

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Glen Brook Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 801 East 16th Street Berwick, PA 18603	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48276</p> <p>Based on a review of grievances filed with the facility and the minutes from resident group meeting and resident and staff interviews, it was determined that the facility failed to provide care in a manner and environment that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by three out of the 35 residents sampled (Residents 8, 50, and 161) and five out of 10 residents interviewed during a group interview (Residents 56, 141, 154, 172, and 173).</p> <p>Findings include:</p> <p>A review of grievances lodged with the facility revealed a grievance from a resident dated April 14, 2024, relaying that the resident had activated her call bell to request staff assistance to be changed. According to the resident's grievance, staff came in to the resident's room and told the resident she would get someone to help her and turned off her call bell but staff did not return to the resident's room to provide the needed care.</p> <p>A resident grievance dated April 16, 2024, indicated that nursing staff gave him hell after he turned his call bell light back on after 45 minutes. The grievance indicated that the resident was told he had to wait an additional 20 minutes because staff was on break.</p> <p>A resident grievance dated April 25, 2024, indicated that the resident reported that the aides left him sitting in sh*t for two hours. The grievance indicated that staff told the resident that she needed to collect lunch trays.</p> <p>A resident grievance dated April 28, 2024, indicated that a resident stated that she rang her call bell and staff told her she would have to wait until night shift because she was changed enough.</p> <p>A grievance dated May 28, 2024, indicated that a resident rang the call bell to request staff provide the bedpan, but staff never came. The grievance indicated that the resident was incontinent with urine and waited almost three hours for care.</p> <p>A review of Resident Council Meeting Minutes dated March 13, 2024 revealed that residents in attendance indicated that some licensed nursing staff are hard to find and nurse aides are not responsive to call bells.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident Council Meeting Minutes dated April 9, 2024, revealed that residents in attendance voiced concerns with how long it takes for nursing staff to respond to their call bells requesting assistance or that staff turn off their call bells, then leave their rooms, but do not provide the needed care.</p> <p>During an interview on June 4, 2024, at 11:13 AM, Resident 161 stated that he knows that the wait times for staff to respond to call bells are long, so even when he needs assistance, he will wait until staff are less busy before he rings his call bell for assistance. He explained that the wait times are at least 20 to 30 minutes when staff are busy. Resident 161 stated he hates to ring for assistance, but when he needs help, he has to rely on staff for care.</p> <p>During an interview on June 4, 2024, at 11:51 AM, Resident 8 stated that she experiences long wait times for care. She explained that at times she waits 35 to 45 minutes for staff to respond to her call bell requests for assistance. Resident 8 stated that she is diabetic and is worried about the time it takes to get assistance from staff. She explained that she waits the longest for care on the evening and night shifts. Resident 8 stated that last week she waited from 8:00 PM until 9:20 PM before someone responded to her call bell for assistance.</p> <p>During an interview on June 5, 2024, at 1:00 PM Resident 50 stated that she waits 20 minutes to an hour for staff to respond to her call bell requests for staff assistance. She explained that the wait time is even longer when the nursing shifts change or during meal times. Resident 50 stated that yesterday she came back to the facility at 3:00 PM and rang her call bell for staff assistance to return to bed. She explained that staff did not respond and help her to bed until 5:00 PM.</p> <p>During a resident group interview on June 5, 2024, at 10:00 AM, five alert and oriented residents reported that they are experiencing long wait times for care after ringing their call bells for staff assistance (Residents 56, 141, 154, 172, and 173).</p> <p>Resident 56 stated that he experiences wait times up to 30 minutes. He explained that lately the wait times are getting worse.</p> <p>Resident 141 stated that she waits up to two hours to receive care from staff. She explained that she believes there are not enough licensed nurses in the building to provide the care the residents need. The resident stated that she has filed many grievances about how long it takes to receive care from nursing staff, but nothing has changed. She explained that she tries not to ring the call bell for staff assistance when she knows staff are busy, but sometimes she can't help it and needs their assistance.</p> <p>Resident 154 stated that she experiences long wait times for staff assistance on the weekends. She explained that sometimes she waits 30 minutes for care after ringing her call bell for staff assistance.</p> <p>Resident 172 stated that she waits 30 minutes for care from staff when requested.</p> <p>Resident 173 stated that she experiences long wait times to receive care when requested, especially during the overnight shifts. She explained that staff will often initially respond to her call bell, turn her call light off, then leave without providing her care. She stated that she sometimes waits up to an hour before being provided care that had requested.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on June 6, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) verified that all residents at the facility should be treated with dignity and respect. The NHA and DON were unable to explain why residents are reporting untimely staff responses to residents' requests for assistance, which is negatively affecting their quality of life in the facility.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p> <p>28 Pa. Code 211.12(c)(d)(1)(5) Nursing services</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a clinical record review and staff interview, it was determined that the facility failed to ensure that the necessary resident specific information was communicated to the receiving health care provider upon transfer for two out of the 35 residents sampled with facility-initiated transfers (Residents 124 and 90).