

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2025
NAME OF PROVIDER OR SUPPLIER  Brookline Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  2 Manor Boulevard 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</b></p> <p>Based on observation and resident and staff interview, it was determined that the facility failed to provide a reasonable accommodation of needs in response to call bell activations for one of two nursing units observed (Unit 2; Residents 14 and 57).</p> <p>Findings include:</p> <p>Clinical record review for Resident 57 revealed a diagnosis list that included dementia (a loss of cognitive function that is caused by the permanent damage or death of the brain's nerve cells, or neurons). Resident 57's annual Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated January 14, 2025, noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 15, which indicated no cognitive impairment.</p> <p>An interview with Resident 57 on March 18, 2025, at 11:31 AM revealed he was sitting in a chair next to the bed. The resident reported concerns that staff do not answer the call bell activations timely and sometimes take an hour or longer to respond and this occurs all the time.</p> <p>Clinical record review for Resident 14 (Resident 57's roommate) revealed a significant change MDS dated [DATE], that noted a BIMS of 13.</p> <p>Nursing documentation for Resident 14 dated March 9, 2025, at 1:31 PM revealed Resident noted with cognitive decline.</p> <p>An attempted interview with Resident 14 on March 18, 2025, at 11:40 AM revealed the resident was asleep and unable to be interviewed.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on March 20, 2025, at 2:00 PM revealed the facility can review call bell logs; however, the logs are not specific to the resident and account for the entire room.</p> <p>A review of the facility documentation titled Room Event Report, for Residents 14 and 57 revealed the following call bell activation dates/times with an elapsed time greater than 20 minutes:</p> <p>March 7, 2025, at 2:16 PM; elapsed time 20 minutes, 33 seconds</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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>March 8, 2025, at 8:14 PM; elapsed time one hour, 16 minutes, 48 seconds</p> <p>March 9, 2025, at 10:14 AM; elapsed time 47 minutes, 55 seconds</p> <p>March 9, 2025, at 11:08 AM; elapsed time 23 minutes, eight seconds</p> <p>March 9, 2025, at 7:25 PM; elapsed time 29 minutes, 15 seconds</p> <p>March 9, 2025, at 8:25 PM; elapsed time 54 minutes, 46 seconds</p> <p>March 10, 2025, at 5:23 AM; elapsed time 20 minutes, 24 seconds</p> <p>March 10, 2025, at 9:28 AM; elapsed time 46 minutes, 15 seconds</p> <p>March 10, 2025, at 10:42 AM; elapsed time 52 minutes, 29 seconds</p> <p>March 10, 2025, at 12:44 PM; elapsed time one hour, eight minutes, 53 seconds</p> <p>March 11, 2025, at 5:29 PM; elapsed time 38 minutes and 27 seconds</p> <p>March 12, 2025, at 6:03 AM; elapsed time one hour, 11 minutes, 52 seconds</p> <p>March 12, 2025, at 8:35 AM; elapsed time one hour, nine minutes, seven seconds</p> <p>March 13, 2025, at 6:17 AM; elapsed time 44 minutes and 59 seconds</p> <p>March 13, 2025, at 9:54 AM; elapsed time one hour, 40 minutes, three seconds</p> <p>March 13, 2025, at 8:15 PM; elapsed time one hour, 12 minutes, 32 seconds</p> <p>March 14, 2025, at 8:52 AM; elapsed time one hour, 28 minutes, 29 seconds</p> <p>March 14, 2025, at 4:54 PM; elapsed time 21 minutes, 43 seconds</p> <p>March 15, 2025, at 12:35 PM; elapsed time one hour, 41 minutes, 26 seconds</p> <p>March 15, 2025, at 6:19 PM; elapsed time one hour, 34 minutes, 35 seconds</p> <p>March 15, 2025, at 8:02 PM; elapsed time 41 minutes, 31 seconds</p> <p>March 16, 2025, at 6:35 AM; elapsed time 23 minutes, and five seconds</p> <p>March 16, 2025, at 8:38 AM; elapsed time 23 minutes, 13 seconds</p> <p>March 16, 2025, at 10:46 AM; elapsed time 33 minutes, 44 seconds</p> <p>March 16, 2025, at 1:10 PM; elapsed time one hour, 27 minutes, six seconds</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>29512</p> <p>Based on observation and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, safe, and orderly environment on one of two nursing units (Unit 3; Residents 51 and 73).</p> <p>Findings include:</p> <p>Observation of the Unit 3 Nursing Unit on the following dates and times revealed the following:</p> <p>On March 18, 2025, at 1:54 PM the drywall was marred behind Resident 51's head of the bed and their recliner.</p> <p>On March 18, 2025, at 2:24 PM the drywall was marred behind Resident 73's head of the bed.</p> <p>The above information was reviewed during an interview with the Nursing Home Administrator and Director of Nursing on March 20, 2025, at 2:00 PM.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to notify a resident and/or their responsible party in writing of a transfer to the hospital with the required information for four of five residents reviewed (Residents 11, 39, 48, and 70).</p> <p>Findings include:</p> <p>Clinical record review for Resident 11 revealed that they were transferred to the hospital on March 17, 2025, after a change in their condition. There was no documentation that the facility provided written notification to the resident or the resident's responsible party regarding the transfer that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred, a statement of the resident's right to appeal, including the name, contact, email, and address, how to obtain and appeal form, assistance completing and submitting the appeal form and hearing request, and contact, email, and address information for the Office of the State Long-Term Care Ombudsman, and information for the agency responsible for the protection and advocacy of individuals with developmental disabilities.</p> <p>The above information was reviewed during an interview with the Nursing Home Administrator and Director of Nursing on March 21, 2025, at 9:10 AM.</p> <p>Clinical record review for Resident 39 revealed she was transferred to the hospital from January 24 to 31, 2025, January 10 to 21, 2025, and December 9 to 16, 2024. There was no evidence to indicate that Resident 39's responsible party was provided written notification to include the above-required contents.