STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395418	A. Building B. Wing	03/22/2024

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19719 Based on clinical record review and staff interview, it was determined that the facility failed to establish clear and consistent resident's wishes regarding advance directives for two of three residents reviewed (Residents 26 and 32). Findings include: Review of Resident 32's clinical record revealed that the facility admitted her on February 11, 2024. Review of a POLST (Physician Orders for Life Sustaining Treatment, a document for specific medical orders to be honored by health care workers during a medical crisis) form signed by Resident 32's responsible party on February 13, 2024, indicated that he wished for Resident 32 to have full treatment, including CPR (cardiopulmonary resuscitation). A physician's order dated February 14, 2024, indicated that Resident 32 was a DNR (Do Not Resuscitate, not to perform cardiopulmonary resuscitation if breathing stops). There was no documented evidence in Resident 32's clinical record to indicate she or her responsible party's advance directive (written instruction, such as a living will or durable power of attorney, relating to the provision of healthcare, for a time when a resident may be incapacitated and not able to make decisions) wishes changed. Resident 32 continued to be a DNR until [DATE], when the facility identified the issue during the on-site survey and corrected the physician's order. Interview with the Director of Nursing on [DATE], at 10:45 AM confirmed the above findings for Resident 32. Review of Resident 26's electronic clinical record revealed an active physician's order dated [DATE], that instructed staff to provide full code treatment. The order included that there were no directions specified for the order. Review of a POLST initialed by Resident 26's physician (with an indecipherable date of signature) and signed by Resident 26's son, indicated treatment wishes included full code treatment; however, limited interventions to refuse intubation (DNI, do not insert a tube into the airway to help with breathing). The registered nurse signed this document on February 16, 2019. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the DNI omission from Resident 26's electronic physician orders during an interview with the Director of Nursing and the Nursing Home Administrator on [DATE], at 2:00 PM. Resident 26's physician order was revised on [DATE] (following the surveyor's questioning) to, Full Code - DNI. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a) Resident rights

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 19719 Based on clinical record review, review of select policies and procedures, and staff interview, it was determined that the facility failed to initiate their abuse policy and thoroughly investigate incidents to rule out the potential for abuse for one of two residents reviewed (Resident 64). Findings include: The policy entitled Abuse Investigation and Reporting, last reviewed on November 17, 2023, indicates that if an incident, suspected incident, or resident abuse is reported, the Administrator will assign the investigation to an appropriate individual. The individual conducting the investigation will review the residents medical record to determine events leading up to the incident, interview the person reporting the incident, and interview any witnesses to the incident. Witness reports will be obtained in writing. Either the witness will write his or her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him or her sign and date it. Review of Resident 64's clinical record revealed nursing documentation dated January 4, 2024, at 10:11 PM that indicated Resident 64 rubbed a female residents butt two times. Nursing staff told him not to do that, and Resident 64 was noted to look at staff and laugh. Interview with Employee 3, licensed practical nurse, on March 21, 2024, at 1:49 PM revealed that she was the nurse who wrote the documentation about Resident 64 on January 4, 2024. Employee 3 indicated that she was not the staff member who witnessed the event. There was no documented evidence that the facility interviewed the staff member who witnessed the event, nor obtained a signed statement. There was no evidence to indicate the facility completed a thorough investigation to rule out resident to resident sexual abuse. Nursing documentation dated February 23, 2024, at 2:54 PM indicated that Resident 64 was found holding on to a females arm and mouth kissing her. The nursing documentation then indicated that a few moments later Resident 64 was blocking the same female from leaving her bathroom. Interview with Employee 3 on March 21, 2024, at 1:49 PM revealed that she was the nurse who wrote the documentation about Resident 64 on February 23, 2024. Employee 3 indicated that she was not the staff member who witnessed the event. There was no documented evidence that the facility interviewed the staff member who witnessed the event, nor obtained a signed statement. There was no evidence to indicate the facility completed a thorough investigation to rule out resident to resident sexual abuse. Interview with the Administrator and Director of Nursing on March 21, 2024, at 2:15 PM acknowledged the above findings for Resident 64. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights

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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. 44738 Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding bowel protocol medication administration for two of two residents reviewed (Residents 43 and 77) and regarding the use of a cardiac pacemaker for one of one resident reviewed with a pacemaker (Resident 26). Findings include: Clinical record review for Resident 43 revealed a current care plan that noted bowel/bladder elimination alteration and constipation related to immobility and medications. Some interventions included: Administer medications per physician order, bowel protocol as needed; report bowel movements and report abnormalities; and report signs and symptoms of constipation such as abdominal cramping, diarrhea, nausea/vomiting, no bowel movement for three days. Clinical record review for Resident 43 revealed the following physician orders to promote bowel movements: Milk of Magnesia Suspension 400 mg (milligrams) per 5 ml (milliliters) (MOM, laxative that pulls water into bowel to soften bowel contents) Give 30 ml by mouth as needed (PRN) and administer if no bowel movement by the third day (nine shifts) and document effectiveness. Dulcolax suppository (Bisacodyl, a laxative medication used to relieve constipation) insert one suppository rectally as needed for constipation for no bowel movement within 24 hours after administration of Milk of Magnesia. Fleet's Enema 7-19 gm (grams) per 118 ml (Sodium Phosphates, liquid medication inserted into the rectum to treat constipation) Insert 1 applicatorful rectally for no bowel movement by the end of the following shift after administration of suppository. Review of bowel elimination records for Resident 43 revealed that staff documented no bowel movements for February 20, 21, 22, 23, and 24, 2024. There was no indication that staff offered (as per the physician orders and bowel management protocol), or Resident 43 refused, any PRN medications. Clinical record review for Resident 77 revealed the following physician orders to promote bowel movements: Milk of Magnesia Suspension 400 mg per 5 ml, give 30 ml by mouth as needed (PRN) and administer if no bowel movement by the third day (nine shifts) and document effectiveness. Dulcolax suppository insert one suppository rectally as needed for constipation for no bowel movement within 24 hours after administration of Milk of Magnesia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fleet's Enema 7-19 gm per 118 ml, insert 1 applicatorful rectally for no bowel movement by the end of the following shift after administration of suppository. Notify the physician if ineffective. Review of bowel elimination records for Resident 77 revealed that staff documented no bowel movements for March 3, 4, 5, 6, 7, 8, 9, 2024. There was no indication that staff offered (as per the physician orders and bowel management protocol), or Resident 77 refused, any PRN medications. The above information for Residents 43 and 77 was confirmed in a meeting with the Nursing Home Administrator and Director of Nursing on March 22, 2024, at 12:30 PM. Clinical record review for Resident 26 revealed an active physician order dated March 5, 2024, that indicated Resident 26 had a cardiac pacemaker (medical device implanted in the chest with wires connected to portions of the heart for the purpose of an electrical stimulation of a heartbeat); and that staff were to follow pacemaker checks per the cardiology schedule. There were no additional directions specified for the order. A plan of care initiated by the facility on February 16, 2019, identified Resident 26 had cardiac disease and required pacemaker checks as ordered. Neither the plan of care or physician orders stipulated the type of pacemaker, the method of pacemaker checks (e.g., in-person cardiac clinic assessments versus bedside monitoring device, etc.), or emergency procedures to follow in the event of outages of power, cell phone, or internet. Progress note documentation by the consulting cardiology provider dated May 11, 2023, indicated that Resident 26 had complete heart block (the most serious type of heart block, where there's a complete separation of electrical activity between the upper and lower chambers