), difficulty in walking, and muscle weakness. Review of the current care plan revealed, Resident 21 was at risk for skin breakdown with an intervention for staff to offload bilateral heels with heel boots (devices to protect the skin of the feet) while in bed. Multiple observations on October 29, 30, and 31, 2024, between 9:30 a.m. and 2:15 p.m., revealed Resident 21 in bed and the heel boots were not applied. In an interview on November 1, 2024, at 10:20 a.m., the Director of Nursing confirmed there was no documented evidence that the care areas were addressed in the care plan or implemented in accordance with the care plans. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 39422 Based on clinical record review and staff interview, it was determined that the facility failed to ensure physician's orders were implemented for six of 33 sampled residents. (Residents 1, 7, 12, 17, 95, 98) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included orthostatic hypotension (low blood pressure when standing, sitting, or lying down) and epilepsy (brain disorder that causes seizures). A physician's order dated January 5, 2024, directed staff to administer a medication (midodrine hydrochloride) three times a day for hypotension. Staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was greater than 130 millimeters mercury (mm/Hg). Review of the Medication Administration Record (MAR) from September 2024 through October 2024 revealed that staff administered the medication nine times when Resident 1's SBP was greater than the ordered parameters. Clinical record review revealed that Resident 7 had diagnoses that included heart failure, muscle weakness, and osteoarthritis. A physician's order dated September 17, 2024, directed staff to apply heel boots (devices to protect the skin of the feet) while in bed. Review of the comprehensive care plan revealed that the resident was at risk for skin breakdown. Multiple observations on October 29 and 30, 2024, between 10:30 a.m. and 2:10 p.m., revealed Resident 7 in bed and the heel boots were not applied. Clinical record review revealed that Resident 12 had diagnoses that included hypertension (high blood pressure) and heart failure. On June 25, 2024, the physician directed staff to administer a medication (midodrine hydrochloride) three times a day for orthostatic hypotension. Staff was not to administer the medication if the resident's SBP was 135 mm/Hg or higher. Review of the MAR revealed that staff administered the medication when the resident's SBP was above 135 mm/HG on 14 occasions in September 2024 and 12 occasions in October 2024. Further review of Resident 12's clinical record revealed on June 25, 2024, the physician directed staff to administer metoprolol (medication for high blood pressure) twice a day; staff were to hold the medication if the resident's SBP was below 100 mm/Hg or the resident's heart rate was below 60 beats per minute. Review of the MAR for September and October 2024 revealed that staff administered the medication 57 of 60 times in September and 61 of 61 times in October with no documentation that the blood pressure was assessed prior to medication administration per physician's order. Clinical record review revealed that Resident 17 had diagnoses that included hemiplegia and hemiparesis (paralysis of one side), heart failure, and muscle weakness. A physician's order dated October 9, 2024, directed staff to apply heel boots while in bed. Review of the comprehensive care plan revealed that the resident was at risk for skin breakdown. Multiple observations on October 29, 30, and 31, 2024, between 9:45 a.m. and 2:00 p.m., revealed Resident 17 in bed and the heel boots were not applied. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that Resident 95 had diagnoses that included Alzheimer's disease, hemiplegia and hemiparesis, and hypertension. Physician's orders dated August 23, 2024, and October 14, 2024, directed staff to administer losartan (medication for high blood pressure) once a day; staff were to hold the medication if the resident's SBP was below 110 mm/Hg or the resident's heart rate was below 60 beats per minute. Review of the MAR for September and October 2024 revealed that staff administered the medication on one occasion in September and on nine occasions in October, when Resident 95's SBP was less than the ordered parameters. Clinical record review revealed that Resident 98 had diagnoses that included hypertension and cerebral infarction (sudden loss of blood flow to the brain). A physician's order dated October 11, 2024, directed staff to administer a medication (carvedilol) every 12 hours for hypertension. Staff were not to administer the medication if the resident's heart rate was below 55 beats per minute. Review of the October 2024 MAR revealed staff administered the medication 27 times with no documentation that the heart rate was assessed prior to the medication administration per the physician's order. In an interview on November 1, 2024, at 9:48 a.m., the Administrator confirmed that staff did not apply the heel boots as ordered by the physician and that medications were administered outside of the established parameters for the aforementioned residents. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43883 Based on clinical record review, observation, staff interview, and review of facility policy, it was determined that that facility failed to implement safety interventions for two of six sampled residents at risk for falls. (Residents 7, 112) In addition, the facility failed to safely administer medications for one of 33 sampled residents. (Resident 53) Findings include: Review of facility policy entitled, Administering Medications, last reviewed September 9, 2024, revealed that residents were permitted to self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, had determined that they had the decision making capacity to do so safely. Clinical record review revealed that resident 53 had diagnoses that included dementia, legal blindness, and dysphagia. Physician's orders dated April 16 and 17, 2024, directed staff to administer carvedilol (a medication for blood pressure) and levetiracetam (a medication for seizures) once daily. On October 30, 2024, Resident 53 was observed in her room. There was a medication cup that contained two pills on the bedside table. The resident stated that the nurse had left the medications on the table and she would take them later. In an interview at 12:35 p.m., RN 1, confirmed that the medication cup contained the resident's levetiracetam and carvedilol and were left on the resident's bedside table. There was no evidence that the resident had been assessed and approved to self-administer medications. In an interview on November 1, 2023, the Director of Nursing (DON) confirmed that the resident was not approved for unsupervised self-administration of medications and the nurse should not have left medications at the residents bedside. Clinical record review revealed that Resident 7 had diagnoses that included stroke, heart failure, and arthritis. Review of the care plan revealed that the resident was at risk for falls, floor mats were to be placed on both sides of the bed, and his bed was to be kept in the lowest position. Multiple observations on October 29 and 30, 2024, between 10:30 a.m. and 2:10 p.m., revealed that the resident was in bed; the bed was elevated, not in the lowest position, and there was no fall mats in place. Clinical record review revealed that Resident 112 had diagnoses that included seizures and cognitive communication deficit. Further review of the clinical record revealed that the resident experienced a fall from bed on June 23, 2024. Review of the care plan revealed that the resident was at risk for falls and his bed was to be kept in the lowest position. Observations on October 29, 2024, at 11:41 a.m., 12:17 p.m., and 12:35 p.m., and again on October 30, 2024, at 9:35 a.m., revealed that the resident was in bed; the bed was elevated and not in the lowest position. position. In an interview on November 1, 2024, at 9:48 a.m., the DON confirmed that the resident's bed should have been in the lowest position and fall mats should have been in place for Resident 7. (continued on next page)

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	395227	A. Building B. Wing	11/01/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	211.10(d) Resident care policies. 211.12(d)(1)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 43883 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to adequately monitor and assess significant weight change for one of four sampled residents at risk for weight loss. (Resident 77) Findings include: Review of the facility policy entitled, Weight Assessment and Intervention, last reviewed September 9, 2024, revealed that any weight change of five percent (%) or more since the last weight assessment was to be retaken the next day for confirmation. If the weight was verified, nursing would immediately notify the dietitian in witting. Clinical record review revealed that Resident 77 had diagnoses that included dementia and adult failure to thrive. On February 5, 2024, the resident weighed 192.6 pounds (lbs.). On March 8, 2024, the resident weighed 178.8 lbs., which reflected a 7.1% weight loss from the prior weight. On April 15, 2024, the resident weighed 174.0 lbs., which indicated continued weight loss. There was no evidence that a second weight was obtained in March or that the dietitian was notified of the weight loss, per the policy. There was no evidence that the resident or the weight change was assessed until April 9, 2024. In an interview on November 1, 2024, at 10:37 a.m., the Administrator confirmed that there was no evidence a second weight was obtained or that the dietitian was notified, per the policy. 28 Pa. code 211.12(d)(1)(3)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43883 Based on observation, it was determined that the facility failed to maintain sanitary conditions in the kitchen. Findings include: Observation of the kitchen on October 29, 2024, at 9:47 a.m., revealed the following: There was no soap in the dispenser at a hand wash sink. There were flies in the dish washing and tray line areas. There was a tray of clean adaptive cups that contained various debris that included crumbs, paper clips, and condiment packets. The lid on a container of cereal was broken; the contents were left open to air. There was debris that included cups, lids, baskets, and trash on the floor at the juice and ice machines. A roll of trash bags was stored on top of a rack of clean bowls. There were ear buds on a food preparation surface, alongside cooking utensils. The molding at the base of the wall behind a food preparation surface was chipped and marred. There was an accumulation of debris that included dirt and a metal nail on the floor by a clean pot shelf. CFR 483.60 Food Procurement Store/Prepare/Serve-Sanitary. Previously cited 11/02/23 28 Pa. Code 201.18(b)(3) Management.