</p> <p>Clinical record review for Resident 48 revealed that he was transferred to the hospital from February 3 to 7, 2025. There was no evidence to indicate that Resident 48's responsible party was provided written notification to include the above-required contents.</p> <p>Clinical record review for Resident 70 revealed she was transferred to the hospital from March 5 to 7, 2025. There was no evidence to indicate that Resident 70's responsible party was provided written notification to include the above-required contents.</p> <p>The Nursing Home Administrator and the Director of Nursing confirmed the above noted findings regarding transfer notices for Residents 39, 48, and 70 during an interview on March 21, 2025, at 10:24 AM.</p> <p>28 Pa. Code 201.14 (a) Responsibility of license</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident or resident representative received written notice of the facility bed hold policy at the time of transfer for two of five residents reviewed for hospitalization s (Residents 11 and 70).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 11 was transferred to the hospital on March 17, 2025, after they had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and the resident's responsible party upon transfer out to the hospital.</p> <p>The above information was reviewed during an interview with the Nursing Home Administrator and Director of Nursing on March 21, 2025, at 9:10 AM.</p> <p>Clinical record review revealed that Resident 70 was transferred to the hospital on March 5, 2025, after she had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and the resident's responsible party upon transfer out to the hospital.</p> <p>The above information for Resident 70 was reviewed during an interview with the Nursing Home Administrator and the Director of Nursing on March 21, 2025, at 10:24 AM. They confirmed the facility had no further documentation indicating Resident 70's representative received written notice of the facility bed hold policy at the time of transfer.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.29(f) Resident rights</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18229</p> <p>Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to provide appropriate treatment and services to promote bladder continence for one of one resident reviewed for incontinence (Resident 31).</p> <p>Findings include:</p> <p>The policy entitled Urinary Continence and Incontinence- Assessment and Management, last reviewed on November 16, 2024, indicates as part of the initial and ongoing resident assessments, the nursing staff and physician will screen residents for information related to urinary incontinence. As part of the facility's assessment, nursing staff will seek and document details related to continence (relevant details include voiding patterns, associated pain or discomfort, and types of incontinence). The nursing staff and physician will identify risk factors for becoming incontinent, or for worsening of the resident's current incontinence. The evaluation will include a review for medications that might affect continence. The staff and physician will summarize the individual's continence status. The staff and physician will identify residents with complications of existing incontinence, or who have risk for such complications. The physician and staff will also address treatable causes, or contributing factors related to urinary incontinence. If the resident remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. The staff will document the results of the toileting trial in the resident's medical record. The staff and physician will evaluate the effectiveness of interventions, and implement additional pertinent interventions as indicated.</p> <p>Review of Resident 31's clinical record revealed a Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated February 8, 2025, that indicated that the facility assessed him as being frequently incontinent of bladder, and that a urinary toileting program has not been attempted. The facility also assessed Resident 31 using a BIMS (brief interview for mental status) assessment, with a score of 15 (cognitively intact), and as being able to understand others, be understood, and having adequate vision and hearing. The MDS dated [DATE], also indicated that the facility assessed Resident 31 as requiring extensive assistance of two staff for toileting.</p> <p>There was no documented evidence in Resident 31's clinical record to indicate that the facility's physician or nursing staff assessed Resident 31 to determine the type of urinary incontinence, or to develop an individualized toileting program or plan of care.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on March 21, 2025, at 10:30 AM confirmed the above findings for Resident 31.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>44738</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to store supplemental oxygen equipment per professional standards of practice for one of one resident reviewed (Resident 19).</p> <p>Findings include:</p> <p>Clinical record review for Resident 19 revealed a diagnosis list that included acute and chronic respiratory failure (a condition that makes it difficult to breathe) with hypercapnia (elevated levels of carbon dioxide in the blood), chronic obstructive pulmonary disease (COPD, a lung disease that causes inflammation and restricted air flow into and out of the lungs), acute and chronic respiratory failure with hypoxia (low oxygen levels in the body), and pulmonary embolism (a blood clot in the lungs).</p> <p>Current physician orders for Resident 19 revealed an order dated September 17, 2024, for supplemental oxygen at five liters per minute (LPM) via nasal cannula (medical tubing that delivers supplemental oxygen to the nose) every shift to maintain pulse ox (pulse oximeter; a non-invasive measure of the body's oxygen level) greater than 90 percent.</p> <p>A review of the current care plan for Resident 19 revealed the resident is at risk for respiratory impairment due to the medical history.