of the heart; it can be fatal if not treated with a pacemaker or other methods) and a dual chamber pacemaker (connects to both the upper and lower chambers of the heart and regulates the pace of contractions). The surveyor requested that the facility provide information regarding the type of Resident 26's pacemaker and the method of her pacemaker checks during interviews with the Nursing Home Administrator and the Director of Nursing on March 21, 2024, at 1:45 PM, and March 22, 2024, at 12:20 PM. Nursing documentation dated March 22, 2024, at 12:48 PM revealed that staff checked Resident 26's room and noted Medtronic pacemaker equipment on her bedside table, plugged in, and functional for automatic pacemaker check transmissions. Review of the Medtronic MyCareLink Patient Monitor manual provided with Resident 26's equipment indicated that the monitor is designed to automatically gather information from the implanted heart device. The monitor must remain plugged in to a power outlet; and that heart device information is sent to the Medtronic CareLink Network using the cellular phone network. Use of the equipment adjacent to or stacked with other equipment should be avoided because it could result in improper operation (e.g., within 6.5 feet of a television, computer monitor/screen, mobile phones, cordless telephones). When choosing a place to set up the monitor, consider a location that receives adequate cellular signal and near the sleeping area (up to 10 feet away). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on March 22, 2024, at 12:51 PM confirmed that Resident 26 had a pacemaker monitoring machine that performed continuous monitoring that would notify the cardiology office of an arrythmia (abnormal heart rhythm) in real time. The Director of Nursing did not know if the communication between Resident 26, the monitor, and the cardiology office was dependent on Bluetooth technology, Wi-Fi connection, landline telephone service, or cellular telephone service. The interview confirmed that this information was not part of Resident 26's plan of care; therefore, Resident 26's plan of care did not include procedures to follow in the event of utility outages. 28 Pa. Code 211.12(d)(1)(3)(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. 29512 Based on observation, clinical record review, review of facility documentation, and staff and a resident's family interview, it was determined that the facility failed to implement interventions to prevent falls and/or injuries for one of seven residents reviewed for falls (Resident 57) and failed to prevent a potential accident hazard at the facility's main entrance. Findings include: Clinical record review for Resident 57 revealed a current physician's order for staff to apply a sensor pad alarm to her chair and check the placement and function every shift for safety. Observation of Resident 57 on March 19, 2024, at 12:38 PM and March 20, 2024, at 12:10 PM revealed that she was in her recliner and her chair alarm was placed on her wheelchair: Concurrent interviews during each date and time with Resident 57's family confirmed the observations. Review of the facility's after-hours entrance procedure indicated that the front main entrance door is open from 5:00 AM to 9:00 PM. Observation of the front main entrance lobby on March 22, 2024, at 8:40 AM revealed no staff within visualization of the front doors; and the doors were unsecured. Resident rooms and a main dining room were within visualization of the front lobby. Interview with the Nursing Home Administrator on March 22, 2024, at 8:42 AM confirmed that the facility did not have a receptionist or staff assigned to monitor the unsecured front doors that led from the main lobby to the main parking lot and public road. Should a resident (who was not previously identified as an elopement risk) become acutely confused or agitated, that resident could exit the facility through the main door without staff knowledge between the hours of 5:00 AM and 9:00 PM unless staff happened to be in the area. Interview with the Nursing Home Administrator and the Director of Nursing on March 22, 2024, at 12:30 PM indicated that, following the surveyor's questioning, the facility practice would be to have a staff member present in the lobby when the doors are not secured. 