</p> <p>The findings include:</p> <p>A review of Resident 124's clinical record revealed that the resident was transferred to the hospital on February 10, 2024, and returned to the facility on [DATE].</p> <p>A review of Resident 90's clinical record revealed that the resident was transferred to the hospital on February 22, 2024, and returned to the facility on [DATE].</p> <p>There was no documented evidence that the facility had communicated specific information to the receiving health care provider for these residents transferred and expected to return, including advance directive information, special instructions, or precautions for ongoing care, as appropriate, or comprehensive care plan goals to ensure a safe and effective transition of care.</p> <p>During an interview on June 6, 2024, at approximately 10:30 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer or discharge.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing Services</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235</p> <p>Based on a review of clinical records, and the Resident Assessment Instrument and resident, and staff interviews, it was determined that the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 35 sampled (Resident 98).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 98 was admitted to the facility on [DATE], with diagnoses to have included cerebral infarction (stroke) and left sided hemiplegia and hemiparesis (one-sided paralysis or weakness caused by brain or spinal cord problem).</p> <p>During an interview on June 4, 2024, at approximately 12:57 PM, with Resident 98, he stated he had suffered a stroke awhile back and has minimal to no use of his left side.</p> <p>A review of Resident 98's Annual MDS assessment dated [DATE], and Quarterly MDS assessment dated [DATE], Section GG - Functional Abilities and Goals, question GG0115 Functional limitations in range of motion, A. upper extremity (shoulder, elbow, wrist, hand) B. lower extremity (hip, knee, ankle, foot) was coded 1 indicating impairment on one side.</p> <p>A review of Resident 98's Quarterly MDS assessment dated [DATE], Section GG - Functional Abilities and Goals, question GG0115 Functional limitations in range of motion, A. upper extremity (shoulder, elbow, wrist, hand) B. lower extremity (hip, knee, ankle, foot) was coded 0 indicating no impairment.</p> <p>Interview with the RNAC (registered nurse assessment coordinator) on June 6, 2024, at approximately 9:20 AM, confirmed that the resident's Quarterly MDS assessment dated [DATE], was inaccurate, with respect to completion of Section GG - Functional Abilities and Goals.</p> <p>Interview with the Director of Nursing (DON) on June 6, 2024, at 10:00 AM, confirmed that Resident 98's quarterly MDS assessment was not accurate.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of clinical records and staff interview, it was determined that the facility failed to follow physician orders for a bowel protocol prescribed for one resident out of 35 sampled (Residents 15) to promote normal bowel activity to the extent possible .</p> <p>Findings include:</p> <p>According to the American Academy of Family Physicians {The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine}the primary goal of constipation management should be symptom improvement, and the secondary goal should be the passage of soft, formed stool without straining at least three times per week).</p> <p>A review of the clinical record revealed that Resident 15 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and constipation.</p> <p>The resident had physician orders dated September 24, 2022, for the following bowel regimen:</p> <p>Milk of Magnesia (MOM) 400 MG/5 ML give 30 ml by mouth as needed for no bowel movement in 72 hours;</p> <p>Dulcolax Suppository 10MG insert 1 suppository rectally as needed if no bowel movement in 4 days and no results from the MOM;</p> <p>Fleet Enema 7-19 GM/118 ML insert 1 dose rectally as needed if no bowel movement for 5 days and no results from the MOM and Dulcolax.</p> <p>Review of Resident 15 's report of bowel activity, the Documentation Survey Report for the month of April 2024, revealed that the resident had a bowel movement on April 4, 2024, at 8:46 PM , and did not have a bowel movement again until six days later on April 10, 2024.</p> <p>Review of Resident 15's Medication Administration Record (MAR) for April 2024, revealed that the facility failed to follow the physician's order and provide the resident with MOM on April 7, 2024, the Dulcolax suppository on April 8, 2024, and the Fleets enema on April 9, 2024, to promote a bowel movement.</p> <p>Review of Resident 15's report of bowel activity, the Documentation Survey Report for the month of May 2024, revealed the resident had a bowel movement on May 9, 2024, at 10:24 PM, and did not have a bowel movement again until 5 days later on May 15, 2024.</p> <p>Review of Resident 15's MAR for May 2024 revealed that the facility failed to follow the physician's order and provide the resident with MOM on May 13, 2024 and the Dulcolax suppository on May 14, 2024 to promote a bowel movement.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing and Nursing Home Administrator on June 7, 2024, at approximately 12:45 PM, confirmed that the facility failed to follow physician orders for bowel protocol prescribed for Resident 15.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5 (f) Medical records</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235</p> <p>Based on observation, a review of clinical records, select incident/accident reports and facility policy and staff interview, it was determined that the facility failed to maintain an environment free of potential accident hazards by failing to prevent accidental ingestion of denture tablets for one resident (Resident 88) out of 35 sampled and safe storage of oxygen cylinders (tanks) on two of four nursing units (North and East Nursing Units).</p> <p>Findings include:</p> <p>A review of clinical record revealed that Resident 88 was admitted to the facility on [DATE], with diagnoses to include diabetes, dysphagia (difficulty in swallowing), bipolar disorder (extreme mood swings), and age-related cataracts.</p> <p>A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated February 26, 2024, revealed that the resident was moderately cognitively impaired.