| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 395418 | A. Building<br>B. Wing | 01/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| Brookline Nursing and Rehab | 2 Manor Boulevard<br>Mifflintown, PA 17059 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
| --- | --- |
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, review of select policies and procedures, and staff interview, it was determined that the facility failed to thoroughly investigate and report allegations of abuse and neglect for two of three residents reviewed (Residents CR1 and CR2). Findings include: The policy entitled, Abuse Investigation and Reporting, last reviewed without changes on November 20, 2025, indicated that all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The policy indicated that if an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported the administrator will assign the investigation to an appropriate individual. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility administrator, or designee, to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility, the local/state ombudsman, the resident's representative, adult protective services, law enforcement, the resident's attending physician, and the facility's medical director. Review of a facility concern/grievance report dated January 8, 2026, communicated to the facility by Resident CR1, revealed that she had a concern that a girl that came into her room the night before (January 7, 2026) and was grumpy right away and stated, you asked for it, now you got it, after she ask for a wedge for behind her back. The form indicated that she had a pad laying on her spine and that she could not find the call bell to ring and she was scared. Attached to the concern form was a summary from the director of nursing that indicated her and the social service director met with Resident CR1 regarding her concern that someone was being rough with her during the night when they put her to bed. Resident CR1 also indicated that the person did not put a wedge under her back and she laid on her back all night. She said she had her call bell but was afraid to use it in case this person came back. The summary indicated that Resident CR1 could not identify who the person was because she had her eyes closed the whole time. The summary reviewed different staff members that the Director of Nursing spoke to and ruled out as perpetrators, and there were written statements from two-night shift nurse aides, regarding the event but no perpetrator was identified through those statements either. The director of nursing's summary indicated that the two night-shift nurse aides felt the resident was hallucinating. The summary was signed by the director of nursing on January 9, 2026. Further clinical record review for Resident CR1 revealed a progress note dated January 9, 2026, at 1:54 PM that indicated a purplish area was noted on her right flank/hip area that extended to just below her right abdominal fold. The certified nurse practitioner was notified and ordered and ultrasound of the area and also ordered Vitamin K (essential to help with blood clotting) be given<br><br>(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 |
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| NAME OF PROVIDER OR SUPPLIER Brookline Nursing and Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 2 Manor Boulevard Mifflintown, PA 17059 | |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | related to Resident CR1 having an elevated PT INR (a blood test that measures how long it takes for blood to clot, used to check for bleeding problems). A progress note for Resident CR1 dated January 9, 2026, at 2:56 PM indicated an ultrasound of the discolored area was completed. A progress note for Resident CR1 dated January 10, 2026, at 10:51 indicated that the ultrasound results showed that Resident she had a hematoma in the right flank/hip and abdominal area. A progress note on January 11, 2026, at 8:01 AM indicated that Resident CR1 was sent to the emergency room. Review of the emergency room documentation dated January 11, 2026, revealed that she had a large bruise to her right abdomen and hip that staff at the nursing facility noted a few days ago. The report also indicated that they use a gait belt to assist Resident CR1 and are unsure if it is from that. The clinical impression specified in the emergency documentation, of the area was noted as a hematoma. The facility was unable to provide any information indicating that they investigated the cause of the hematoma on Resident CR1's right flank/hip and abdominal area to rule out abuse. Interview with the Director of Nursing and the Nursing Home Administrator on January 22, 2026, at 11:30 AM revealed that they did not report or more thoroughly investigate the above noted events because they did not feel they was any allegation of abuse. Closed clinical record review for Resident CR2 revealed an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], that assessed Resident CR2 as frequently incontinent of both bowel and bladder and that she was dependent on staff for personal and toileting hygiene. Nursing documentation dated November 10, 2025, at 4:34 PM revealed that Resident CR2's granddaughter informed the nurse that no nurse aide staff had been in the room all day to do care. Per the nurse's documentation, a nurse aide went into the room at approximately 2:10 PM (no indication of staff providing care earlier that day) and was refused entry to provide care by Resident CR2's granddaughter. When the nurse aide returned to provide care after the granddaughter's report, Resident CR2 was noted to be, .soaked from incontinence through the sheets and the bed pads. Interview with the Nursing Home Administrator on January 22, 2026, at 2:35 PM revealed that the facility did not identify the report from Resident CR2's granddaughter (no care all day) as an allegation of neglect, did not obtain statements from staff who provided (or attempted to provide) care on the day in question to rule out the potential for resident neglect, and did not report the allegation to the appropriate agencies (e.g., the local field office for the Department of Health). The facility failed to report and thoroughly investigate allegations of abuse and neglect as noted above for Residents CR1 and CR2. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.29(a)(c) Resident rights |