</p> <p>Observation of a wheelchair outside of Resident 19's room on March 18, 2025, at 1:02 PM and 2:25 PM; and March 19, 2025, at 12:10 PM revealed a nasal cannula attached to a portable supplemental oxygen cylinder. The nasal cannula was stuffed into the back canvas storage area of the backrest of the wheelchair. There were also two footrests for the wheelchair in this storage area. The nasal cannula tubing was not protected from contamination from the ambient environment or the footrests in the same storage compartment.</p> <p>An interview with Employee 5, registered nurse unit manager, on March 19, 2025, at 12:10 PM revealed the wheelchair belonged to Resident 19 and the findings were reviewed with Employee 5.</p> <p>The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 19, 2025, at 1:45 PM.</p> <p>483.25(i) Respiratory/tracheostomy Care and Suctioning</p> <p>Previously cited deficiency 3/22/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>29512</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to assess for the risk of side rail entrapment for one of three residents reviewed for accident hazards (Resident 72).</p> <p>Findings include:</p> <p>Observation of Resident 72's room on March 18, 2025, at 2:02 PM revealed that there was a left one-quarter side rail observed on the bed.</p> <p>Clinical record review for Resident 72 revealed that the facility completed a side rail assessment, review of potential risks, and obtained consent on February 7, 2025. The facility also completed a side rail entrapment evaluation on February 7, 2025, which revealed that the facility assessed zone six (between the end of the enabler device and the side of the headboard). There was no documentation that the facility assessed the risk for entrapment posed in zones one (within the rail), two (between the bottom of the rail and top of compressed mattress), three (between the edge of the mattress and inside of the rail, and four (between the top of the compressed mattress and the bottom of the rail at the end of the rail).</p> <p>The above information was reviewed during an interview with the Nursing Home Director and the Director of Nursing on March 20, 2025, at 2:00 PM.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by three of three residents reviewed (Residents 18, 55, and 61).</p> <p>Findings include:</p> <p>Clinical record review for Resident 18 revealed the facility admitted him on July 13, 2018. A diagnosis of dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) was added on October 3, 2022. A review of Resident 18's most recent annual Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated February 9, 2025, indicated that the facility assessed Resident 18 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 18's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>Clinical record review for Resident 55 revealed that the facility admitted her on May 15, 2022, with diagnoses including dementia. A review of Resident 55's most recent annual MDS dated [DATE], indicated that the facility assessed Resident 55 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 55's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>Clinical record review for Resident 61 revealed that the facility admitted her on May 27, 2023, with a dementia diagnosis added May 31, 2023. A review of Resident 61's most recent annual MDS dated [DATE], indicated that the facility assessed Resident 61 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 61's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>These findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on March 20, 2025, at 2:00 PM for Residents 18, 55, and 61.</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa Code 211.11(d) Resident care plan</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</b></p> <p>Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner, maintain equipment in a sanitary condition, and prepare food items in accordance with professional standards in the facility's main kitchen.</p> <p>Findings include:</p> <p>Initial tour of the facility's main kitchen with Employee 4, Dietary Manager, on [DATE], at 10:00 AM revealed the following:</p> <p>There was a large hole observed in the wall of the dishwashing area. Two wall tiles adjacent to the hole had fallen off the wall onto the ground.</p> <p>There was an extensive build-up of dust on the appliance that Employee 4 referred to as the air handler.</p> <p>A wall-mounted first aid kit held burn spray that expired in 2021 and eye wash that expired in 2023.</p> <p>A smaller pantry area located in the hallway outside of the main kitchen held hand wipes that expired in [DATE].</p> <p>The pantry area also held a bottled drink that Employee 4 reported was used for colonoscopy (an exam where a flexible medical device is inserted into the colon to assess for abnormalities) preps. This drink was being stored in the same area as commercial sanitizer/cleaner.</p> <p>A review of the food temperature logs for February 2025, with Employee 4 on [DATE], at 11:50 AM revealed the dates of February 19 and 26 had no dinner food temperatures documented as assessed by kitchen staff.</p> <p>The findings were reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on [DATE], at 2:00 PM.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2025
NAME OF PROVIDER OR SUPPLIER  Brookline Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  2 Manor Boulevard 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>18229</p> <p>Based on review of employee education records and staff interview, it was determined that the facility failed to ensure that nurse aides received 12 hours of in-service training annually for three of three nurse aides reviewed (Employees 1, 2, and 3).</p> <p>Findings include:</p> <p>During a meeting with the Nursing Home Administrator and Director of Nursing on March 20, 2025, at 2:00 PM the surveyor asked for training records to indicate that nurse aides had received at least 12 hours of in-service training in the last year for Employees 1, 2, and 3 (nurse aides).</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on March 21, 2025, at 10:55 AM confirmed there was no documented evidence that the above employees received the required 12 hours of annual in-service training.</p> <p>28 Pa. Code 201.19 (7) Personnel policies and procedures</p>