</p> <p>A review of a late entry nurses note dated March 22, 2024, at 1302 hours (1:02 PM) indicated that Resident 88 was found with a small amount of green debris on the right side of her mouth. It was noted that nursing staff found several denture cleaning tablets (denture cleaning tablets that use chemicals to remove stains caused by food) in the resident's room and removed them. Resident 88 denied that they are for cleaning dentures. The incident was reported to the physician and no new orders were received. The resident's vital signs were obtained and within normal range, 97.4, 83, 18, 112/55, 97% room air, no injuries were noted.</p> <p>A nurses note dated March 22, 2024, at 1342 hours (1:42 PM) noted that staff found denture cleaning tablets in resident's room, and the resident has no dentures. A small amount green debris was coming out of the right side of the resident's mouth. The resident reported that she was eating candy. The RN was notified.</p> <p>A review of a late entry nurses note dated March 22, 2024, at 1808 hours (6:08 PM) indicated that staff noted earlier this day that the resident had some green material around her mouth. It was determined to be from a denture tab that the resident thought was candy and had placed in her mouth. The denture tab was spit out and not consumed. Attempts to educate the resident that the denture tab was not food or candy was ineffective as she refused to believe staff. Her room was searched with her permission and the remaining two denture tablets were removed. MD and RP were made aware of all of the above and no new orders were received.</p> <p>A review of a nurses note dated March 22, 2024, at 1342 hours (1:42 PM) stating the incident from March 22, 2024, discussed with Interdisciplinary Team (IDT) members. Resident does not have dentures, but her roommate (Resident 45) does, and resident is known to rummage through other resident's belongings and take things that do not belong to her. New intervention is to do a sweep of resident's room x 1 week and make sure that no denture tabs or other non-edible items are within her reach and/or removed from the room. MD and RP made aware of same.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A facility provided incident report (IR) dated March 22, 2024, at 1303 (1:03 PM) indicated that the resident had some green debris on her chin, and around the right side of her mouth. [NAME] denture cleaning tablets (2) found in her room. Resident does not have dentures. She (Resident 88) said it was candy.</p> <p>A witness statement from Employee 1, Licensed Practical Nurse (LPN), dated March 22, 2024, indicated she had last seen Resident 88 at 10:00 AM, at which time the resident was sitting on her bed.</p> <p>A review of clinical record revealed that Resident 45 (Resident 88's roommate) was admitted to the facility on [DATE], with diagnosis to include cerebral infarction (stroke), and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>A quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired.</p> <p>A review of Resident 45's plan of care revealed she has upper/lower dentures, but the care plan did not identify who was responsible for cleaning or storing supplies needed for the dentures in the resident's room.</p> <p>Resident 45's physician orders at the time the survey ending June 7, 2024, revealed no orders that the resident may keep denture cleaning supplies in the resident's room.</p> <p>Interview with the Director of Nursing (DON) on June 5, 2024, at approximately 12:55 PM, confirmed that treatments, including denture cleaning tablets were not to be left in the residents rooms, unless physician ordered and if the resident had demonstrated the ability to safely use, and safely store them.</p> <p>Interview with the Nursing Home Administrator (NHA) on June 5, 2024, at approximately 1:05PM, confirmed that the facility failed to maintain the residents' environment free of potential accident hazards by leaving the denture cleaning tablets accessible to residents and potential misuse or ingestion</p> <p>Review of a facility policy entitled Oxygen Safety last reviewed on April 17, 2024, indicated that it is the policy of the facility to provide a safe environment for residents, staff, and the public. Oxygen Storage requires that cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty.</p> <p>Observation of Resident room [ROOM NUMBER]W on the North Nursing Unit on June 4, 2024, at 11:45 AM revealed an oxygen cylinder (tank) standing upright under the windowsill. The oxygen cylinder was not secured.</p> <p>Interview with Employee 5 (LPN) at this time confirmed the observation and the employee stated that all oxygen cylinders were to stored securely.</p> <p>Observation of Resident room [ROOM NUMBER]W on the East Nursing Unit on June 6, 2024, at 12:30 PM revealed an oxygen cylinder standing upright in the corner of the room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 6 (RN) at this time confirmed that oxygen tanks should be stored in a secure manner</p> <p>Interview with the nursing home administrator on June 6, 2024, at approximately 1:00 PM, confirmed that the oxygen tanks were to be stored securely at all times.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p> <p>28 Pa. Code 211.10 (a) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235</p> <p>Based on observation, a review of clinical records, select facility reports, and employee personnel files and interviews with staff, it was determined that the facility failed to provide nursing staff with the necessary competencies and skills to administer prescribed medications, according to professional standards of nursing practice to residents for 5 out of 35 residents residing in the facility. (Residents 83, 32, 92, 50, and 3).</p> <p>Findings include:</p> <p>According to the American Nurses Association the Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, out- comes identification, planning, implementation, and evaluation. Nurses' responsibility for medication administration includes ensuring that the right medication is properly drawn up in the correct dose and administered at the right time through the right route to the right patient.</p> <p>A review of clinical record revealed that Resident 83 was admitted to the facility on [DATE], with diagnosis to include dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), gastro-esophageal reflux disease (GERD), and anxiety.</p> <p>A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated December 16, 2023, revealed that the resident was severely cognitively impaired.