

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/27/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain equipment in a sanitary condition in the facility's main kitchen. Findings include: Initial tour of the facility's main kitchen with Employee 5, dietary manager, on February 24, 2026, at 10:20 AM revealed the following: Shelves in a cupboard that held drink pitchers adjacent to the food preparation sink were flaking and/or peeling. A large white pipe going into the ceiling near a corner of the kitchen had an accumulation of black-colored dust around it. The wall behind the refrigerators that held tray carts had an accumulation of dust on it. A baseball sized area of peeling paint on the ceiling above a food prep area. Two dry goods storage rooms contained a large gap surrounding the interior perimeter of the room where the ceiling meets the wall. Cobwebs were also observed in the area. The wall area behind the dishwasher had an accumulation of a black substance on the wall. The wall under the stainless-steel table to the right of the dishwashing machine had an accumulation of dried stains on it. Observation of an adjacent area (one foot by one foot) where pipes extend from the wall to a sink revealed a large open area on the wall exposing the wall joists and pieces of insulation. Observation on February 24, 2026, at 10:25 AM revealed the dishwasher was not in use. A manufacturer placard located adjacent to the temperature monitoring gauge noted the required operating wash temperature as a minimum of 155 degrees Fahrenheit. Concurrent observation of the dishwasher through several cycles revealed that the dishwasher temperature monitoring gauge only reached a maximum temperature of 152 degrees Fahrenheit during the wash cycle and not the minimum 155 degrees as specified by the placard. Observation on February 26, 2026, at 10:06 AM with Employee 5 revealed that the dishwasher was in use by two staff members. Two observations of the dishwasher cycle revealed that the maximum temperature reached for the wash cycle was 150 degrees Fahrenheit and not the minimum 155 degrees as specified by the placard. A concurrent interview with Employee 5 revealed that the dishwasher was a hot water sanitizing dishwasher. A review of the facility documentation titled, Dishwasher Temperature Log dated February 2026, revealed that staff are to record temperatures three times daily (after breakfast, dinner, and supper). The staff documentation revealed that staff documented the temperature as below the minimum 155 degrees specified by the manufacturer placard on the following: February 7, 2026, supper; 150 degreesFebruary 10, 2026, supper; 150 degreesFebruary 14, 2026, supper; 150 degreesFebruary 15, 2026, supper; 150 degreesFebruary 16, 2026, breakfast and dinner; 152 degreesFebruary 17, 2026, breakfast and dinner; 150 degreesFebruary 18, 2026, breakfast; 150 degreesFebruary 19, 2026, breakfast; 152 degreesFebruary 19, 2026, supper; 150 degreesFebruary 20, 2026, supper; 150 degreesFebruary 21, 2026, supper; 150 degreesFebruary 22, 2026; supper; 150 degrees The above information for the dishwasher was reviewed in a meeting with the Nursing Home Administrator on February 26, 2026, at 10:15 AM. The above information about the kitchen was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 26, 2026, at 2:10 PM. 483.60(i)(1)-(2) Food safety requirementsPreviously cited deficiency 3/21/25 28 Pa. Code 201.14(a) Responsibility of licensee		

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to store indwelling urinary catheter equipment in a manner to prevent the potential for infection for one of one resident reviewed for catheter concerns (Resident 9). Findings include: Clinical record review for Resident 9 revealed that his diagnoses included urinary retention (inability of the bladder to empty completely after urination). Review of Resident 9's active physician orders revealed instructions for staff to change a Foley catheter (flexible tubing inserted through the penis into the bladder to drain urine) as needed for obstruction or dislodgement, and every thirty days for routine care of the indwelling urinary catheter. An active physician order instructed staff to place a leg bag (smaller urinary collection bag secured by straps onto the leg underneath clothing) on Resident 9 in the morning and a drainage bag (larger bag used to contain a larger amount of urine that is hung below the bladder on an item such as the side of the bed) for Resident 9 during hours of sleep. Observation of Resident 9 on February 24, 2026, at 3:26 PM revealed him in his wheelchair, fully clothed. Resident 9 stated that his Foley urine collection bag was underneath his clothing, secured to his leg. Observation of the storage of the larger urinary collection bag equipment that was not in use at the time on February 24, 2026, at 3:26 PM with Employee 1 (licensed practical nurse), revealed that the larger urine collection bag was stored in an