483.25(d)(1)(2) Free Of Accident Hazards/supervision/devices Previously cited 4/21/23 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 20725 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the appropriate physician ordered enteral nutrition for one of one resident reviewed for tube feeding concerns (Resident 27). Findings include: Clinical record review for Resident 27 revealed an active physician's order dated January 14, 2023, that instructed staff to provide enteral feeding (provision of food and fluids via the gastrointestinal tract, e.g., directly into the stomach, not through the mouth) of Isosource 1.5, 65 ml (milliliters) continuously with 250 ml water every six hours. An active physician's order dated January 26, 2023, instructed staff to clear the feeding pump and document the amount given for both water and feeding every shift. Observation of Resident 27 on March 19, 2024, at 1:29 PM revealed Isosource 1.5 liquid nutrition infusing via a pump set at a rate of 65 ml per hour and a stop setting at 520 ml. A bag of water was also attached to the pump system. Observation of Resident 27 on March 21, 2024, at 3:21 PM with Employee 3 (licensed practical nurse) verified that Isosource 1.5 liquid nutrition infused at a rate of 65 ml per hour. Employee 3 explained that the pump settings would allow 520 ml of liquid nutrition to infuse and then automatically initiate the water flush until 250 ml of water infused. The pump would then shut off, alarm for staff attention, and staff would reset the liquid nutrition infusion. Employee 3 stated that she typically must clear and reset the pump settings at the beginning of her shift and at the end of her shift (in approximately eight hours). Employee 3 confirmed that 520 ml of liquid nutrition would not infuse until eight hours have elapsed (65 ml for eight hours equaled 520 ml); therefore, the automatic flush would not initiate until eight hours have elapsed. Employee 3 verified that the active physician orders for Resident 27 instruct staff to ensure that he received 250 ml of water every six hours. Clinical record review for Resident 27 revealed a revision dated March 21, 2024 (following the surveyor's questioning) that changed the active physician order for Resident 27's enteral feeding to now instruct staff to clear the feeding pump and document the amount given for both water and feeding every shift; infuse Isosource at 390 ml every six hours (65 ml for six hours equaled 390 ml) and water at 250 ml every six hours. Review of Resident 27's treatment administration record (TAR, electronic documentation of the provision of treatments) dated March 2024 revealed that staff documented that they provided 520 ml of feeding and 250 ml of water every shift (three times a day) from March 1, 2024, through the first shift of March 21, 2024. Staff began to document 390 ml of feeding and 250 ml of water on the evening shift of March 21, 2024. The facility failed to provide evidence that Resident 27 received 250 ml of water every six hours per the physician's order until after the surveyor's questioning. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 20725 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to administer supplemental oxygen as prescribed by the physician for one of one resident reviewed for oxygen concerns (Resident 27). Findings include: Clinical record review for Resident 27 revealed an active physician's order dated January 12, 2023, that instructed staff to administer supplement oxygen via a nasal cannula (NC, flexible tubing with small prongs at one end inserted into the nostrils for the application of supplemental oxygen) at three liters per minute (3 l/m). Observation of Resident 27 on March 19, 2024, at 1:37 PM revealed the application of supplemental oxygen via a NC and room oxygen concentrator (medical device used to concentrate the oxygen available in room air to administer oxygen-enriched supply back to the resident). The administration setting on the room concentrator was two liters per minute (2 l/m). Observation of Resident 27 on March 21, 2024, at 3:02 PM again revealed the application of supplemental oxygen via a NC and room concentrator at a rate of 2 l/m. Interview with Employee 2 (nurse aide) on the date and time of the observation confirmed the concentrator setting of 2 l/m. Observation of Resident 27 on March 21, 2024, at 3:21 PM with Employee 3 (licensed practical nurse) confirmed the oxygen concentrator setting of 2 l/m when the current physician orders instructed staff to administer the supplemental oxygen at 3 l/m. 483.25(i) Respiratory/tracheostomy Care and Suctioning Previously cited deficiency 4/21/23 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 19719 Based on clinical record review and staff interview, it was determined that the facility failed to ensure necessary behavioral health treatments were initiated for one of one resident reviewed (Resident 64). Findings include: Review of Resident 64's clinical record from August 9, 2023, until October 24, 2023, revealed multiple documented behaviors including holding on to a females arm tightly and rubbing it, rubbing females backs, pulling fire alarms, cornering females, and not letting them pass, inappropriate sexual behaviors, wanting females to sit on his lap, and following females around the facility. Review of a psychiatric evaluation dated October 24, 2023, indicated a new order for Resident 64 to start Prozac (used to treat some mood disorders) 10 mg (milligrams) every day. The new order for Prozac was noted by nursing staff on October 30, 2023, but never added to Resident 64's medication regimen until November 23, 2023, a month after it was ordered. Interview with the Director of Nursing on March 21, 2024, at 2:15 PM, confirmed the above findings for Resident 64. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 44738 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure a medication error rate of less than five percent (Resident 45). Findings include: The facility's medication error rate was 5.56 percent based on 36 medication opportunities with two medication errors. Observation of Resident 45's medication administration pass on March 22, 2024, at 9:15 AM revealed Employee 1, licensed practical nurse, prepared the resident's medications prior to administration. Employee 1 proceeded to open the medication capsules and pour the contents into a medication administration cup. Employee 1 mixed the contents with applesauce and then administered the medications to the resident. Clinical record review for Resident 45 revealed a current physician's order to administer Tolterodine Tartrate ER (extended release) capsule (a medication used to treat an overactive bladder) 4 milligrams one time a day. The instructions on the medication package provided by the pharmacy instructed to swallow whole and do not crush or chew. An interview with Employee 1 on March 22, 2024, at 10:00 AM confirmed she opened the capsule prior to administration. Clinical record review for Resident 45 revealed a current physician's order to administer Trelegy Ellipta Inhalation Aerosol Powder Breath Activated (a medication used to treat certain breathing disorders) 100-62.5-25 micrograms/activation (Fluticasone-Umeclidinium-Vilanterol); administer one puff and inhale orally one time a day. The order instructed to rinse the mouth with water and spit after use. A review of the manufacturer's instructions for the Trelegy offers step by step directions on use that instructed to, Rinse your mouth with water after you have used the inhaler and spit the water out. Do not swallow the water. Employee 1 administered the Trelegy inhaler to Resident 45 and immediately after administration the resident took a drink and swallowed the liquid. Employee 1 then administered the remaining resident medications. The resident did not rinse her mouth with water and spit after use of the inhaler as the physician order directed immediately following administration of the inhaler. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 22, 2023, at 12:35 PM. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 29512 Based on review of select facility policies, observations, and staff and resident family interviews, it was determined that the facility failed to ensure safe and sanitary storage and handling of personal food products brought in from outside sources for one of two nursing units. (200 Nursing Unit, Resident 57). Findings Include: Review of Facility Policy: Foods Brought by Family/Visitors, last reviewed without changes on November 17, 2023, revealed that the facility will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. Facility staff will discard perishable foods on or before the use by date. Nursing and/or food service staff will discard any food any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). Observation of Resident 57's room on March 19, 2024, at 12:39 PM revealed that she had a personal refrigerator. The temperature monitoring log was dated April 2023, and completed through April 21, 2023. There was no current temperature monitoring log for Resident 57's refrigerator. Inside Resident 57's refrigerator was a bottle of opened ranch dressing with a use by date of November 24, 2022, two cartons of single serve lemonade with a use by date of March 15, 2024, and a single serve cheese stick with a use by date of July 26, 2023. Inside Resident 57's freezer area of the refrigerator there was 1.5 inches of ice incasing two single serve containers of ice cream with an unknown use by date due to being unable to remove them from the freezer area. On top of Resident 57's refrigerator there were two undated squares of homemade peanut butter fudge that was dried and hard. Resident 57's family member confirmed the observation. Observation of Resident 57's refrigerator on March 22, 2024, at 9:34 AM with the Director of Nursing (DON) revealed that there was an open container of butter with a use by date of September 28, 2023. On Resident 57's wheelchair there was a container of snacks including a bag of peanuts with a use by date of July 23, 2023. The DON confirmed the observations. 28 Pa. Code 201.18(b)(1) Management