</p> <p>A review of a nurses note dated March 9, 2024, at 0845 hours (8:45 AM) indicated that Resident 83 was laying in bed no complains of pain, difficulty breathing or discomfort noted. A narcotic medication error was identified during change of shift at 7 AM on that date whereas Employee 2, an agency LPN, on the 11 PM to 7 AM shift administered Tramadol (opioid pain medication) 50 milligram (mg) instead of the prescribed Oxycodone (opioid pain medication) 5 mg capsule. Employee 2, agency LPN, stated she must have been confused by same last name with another resident. Vitals are stable, Temperature 97.7 Pulse 78 Blood Pressure 148/72 Respiration 18 oxygen saturation 94%. Supervisor on call made aware, MD made aware, called family member (son), left message, will continue to monitor resident status.</p> <p>A nurse's note dated March 9, 2024, at 1236 hours (12:36 PM) indicated that the resident's son was made aware of medication error, advised him that resident is stable no signs or symptoms of discomfort noted. Son verbalized understanding and he will call resident later today.</p> <p>A medication error report dated March 9, 2024, revealed that at 1:43 AM, on March 9, 2-24, Employee 2, agency LPN administered Tramadol 50 mg, instead of the physician ordered Oxycodone 5 mg to Resident 83. Physician, supervisor, pharmacy, and family notified. The corrective action was an in-service (education) on the 7 rights of medications.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Glen Brook Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 801 East 16th Street Berwick, PA 18603	
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employee 2 (Agency LPN)'s facility orientation, job orientation, skills check, and or medication competency evaluation was requested at the time of the survey ending June 6, 2024.</p> <p>Interview with the Nursing Home Administrator (NHA) on June 6, 2024, at approximately 9:35AM, confirmed that the facility was unable to provide any of the requested orientation and competency information regarding Employee 2 (Agency LPN). According to the NHA, Employee 2 agency LPN, employment with the facility was terminated and the nurse was do not return (DNR).</p> <p>During an observation of the medication administration pass on June 4, 2024, at approximately 9:45 AM, Employee 1 Licensed Practical Nurse (LPN) was working on the East E/F medication cart. As Employee 1 (LPN) opened the top drawer of the medication cart, she moved her right hand, which was holding a few medication blister cards over to the right side in an apparent attempt to cover something. When asked what was on the right side of the drawer, she moved her hand displaying stacks of several clear, plastic, disposable medication cups containing medications. The cups were not labeled with any resident names.</p> <p>Interview with Employee 1, LPN, at that time, revealed that Employee 1 stated that the cups of medications observed in the top drawer of the medication cart were the medications prepared for the morning med pass. Employee 1, LPN, stated she had already pre-poured the medications (pre-pouring medications is the process of preparing medications in advance and then storing them until administering to the patient), and stated I will probably get in trouble for this, and in questioning why the medications were pre-poured Employee 1 (LPN) stated it is a shortcut that I do.</p> <p>During continued interview with Employee 1, Licensed Practical Nurse (LPN), at that time revealed that she stated that she pre-poured medications for the following residents:</p> <p>Resident 32: aspirin 81 milligram (mg), carbidopa-levodopa 25-100 mg, Lexapro 20 mg, Keppra 750 mg, lorazepam 0.5 mg, metoprolol 50 mg, potassium chloride 20 meq, and risperidone 1 mg.</p> <p>Resident 92: atenolol 25 mg, metformin 500 mg, amlodipine 10 mg, omeprazole 40 mg, senna 8.6 mg, rosuvastatin 5 mg, and hydrochlorothiazide 25 mg.</p> <p>Resident 50: tramadol 50 mg.</p> <p>Resident 83: Xanax 0.5 mg.</p> <p>Resident 3: Ativan 0.5 mg.</p> <p>A review of Employee 1 (LPN) personnel file conducted on June 5, 2024, at approximately 1:40 PM, with the Director of Human Resources identified the date of hire [Employee 1 (LPN)] was May 15, 202. The facility was unable to locate - provide documented evidence of the nursing specific orientation, skills check upon hire, yearly performance evaluation, and or recent competency evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Nursing Home Administrator (NHA) on June 6, 2024, at approximately 9:35AM, confirmed the facility was unable to locate - provide documented evidence of the nursing specific orientation, skills check list upon hire, yearly performance evaluation, and or competency evaluation. The NHA further confirmed the facility failed to provide nursing staff with the necessary competencies and skills to administer prescribed medications, according to professional standards of nursing practice.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.</p> <p>28 Pa. Code 201.19 (6)(7) Personnel records</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of clinical records and staff interview, it was determined that the attending physician failed to act upon pharmacist identified irregularities in the medication regimen of one of 35 residents sampled (Resident 124).</p> <p>Findings include:</p> <p>Regulatory requirements under S483.45(c)(4)(iii) requires that the resident's attending physician review and act on any identified irregularities.</p> <p>A review of the clinical record revealed Resident 124 was admitted to the facility on [DATE], and had diagnoses that included dementia with agitation (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), major depressive disorder, and generalized anxiety disorder.</p> <p>A review of December 2023 monthly pharmacy reviews revealed that the consultant pharmacist identified three irregularities in Resident 124's drug regimen. The consultant pharmacist recommended that the resident's as needed (prn) Olanzapine (Zyprexa an antipsychotic medication) with severe agitation diagnosis will trigger quality indicator for inappropriate antipsychotic use. The pharmacist suggested that the physician indicate 14 days length of therapy. The pharmacist also identified that the prescribed Brexpiprazole (Rexulti and antipsychotic medication) with a dementia diagnosis will trigger quality indicator for inappropriate antipsychotic use.