open plastic bag that was tied to the toilet assist bar. The tubing connected to the larger urinary collection bag was not capped, which exposed the tip to potential contamination. The plastic bag containing the collection bag also contained a plastic graduate (container marked with units of measurement such as milliliters for accurate measurements of urinary output). Interview with Employee 1 at the time of the observation confirmed that Resident 9's roommate ambulates independently and utilizes the bathroom for his toileting needs. Interview with the Nursing Home Administrator and the Director of Nursing on February 25, 2026, at 2:00 PM indicated that the facility had no policy, procedure, or competency education materials that relayed to staff the appropriate storage of indwelling urinary catheter equipment to prevent potential contamination from the environment (e.g., ensure the ends of all tubing are capped, and store equipment outside the bathroom area where another resident/roommate could inadvertently contaminate the equipment) during non-use. The surveyor reviewed the above concerns regarding Resident 9's urinary catheter equipment storage during the interview. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review and staff interview it was determined that the facility failed to identify and monitor the medical symptoms that warranted the use of an antipsychotic medication and monitor for potential adverse consequences of antipsychotic medication use for one of five residents reviewed for potentially unnecessary medication (Resident 9). Findings include: Clinical record review for Resident 9 revealed active physician orders (dated January 9, 2026) for admission to the skilled care facility for diagnoses of: Major depressive disorder (persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems) PTSD (Post Traumatic Stress Disorder, thoughts, avoidance behaviors, negative changes in mood and cognition, and intrusive thoughts related to a traumatic event) Suicidal attempt CKD (chronic kidney disease, loss of the kidney(s)' ability to filter waste and excess fluid from the blood) Vascular dementia (decreased blood flow to the brain resulting in loss of memory and cognition) Progress note documentation from the facility's psychological services provider dated January 13, 2026, noted that Resident 9 was in the hospital after a suicide attempt (put call bell rope around his neck) due to losing his wife. Review of active physician orders for Resident 9 revealed instructions to administer Abilify (Aripiprazole, an antipsychotic medication that alters brain chemicals) 5 mg (milligrams) at bedtime from January 28, 2026, until decreased on February 24, 2026, to Aripiprazole 2.5 mg at bedtime. Resident 9's medication regime also included active physician orders for the following antidepressants: Mirtazapine 15 mg at bedtime Sertraline HCL (Zoloft) 150 mg daily The medication reference, Drugs.com, noted that important warnings for the use of Aripiprazole include that there is increased risk for mortality in elderly patients with dementia-related psychosis and suicidal thoughts and behaviors with antidepressant drugs. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Aripiprazole is not approved for the treatment of patients with dementia-related psychosis, suicidal thoughts, and behaviors. Closely monitor all antidepressant-treated patients for clinical worsening, and for emergence of suicidal thoughts and behaviors. Advise families and caregivers of the need for close observation and communication with the prescriber. The medication reference also noted potential physical symptoms while using Aripiprazole: convulsions (seizures), difficulty with breathing, a fast heartbeat, a high fever, high or low blood pressure, increased sweating, loss of bladder control, severe muscle stiffness, unusually pale skin, or tiredness. These could be symptoms of a serious condition called neuroleptic malignant syndrome (NMS). Resident 9's clinical record did not include evidence that the facility identified the traumatic event that precipitated his PTSD, identified potential triggers that could worsen the symptoms of the disorder, implemented ongoing tracking of his distressing target behaviors that warranted the use of the antipsychotic, or established non-medicinal behavioral interventions used to reduce or eliminate distressing target behaviors. Resident 9's clinical record also did not provide evidence that the facility monitored Resident 9's potential physical side effects from the use of the antipsychotic. Review of plans of care developed by the facility to address Resident 9's care needs and psychotropic medication use did not provide evidence of a plan of care to address his potential distressing behaviors or symptoms (e.g., hallucinations, aggression, self-harm, isolation, etc.). The surveyor reviewed the above concerns regarding inadequate monitoring and adequate indications for Resident 9's use of the