</p> <p>At the time of the survey ending June 7, 2024, the facility was unable to provide documented evidence of the above pharmacy recommendations that were sent to the physician and failed to provide written documentation of the attending physician's response to the identified drug irregularities.</p> <p>A review of a Consultant Pharmacist Nursing Unit Inspection Report dated March 28, 2024, revealed that the consultant pharmacist identified that Quetiapine (Seroquel and antipsychotic medication) with an anxiety disorder will trigger quality indicator for inappropriate antipsychotic use. The pharmacist requested that the physician Please review the diagnosis.</p> <p>At the time of the survey ending June 7, 2024, the resident's attending physician failed to document an appropriate response to the identified irregularity, but instead, the facility's consultant psychiatric CRNP (certified registered nurse practitioner) had responded to the pharmacy recommendation and signed off as he reviewed it.</p> <p>A review of a Consultant Pharmacist Nursing Unit Inspection Report dated April 29, 2024, revealed the consultant pharmacist indicated Seroquel with a dementia diagnosis will trigger inappropriate use. Please review the diagnosis and usage and consider a GDR (gradual dose reduction).</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review revealed the resident's attending physician failed to document an individualized response to the pharmacy recommendation. Instead, the facility's consultant psychiatric CRNP had responded stating behavioral history benefits outweigh risks to the pharmacy recommendation and signed off as he reviewed the recommendation.</p> <p>In an interview with the Director of Nursing on June 7, 2024, at approximately 10:00 AM revealed that the facility was unable to locate the pharmacy recommendations for December 2023 and confirmed that consultant psychiatric CRNP was responding to the pharmacy recommendations and not the resident's attending physician as noted in the regulation.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services.</p> <p>28 Pa. Code 211.12 (c) Nursing services.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident's drug regimen was free of unnecessary antibiotic drugs for two out of 35 residents sampled (Residents 50 and 18).</p> <p>Findings included:</p> <p>A clinical record review revealed that Resident 50 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function) and cerebral infarction (brain damage that results from a lack of blood).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 4, 2024, revealed that Resident 50 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>A nursing progress note dated April 5, 2024, at 9:15 PM indicated that the physician was aware that Resident 50 had complaints of pain, burning, and frequency with urination. The note indicated that a new physician's order was received for a urine analysis (U/A) and culture and sensitivity (C&S- a laboratory test used to identify organisms present in the urine and determine their susceptibility to antibiotic treatment).</p> <p>A physician's order dated April 5, 2024, was noted for Resident 50 to have a U/A and C&S for complaints of pain, burning, and {urinary} frequency.</p> <p>Clinical record review conducted at the time of the survey ending June 7, 2024, revealed no documentation that staff attempted to obtain a urine sample to complete the testing.</p> <p>A nursing progress note dated April 8, 2024, at 2:18 PM was noted that the physician was notified that a urine sample was not been collected because Resident 50 is incontinent.</p> <p>A nursing progress note dated April 9, 2024, at 2:25 PM indicated that the physician was notified because the resident continues to complain of urinary frequency and burning with urination and a urine sample was not collected as the resident is 100% incontinent.</p> <p>A physician's order was noted Resident 50 to receive Doxycycline Hyclate Oral Capsule 100 mg (an antibiotic medication) with the direction to give 100 mg by mouth every 12 hours for dysuria, a possible urinary tract infection for five days.</p> <p>A Medication Administration Record (MAR) dated April 2024 revealed that Resident 50 received her first dose of Doxycycline Hyclate Oral Capsule 100 mg on April 9, 2024, at 8:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note dated April 10, 2024, indicated that an order for antibiotic medication was initiated for symptoms of dysuria without a urine analysis or culture and sensitivity completed. The physician indicated that the risk of antibiotic therapy to treat bacterial infection of the urine does not outweigh the risk of complications from catheterization required to obtain a specimen.</p> <p>A progress note dated April 11, 2024, at 2:12 PM indicated that Resident 50 reported that she still has {increased} frequency and burning {with urination}.</p> <p>A progress note dated April 12, 2024, at 1:23 PM indicated that Resident 50 reported that she still has {increased} frequency and burning {with urination}.</p> <p>A Medication Administration Record dated April 20, 2024, revealed that Resident 50 received her last ordered dose of Doxycycline Hyclate Oral Capsule 100 mg on April 14, 2024, at 8:00 AM.</p> <p>A progress note dated April 15, 2024, at 1:11 PM indicated that Resident 50 reported that she still has some burning with urination.</p> <p>According to the MAR dated April 2024, Resident 50 received 10 doses of Doxycycline Hyclate Oral Capsule 100 mg.</p> <p>During an interview on June 5, 2024, at 13:00 PM, Resident 50 stated that she gets urinary tract infections regularly. She explained that in the past, the facility would assist her in collecting a sample of her urine. She stated that she is able to hold her urine occasionally and would be able to urinate in a container with staff assistance. She stated that during April, staff never attempted to assist her to provide a sample of her urine for the necessary lab testing.</p> <p>During an interview on June 6, 2024, at approximately 10:30 AM, the Director of Nursing (DON) was unable to provide evidence that Resident 50 was free from unnecessary antibiotic medications. The DON was unable to provide evidence that staff attempted to collect a urine sample from Resident 50 prior to the administration of antibiotic medication or during the course of treatment as the resident continued to have complaints of burning and increased urinary frequency.</p> <p>A clinical record review revealed that Resident 18 was admitted to the facility on [DATE], with dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities).</p> <p>A review of a nursing note dated March 4, 2024, at 12:45 PM revealed that the resident was continuing to hallucinate. The resident vital signs were stable. The resident did not have any complaints of pain or dysuria (discomfort, pain, or burning when urinating) The physician was called, and an order was obtained for a urinalysis with culture and sensitivity. The physician, at that time, also ordered Ciprofloxacin 500MG every 12 hours for 10 days.</p> <p>Nursing documentation, dated March 5, 2024, following the collection of the urine sample, revealed that the resident did not display any other signs or symptoms of a UTI.</p> <p>A review of documentation provided by the infection preventionist during the survey ending June 7, 2024, revealed the resident's only symptom of possible UTI was altered mental status and a sticky note was present, which stated did not meet McGeer's criteria.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review the resident's laboratory report results dated March 6, 2024, at 9:34 AM revealed the urine showed multiple flora suggesting either the sample was contaminated or colonized.</p> <p>A review of a nursing note dated March 6, 2024, at 4:45 PM revealed that the physician was made aware of the urine sample being contaminated and the physician advised to continue Cipro for the 10 days.</p> <p>A review of Resident 18's March 2024 Medication Administration Record revealed the resident received 20 doses of an unnecessary antibiotic, Cipro.</p> <p>An interview with the Director of Nursing on June 7, 2024, at approximately 12:45 PM, confirmed that the administration of Ciprofloxacin was not clinically justified, and the resident received medication that was unnecessary.</p> <p>Refer 881</p> <p>28 Pa. Code 211.2(d)(3)(5) Medical Director</p> <p>28 Pa. Code 211.5 (f)(x) Medical records</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>21738</p> <p>Based on a review of clinical records and staff interview, it was determined that the facility failed to consistently attempt non-pharmacological interventions prior to the administration of an antipsychotic medication prescribed on an as needed basis (PRN) for one resident out of 35 reviewed (Resident 230).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 230 had diagnoses, which included cerebral infarction with left-side hemiplegia and anxiety.</p> <p>An admission Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated May 25, 2024, revealed that the resident was moderately cognitively impaired with a BIMS score of 10 (the Brief Interview for Mental Status a tool that assesses cognition; a score of 8-12 equates to being moderately cognitively impaired).</p> <p>A current physician's order, initially dated May 30, 2024, was noted for Seroquel (an antipsychotic) 25 mg one tablet as needed every 24 hours for anxiety for 14 days. Non-pharmacological interventions planned included activities, redirection, repositioning, food/fluids, rest period, and quiet environment.</p> <p>A review of the resident's June 2024 Medication Administration Record (MAR) revealed that staff administered the prn antipsychotic medication on June 1, 2024, at 8:46 PM and June 3, 2024, at 1:32 AM for behaviors of the resident being very restless and increased yelling out.</p> <p>There was no documented evidence that the planned non-pharmacological interventions were attempted prior to administering the prescribed antipsychotic prn medication.</p> <p>During an interview with the Director of Nursing (DON) on June 7, 2024, at approximately 1:00 PM failed to provide documented evidence planned non-pharmacological interventions were attempted prior to administering the prescribed prn antipsychotic medication.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a review of resident clinical records and select facility policy and staff and resident interviews, it was revealed that the facility repeatedly failed to assure that one of the 35 residents sampled was free of significant medication errors (Resident 8).</p> <p>Findings include:</p> <p>A review facility policy titled Timely Administration of Insulin, dated March 29, 2024, revealed that it is the facility policy to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition.</p> <p>A clinical record review revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces).</p> <p>A review of a comprehensive Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 30, 2024 revealed that Resident 8 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>Resident 8 had a current physician order to receive Novolin subcutaneous suspension (70-30) 100 units/ml (insulin isophane and regular) with directions to inject 28 units subcutaneously in the morning and 15 units in the evening related to diabetes mellitus.</p> <p>Resident 8 was scheduled to receive her morning dose of Novolin subcutaneous suspension (70-30) 100 units/ml (insulin isophane and regular) at 8:00 AM and her evening dose at 5:00 PM according to the clinical record.</p> <p>A review of the resident's April 2024 medication administration record (MAR) revealed that staff did not administer the resident's AM dose of Novolin subcutaneous suspension (70-30) 100 units/ml (insulin isophane and regular) on April 30, 2024, at 8:00 AM. The document indicated the reason as other.</p> <p>The clinical record revealed no documented evidence explaining why Resident 8's insulin medication was not administered on April 30, 2024, at 8:00 AM as ordered</p> <p>A review of the resident's MARs dated from May 1, 2024, through June 3, 2024 revealed that staff failed to timely administer Novolin subcutaneous suspension (70-30) 100 units/ml (insulin isophane and regular) to the resident on the following dates:</p> <p>May 2, 2024, at 9:13 AM (one hour and 13 minutes late)</p> <p>May 3, 2024, at 9:11 AM (one hour and 11 minutes late)</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>May 6, 2024, at 11:20 AM (three hours and 20 minutes late)</p> <p>May 7, 2024, at 11:18 AM (three hours and 18 minutes late)</p> <p>May 10, 2024, at 9:54 AM (one hour and 54 minutes late)</p> <p>May 11, 2024, at 9:15 AM (one hour and 15 minutes late)</p> <p>May 13, 2024, at 9:38 AM (one hour and 38 minutes late)</p> <p>May 18, 2024, at 9:49 AM (one hour and 49 minutes late)</p> <p>May 21, 2024, at 9:45 AM (one hour and 45 minutes late)</p> <p>May 26, 2024, at 6:40 PM (one hour and 40 minutes late)</p> <p>May 31, 2024, at 10:44 AM (two hours and 44 minutes late)</p> <p>June 2, 2024, at 11:03 AM (three hours and 3 minutes late)</p> <p>June 2, 2024, at 6:14 PM (one hour and 14 minutes late)</p> <p>June 3, 2024, at 6:27 PM (one hour and 27 minutes late)</p> <p>During an interview on June 4, 2024, at 11:50 AM, Resident 8 stated that she continually has concerns that her diabetic medication is administered late or at the wrong time. She explained that she could recall five times recently staff administered her diabetes medications late.</p> <p>During an interview on June 6, 2024, at approximately 10:30 AM, the Director of Nursing (DON) confirmed that the facility failed to ensure that Resident 8 was free from significant medication errors. The DON was unable to explain why staff did not administer Novolin subcutaneous suspension (70-30) 100 units/ml (insulin isophane and regular) on April 30, 2024.</p> <p>28 Pa. Code 211.10 (a)(c)(d)</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.</p> <p>28 Pa. Code 211.9 (a)(1)(d) Pharmacy Services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
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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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>39235</p> <p>Based on observation, a review of select facility policy, and staff interview, it was determined that the facility failed to adhere to acceptable storage and use by dates for multi-dose diabetes medication on two of four medication carts observed (Spruce 400 hall, [NAME] 800 hall medication cart - Resident's 107, 6, 27, 147, 34, 57, and M1).</p> <p>Findings include:</p> <p>A review of facility policy entitled Multi-Dose Vials last reviewed by the facility April 17, 2024, revealing once opened and used, the vials needs to be stored in the body of the refrigerator when not in use, be dated when opened, and it expires 30 days after opening.</p> <p>Observation of the Spruce 400 hall medication cart on June 4, 2024, at approximately 9:08 AM, in the presence of Employee 3, Licensed Practical Nurse (LPN), revealed the following opened multi-dose diabetes medications:</p> <p>One (1) Novolin N Flex Pen opened and available for use, not dated when initially opened, Two (2) Insulin Lispro vials, both opened and available for use, the first was dated April 20, 2024, and the second not dated when initially opened, belonging to Resident 107.</p> <p>One (1) Fiasp vial, opened and available for use, dated April 20, 2024, belonging to Resident 6.</p> <p>One (1) Fiasp Kwik pen, and One (1) Novolog flex pen, opened and available for use, not dated when initially opened, belonging to Resident 27.</p> <p>One (1) Lantus Solo Star flex pen, opened and available for use, dated April 22, 2024, and one (1) Insulin Aspart pen, opened and available for use, dated May 1, 2024, belonging to Resident 147.</p> <p>One (1) Insulin Degludec pen, and one (1) Insulin Aspart pen, opened and available for use, not dated when initially opened, belonging to Resident 34.</p> <p>One (1) Humalog Kwik pen, opened and available for use, not dated when initially opened, belonging to Resident 57.</p> <p>Interview at that time with Employee 3, Licensed Practical Nurse (LPN), confirmed the above findings and that the medications should have been dated when initially opened.</p> <p>Observation of the [NAME] 800 hall medication cart on June 4, 2024, at approximately 9:37 AM, in the presence of Employee 4, Licensed Practical Nurse (LPN), revealed the following opened multi-dose diabetes medications:</p> <p>One (1) Humalog vial, opened and available for use, not dated when initially opened, belonging to Resident M1.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview at that time with Employee 4, Licensed Practical Nurse (LPN), confirmed the above finding and that the medication should have been dated when initially opened.</p> <p>Interview with the Director of Nursing (DON) on June 5, 2024, at approximately 12:55 PM, confirmed the that the facility failed to date multi-dose medications when opened to assure acceptable storage times.</p> <p>28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>48276</p> <p>Based on a review of the minutes from Resident Council and Food Committee Meetings, scheduled facility mealtimes, select facility policy, and resident and staff interviews, it was determined that the facility failed to consistently provide snacks as desired by residents, including one out of the 35 residents sampled and experiences reported by residents during a group interview (Residents 42, 56, 141, 154, and 173).</p> <p>Findings include:</p> <p>A review of the facility's policy titled Offering/Serving Bedtime Snacks, last reviewed on April 17, 2024, indicated that it is the practice of the facility to offer and serve residents with a nourishing snack in accordance with their needs, preferences, and requests at bedtime on a daily basis.</p> <p>A review of the facility's scheduled mealtimes revealed that the time between dinner and breakfast the next day exceeds fourteen hours.</p> <p>A review of Resident Council Meeting Minutes dated March 13, 2024, revealed that residents in attendance stated that snacks and sugar-free snacks are not always available or not distributed by staff.</p> <p>A review of Food Committee Meeting Minutes dated April 8, 2024 revealed that residents in attendance stated that nursing staff report that at times there are no snacks available for the residents.</p> <p>During interview with Resident 117, a cognitively intact resident, on June 4, 2024, at 11:45 AM the resident stated that she is not always offered a snack at bedtime. The resident confirmed that she would like to be asked in the evening if she would like a snack.</p> <p>During a resident group interview on June 5, 2024, at 10:00 AM, five alert and oriented residents stated that they were not being offered evening snacks (Residents 42, 56, 141, 154, and 173). The residents stated that they are not regularly offered snacks in the evening, and sometimes there are no snacks available when they request an evening snack.</p> <p>During an interview on June 6, 2024, at 10:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to explain why Residents 42, 56, 141, 154, 173, and 117 are indicating that the facility is not offering nutritious snacks. The NHA confirmed that it is the facility's policy to offer and serve residents a nourishing snack in accordance with their needs, preferences, and requests at bedtime on a daily basis.