antipsychotic medication during an interview with the Nursing Home Administrator and the Director of Nursing on February 26, 2026, at 10:50 AM. The facility initiated a plan of care following the surveyor's questioning (dated February 26, 2026) to address Resident 9's potential to exhibit behaviors that are a result of past trauma, which may impact moods or behaviors, including his suicide attempt on December 23, 2025. The facility also obtained a physician's order (dated February 26, 2026) to monitor potential side effects of antipsychotic medication use (e.g., blurred vision, dry mouth, drowsiness, muscle spasms or tremors, weight gain, hallucinations) every (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift, and a physician's order (dated February 26, 2026) to monitor potential socially inappropriate or disruptive behaviors (self-injury, pacing/wandering, screaming/yelling out, suicidal ideations, physically abusive behavior: hitting, kicking, pushing, biting, etc.) every shift. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, review of facility documentation, and staff interview it was determined that the facility failed to provide written notice of transfer to the resident representative for three of six residents reviewed (Residents 5, 9, and 12) and written notice of the facility bed-hold policy for two of six residents reviewed for hospitalization (Residents 9 and 12). Findings include: Clinical record review for Resident 5 revealed the resident had an emergency contact listed. Nursing documentation for Resident 5 dated December 16, 2025, at 9:36 AM revealed the resident had a change in condition and the licensed practical nurse (LPN) evaluated the resident. Nursing documentation for Resident 5 dated December 16, 2025, at 10:19 AM revealed that a message was left for the responsible party and son. Nursing documentation for Resident 5 dated December 16, 2025, at 10:45 AM revealed that EMS (emergency medical services) arrived and care was transferred to EMS. Nursing documentation for Resident 5 dated December 16, 2025, at 5:00 PM revealed that the resident was being admitted to the hospital for bilateral kidney stones. Facility documentation titled, Notice of Transfer or Discharge, dated December 16, 2025, noted the resident was transferred to the hospital due to the medical condition. The resident signed and dated the document on December 16, 2025. There was no evidence of any documentation that the resident representative was notified in writing as soon as it was practicable of Resident 5's transfer to the hospital. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on February 27, 2026, at 1:08 PM. Clinical record review for Resident 9 revealed profile information that listed a daughter and a son as potential resident representatives. Nursing documentation dated December 23, 2025, at 9:42 AM revealed that Resident 9 left the facility via emergency medical services transport due to a mental health crisis. Review of a Bed-Hold Notification form dated December 23, 2025, indicated that Resident 9 signed the notice on December 23, 2025. The section of the notice for the resident's responsible party (representative) signature was blank. Review of a Notice of Transfer or discharge date d December 23, 2025, indicated that Resident 9 signed the notice on December 23, 2025. There was no documentation on the notice to indicate that the facility ensured that either of Resident 9's designated resident representatives received a written copy of the notice. Interview with the Nursing Home Administrator and the Director of Nursing on February 26, 2026, at 2:00 PM confirmed that the facility had no evidence that Resident 9's resident representative received written notice of either the transfer or the bed-hold notices. Clinical record review for Resident 12 revealed profile information that listed an ex-wife as his first emergency contact and his daughter as his second emergency contact (potential resident representatives). Nursing documentation dated January 27, 2026, at 4:11 AM revealed that Resident 12 transferred out of the facility to the hospital for a surgical procedure. Nursing documentation dated February 6, 2026, at 5:12 PM indicated that Resident 12 returned to the facility following the surgical procedure. Review of a Bed-Hold Notification form dated January 27, 2026, indicated that Resident 12 signed the notice on January 27, 2026. The section of the notice for the resident's responsible party (representative) signature was blank. Review of a Notice of Transfer or discharge date d January 27, 2026, indicated that Resident 12 signed the notice on January 27, 2026. There was no documentation on the notice to indicate that the facility ensured that either of Resident 12's designated resident representatives received a written copy of the notice. Interview with the Nursing Home Administrator and the Director of Nursing on February 26, 2026, at 2:00 PM confirmed that the facility did not take measures to ensure Resident 12's representative received a written copy of either the Bed-Hold Notification or Notice of Transfer in response to his January 27, 2026, transfer to the hospital. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(a) Resident rights		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined that the facility failed to ensure an assessment accurately reflected the resident's status for one of 18 residents reviewed (Resident 9). Findings include: Clinical record review for Resident 9 revealed psychiatry progress note documentation dated [DATE], that Resident 9 was a military veteran and his wife died three weeks before the assessment. Diagnoses listed by the practitioner included PTSD (Post Traumatic Stress Disorder, thoughts, avoidance behaviors, negative changes in mood and cognition, and intrusive thoughts related to a traumatic event). An active physician's order dated [DATE], admitted Resident 9 to skilled care for diagnoses that included PTSD. Review of an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated [DATE], revealed that staff coded the MDS item for PTSD incorrectly as that Resident 9 did not have PTSD. Interview with the Director of Nursing on February 27, 2026, at 8:45 AM confirmed that staff failed to code Resident 9's admission MDS to include his PTSD diagnosis. 28 Pa. Code 211.12(d)(3)(5) Nursing services		

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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** Based on clinical record review and staff interview it was determined that the facility failed to develop and implement a comprehensive, person-centered, trauma-informed care plan to meet a resident's mental and psychosocial needs for one of 18 residents reviewed (Resident 9). Findings include: Clinical record review for Resident 9 revealed nursing documentation dated [DATE], at 9:42 AM that Resident 9 was noted in his bed with a cord around his neck. Resident stated that he wanted to get staff's attention, so he decided to wrap it around his neck. Resident 9 then started with paranoid thoughts and stated that his daughter killed his wife and shot her in the chest. He stated that, (acquaintances' surname) was also in on it to help cover it up. Resident 9 continued with paranoid thoughts on how his daughter killed his wife and, .wants to try and kill him so she can get his pension and get all of his money. Resident 9 left the topic of conversation easily and was noted with scattered thought processes. Resident 9 stated that he could easily wrap his hands around someone's neck and just, snap, it and no one would ever know. Resident 9 had paranoid thoughts of his wife marrying him because of money, and that his mother cheated on his father and had a baby. Resident 9 stated that, they threw the (ethnic description) baby into the river, because no one wanted the baby. Resident 9 was described as very distraught with expressions of how people go away to the war and women, .just do what they want and cheat on people. Clinical record review for Resident 9 revealed psychiatry progress note documentation dated [DATE], that Resident 9 was a military veteran and his wife died three weeks before the assessment. Diagnoses listed by the practitioner included PTSD (Post Traumatic Stress Disorder, thoughts, avoidance behaviors, negative changes in mood and cognition, and intrusive thoughts related to a traumatic event). An active physician's order dated [DATE], admitted Resident 9 to skilled care for diagnoses that included PTSD. Review of an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated [DATE], revealed that staff coded the MDS item for PTSD incorrectly as that Resident 9 did not have PTSD. Resident 9's clinical record did not include evidence that the facility identified the traumatic event that precipitated his PTSD, identified potential triggers that could worsen the symptoms of the disorder, implemented ongoing tracking of his distressing target behaviors, or established non-medicinal behavioral interventions used to reduce or eliminate distressing target behaviors. Review of plans of care developed by the facility to address Resident 9's care needs did not provide evidence of a plan of care to address his potential distressing behaviors or symptoms (e.g., hallucinations, aggression, self-harm, isolation, etc.). The surveyor reviewed the concern that the facility had not developed a plan of care for Resident 9's PTSD diagnosis during an interview with the Nursing Home Administrator and the Director of Nursing on February 26, 2026, at 10:50 AM. The facility initiated a plan of care following the surveyor's questioning (dated February 26, 2026) to address Resident 9's potential to exhibit behaviors that are a result of past trauma, which may impact moods or behaviors, including his suicide attempt on [DATE]. The facility also obtained a physician's order (dated February 26, 2026) to monitor potential side effects of antipsychotic medication use (e.g., blurred vision, dry mouth, drowsiness, muscle spasms or tremors, weight gain, hallucinations) every shift; and a physician's order (dated February 26, 2026) to monitor potential socially inappropriate or disruptive behaviors (self-injury, pacing/wandering, screaming/yelling out, suicidal ideations, physically abusive behavior: hitting, kicking, pushing, biting, etc.) every shift. Interview with the Director of Nursing on February 27, 2026, at 8:45 AM confirmed that staff failed to initiate a plan of care upon Resident 9's readmission to the facility following his in-patient psychiatric stay to incorporate his PTSD diagnosis, grief secondary to the recent death of his wife, and his suicide attempt. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical record review, observation, and staff and family interview, it was determined that the facility failed to ensure assistance with activities of daily living for a dependent resident for one of one resident reviewed for activities of daily living concerns (Resident 66). Findings include: Interview with Resident 66's daughter on February 24, 2026, at 11:15 AM revealed that she believed that her father's fingernails were long, that his hair was long, and that she was upset by how he looked during her visit on February 12, 2026. Review of a plan of care developed by the facility on December 11, 2025, to address Resident 66's self-care deficits with activities of daily living (ADL) revealed that Resident 66 was dependent on staff for showering/bathing and personal hygiene needs. Observation of Resident 66 on February 25, 2026, at 8:50 AM revealed that his hair was cut short. Resident 66 stated that he was on his way to the therapy department where he was going to shave. Interview with Resident 66 on February 25, 2026, at 9:12 AM indicated that the barber cut his hair that morning. Observation of Resident 66's fingernails revealed that they were long (several millimeters beyond the tips of his fingers), uneven, and the fingernail of his right ring finger was broken. Resident 66 stated that he needed to cut his fingernails, however, he confirmed that he did not have clippers to cut his fingernails. Interview with Employee 4 (nurse aide) on February 25, 2026, at 9:11 AM indicated that staff should trim a resident's nails with each shower, however, Employee 4 confirmed that it appeared that Resident 66 did not have his fingernails trimmed with his shower. Employee 4 asked Resident 66's permission to cut his fingernails at that time and Resident 66 offered no resistance to the care. Review of Documentation Survey Report (electronic documentation completed by nurse aide staff to record completed assistance with ADL care) information for Resident 66 revealed that he had a shower on January 7, 14, 21, and 28, 2026. Staff documented that a shower was, not applicable, on February 4, 2026, and that he only had a bed bath on February 11 and 15, 2026. Staff initialed the completion of a shower for Resident 66 on February 22, 2026 (three days before the observation of his fingernails documented above). Although the documentation indicated that Resident 66 was to shower every Sunday, staff only referenced bathing for Resident 66 on Wednesdays; and that he only received one shower between January 28, 2026, and February 22, 2026. The surveyor reviewed the above concerns regarding Resident 66's showers and nail care during an interview with the Nursing Home Administrator and the Director of Nursing on February 26, 2026, at 2:00 PM. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policy and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to provide respiratory care for non-invasive ventilation consistent with professional standards of practice and develop a comprehensive and person-centered care plan for one of two residents reviewed (Resident 5) and maintain respiratory related equipment supplies in a safe and sanitary manor in two of two dining rooms observed (main dining room and restorative dining room). Findings include: Review of the facility policy titled CPAP (continuous positive airway pressure)/BiPAP (bilevel positive airway pressure) Support, revealed preparation for use included, in part, reviewing the physician's order to determine the oxygen concentration and flow and the PEEP (positive end expiratory pressure). Further review of the policy included a section on documentation that noted, in part, that mode and settings for the device should be documented in the resident's medical record. Clinical record review for Resident 5 revealed a diagnosis list that included acute and chronic respiratory failure with hypercapnia (high levels of carbon dioxide in the blood) and obstructive sleep apnea (periods of breathing cessation during sleep). A review of current physician orders for Resident 5 revealed an order dated [DATE], for NIV (non-invasive ventilation) at night and with naps; make sure the machine is upright and not lying flat to prevent air intake