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing Services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>21738</p> <p>Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in two of four resident pantries (Spruce Nursing Unit and North Nursing Unit).</p> <p>Findings include:</p> <p>Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).</p> <p>Observation of the resident food pantry located on the Spruce Nursing Unit on June 5, 2024, at 12:00 PM revealed that inside the refrigerator there was an opened 46-ounce container of cranberry nectar-thickened juice which was not dated when opened (manufacturer's label noted that the juice was to be used within 10 days of opening).</p> <p>Observation of the resident food pantry located on the North Nursing Unit on June 5, 2024, at 12:30 PM revealed that inside the refrigerator there was an opened 46-ounce container of lemon nectar-thickened water which was dated May 23, 2024. The manufacturer's label noted to keep under refrigeration after opening for up to seven days.</p> <p>Interview with the Nursing Home Administrator on June 5, 2024, at 2:00 PM confirmed that all food items in the resident pantries were to be properly dated upon opening and discarded according to manufacturer recommendations to ensure food quality and reduce the risk of food-borne illness.</p> <p>28 Pa. Code 211.6 (f) Dietary services</p> <p>28 Pa. Code 201.18 (e) (2.1) Management</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of the facility's infection control policies and procedures and clinical records, and staff interview, it was determined that the facility failed to fully implement an antibiotic stewardship program and maintain a system to effectively monitor antibiotic usage for two of 35 sampled residents (Residents 50 and 18).</p> <p>Findings include:</p> <p>A review of facility policy entitled Antibiotic Stewardship Program last reviewed April 17, 2024, revealed it is the policy of the facility to implement an antibiotic stewardship program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Further it is indicated the facility will use McGeer criteria to define an infection and will use the Loeb Minimum criteria to determine whether to treat an infection with an antibiotic.</p> <p>A clinical record review revealed that Resident 50 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function) and cerebral infarction (brain damage that results from a lack of blood).</p> <p>A nursing progress note dated April 5, 2024, at 9:15 PM indicated that the physician was made aware that Resident 50 had complaints of pain, burning, and frequency with urination. The entry noted a new physician's order was received to obtain a urine analysis (UA) and culture and sensitivity (C&S- a laboratory test used to identify organisms present in the urine and determine their susceptibility to antibiotic treatment).</p> <p>A physician's order dated April 5, 2024, was noted to obtain UA and C&S for Resident 50's complaints of pain, burning, and {urinary} frequency.</p> <p>However, there was no documented evidence in the resident's clinical record that nursing staff attempted to obtain urine sample to perform the diagnostic lab studies as ordered.</p> <p>A nursing progress note dated April 8, 2024, at 2:18 PM indicated that the physician was notified that a urine sample was not collected because Resident 50 is incontinent of urine.</p> <p>A physician's order was noted for Resident 50 to receive Doxycycline Hyclate Oral Capsule 100 mg (an antibiotic medication) with the direction to give 100 mg by mouth every 12 hours for dysuria, a possible urinary tract infection for five days.</p> <p>According to the resident's April 2024 MAR Resident 50 received 10 doses of Doxycycline Hyclate Oral Capsule 100 mg.</p> <p>The facility failed to obtain a urine sample to confirm the resident had a urinary tract infection and the most effective antibiotic for treatment and the necessity of the antibiotic therapy prescribed.</p> <p>(continued on next page)</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A clinical record review revealed that Resident 18 was admitted to the facility on [DATE], with dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities).</p> <p>A nursing note dated March 4, 2024, at 12:45 PM revealed that the resident was continuing to hallucinate. The resident's vital signs were stable. The resident did not have any complaints of pain or dysuria (discomfort, pain, or burning when urinating) The physician was called, and an order was obtained for a urinalysis with culture and sensitivity and to start Ciprofloxacin 500MG every 12 hours for 10 days.</p> <p>The resident's clinical record revealed no further symptoms after the urine sample was obtained. A review the resident's laboratory report results, that were dated as available on March 6, 2024, at 9:34 AM revealed the urine showed multiple flora suggesting either the sample was contaminated or colonized.</p> <p>A review of a nursing note dated March 6, 2024, at 4:45 PM revealed the physician was made aware of the urine sample being contaminated and he stated to continue Cipro for the 10 days.</p> <p>A review of Resident 18's March 2024 Medication Administration Record revealed the resident received 20 doses of an unnecessary antibiotic.</p> <p>An interview with the infection preventionist (IP) on June 6, 2024, at approximately 10:30 AM, revealed the facility was not using McGeer's criteria to identify infections as indicated in their policy. The IP stated that she puts the symptoms into the PA-PSRS system, and it will identify if it meets criteria. The IP stated she does not have any documentation, however, that the above residents' symptoms were inputted to apply any type criteria to identify if the resident's symptoms met defined criteria as an infection. Further the IP stated she was not using the Loeb Minimum criteria to determine if an infection is to be treated with an antibiotic.</p> <p>At the time of the survey ending June 7, 2024, the facility failed to demonstrate appropriate actions designed to optimize the treatment of infections through improving antibiotic prescribing, administration, and management practices thus reducing inappropriate use.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on June 7, 2024, at approximately 12:45 PM confirmed the facility failed to have a functioning antibiotic stewardship program.</p> <p>Refer F757</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.2 (d)(3)(5) Medical Director</p> <p>28 Pa. Code 211.10 (a) Resident care policies</p>