from being blocked. There were no settings for the device in the physician order. A review of the February 2026 Treatment Administration Record (TAR) for Resident 5 revealed that staff were documenting the application of the device. A review of Resident 5's current care plan revealed that the resident was at risk for respiratory impairment related to the medical history. An intervention included NIV (CPAP) use per physician orders. The care plan did not address additional areas (i.e. settings, cleaning the device, resident assessment, and/or monitoring for complications). An interview with Employee 6, registered nurse, on February 26, 2026, at 10:05 AM revealed that the settings for the device should be located in the physician orders. Observation of the restorative dining room on February 26, 2026, at 9:40 AM revealed a suction unit on a countertop. The following packaged items kept with the suction were expired: connection tubing (expired February 1, 2024), connective tubing (expired [DATE]), and connection tubing 6' (expired [DATE]). Observation of the main dining room on February 26, 2026, at 9:55 AM revealed a suction unit on a countertop. The following packaged items kept with the suction were expired: connective tubing (expired [DATE]) and a yankauer suction tip (expired [DATE]). The Director of Nursing was notified of the expired items on February 26, 2026, at 10:05 AM. The above information for Resident 5 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 26, 2026, at 10:45 AM. 483.25(i) Respiratory/tracheostomy Care and Suctioning Previously cited deficiency [DATE] 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered pain medications and pain parameters for one of one resident reviewed for pain (Resident 3). Findings include: Clinical record review for Resident 3 revealed a diagnosis list that included pain in unspecified shoulder and myalgia (muscle pain). Resident 3's care plan revealed the resident has pain related to the medical history. An intervention included pain medications per physician orders. Review of the current physician orders for Resident 3 revealed the following medications for pain: Tramadol (a pain medication used to treat moderate to moderate severe pain) HCl oral tablet 50 milligrams (mg) give one tablet by mouth every four hours as needed for moderate to severe pain AND give one tablet by mouth two times a day for moderate to severe pain dated December 3, 2025, at 4:45 PM. Acetaminophen (Tylenol, a medication used to treat mild pain and reduce fever) tablet 325 mg give two tablets by mouth every four hours as needed for pain dated August 21, 2025, at 11:52 AM. The order did not specify the pain parameters for administration. Morphine Sulfate (an opioid medication used to treat moderate to severe pain) oral solution 20 mg/ml (milliliter) give 0.5 ml by mouth every one hour as needed for shortness of breath / pain dated February 24, 2026, at 11:30 AM. The order did not specify the pain parameters for administration. The above information for Resident 3 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 26, 2026, at 2:10 PM. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

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 02/27/2026
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)		
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure a resident received pneumococcal immunizations unless refused or clinically contraindicated for one of five residents reviewed for immunization concerns (Resident 12). Findings include: The facility policy entitled, Pneumococcal Vaccine, last reviewed without changes on November 20, 2025, revealed that all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. For residents who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. Clinical record review for Resident 12 revealed that he last refused a pneumococcal vaccine (Pneumovax 23) on November 16, 2018. Resident 12's clinical record contained no evidence that the facility offered Resident 12 a pneumococcal vaccine in the more than seven years after November 16, 2018. The surveyor requested any evidence of education provided to Resident 12 regarding the risks and benefits of pneumococcal vaccination administrations after November 2018 during an interview with the Director of Nursing on February 25, 2026, at 2:00 PM. Review of a Vaccination Consent Form, dated September 12, 2025 (provided after the surveyor's questioning), revealed an acknowledgement by Resident 12 that he understood the benefits and risks of a PCV20 (Prevnar 20 pneumococcal) vaccination, and that he requested that the vaccination be given to him. There was no evidence that the facility administered the PCV20 immunization to Resident 12. The surveyor reviewed the above concerns regarding Resident 12's pneumococcal vaccinations during an interview with the Director of Nursing on February 27, 2026, at 9:23 AM. 28 Pa. Code 211.5(f)(i)-(xi) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services		