STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395421	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Brook Rehabilitation and Healthcare Center	801 East 16th Street Berwick, PA 18603

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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** 41581 Based on a review of clinical records and staff interview, it was determined the facility failed to develop and/or implement a person-centered comprehensive care plan for three residents out of 35 sampled (Resident 103, 58, and 404). Findings include: A review of the clinical record revealed Resident 103 was admitted to the facility on [DATE], with diagnoses to include Type 2 diabetes and difficulty walking. A review of a bowel and bladder assessment dated [DATE], revealed the resident is always incontinent of urine and feces. A review of the resident's clinical record revealed the resident is on a two hour check and change program to check for incontinence. A review of the current resident's plan of care revealed the resident's care plan failed to identify the resident's bowel and bladder incontinence and interventions to address the resident's concerns. A review of Resident 58's clinical record revealed that the resident was admitted to the facility July 30, 2023, with diagnoses that included dementia with behavioral disturbances, muscle wasting and atrophy (is a progressive and degeneration or shrinkage of muscles or nerve tissues), lack of coordination, and difficulty walking. A review of the resident's comprehensive person-center care plan that for communication initiated on December 19, 2023, identified that Resident 58 was fluent in both Spanish and English and the resident's needs would be met. Planned interventions included to anticipate and meet the needs of the resident, communicate with family/resident PRN (as needed) about any suspected changes in expression/understanding, and observe for evidence that language expression/understanding is changing in relation to his dementia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews with Employees 3 and Employee 4, both nurse aides (NA), on October 17, 2024, at 11:15 AM, revealed that Resident 58 had behaviors such as frequently self-transferring to the bathroom and resistive during care and the resident required Spanish speaking staff to translate care being rendered to deter escalating behaviors. Staff also reported the resident's family was present most afternoons and would translate for the resident and when there wasn't anyone readily available to translate for the resident, the staff would use translating devises to communicate. Resident 58's comprehensive plan of care failed to include intervventions required to effectively communicate with the resident. A review of the clinical record revealed Resident 401 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (a brain disorder that causes problems with memory, thinking and behavior) and Depression (a mood disorder that causes a persistent feeling of sadness or loss of interest). A review of the documentation provided by the facility listed Resident 401 as Spanish speaking resident. An interview with Employee 1, a NA, on October 24, 2024, at 11:32 AM, revealed the facility had Spanish speaking staff members to help translate and that Resident 401 had been provided a 1:1 sitter (one staff member to one resident to ensure the safety of that resident) that was able to speak Spanish and communicate with Resident 401. An interview with Employee 2, a NA, on October 24,2024 at 11:40 AM, revealed the facility provided staff who did not speak Spanish a translation service so that staff was able to communicate with the resident. A review of Resident 401's care plan, last updated on October 14, 2024, determined the facility failed to develop a person-centered care plan that addressed the resident's inability to communicate with staff. Interview with the Nursing Home Administrator and Director of Nursing on October 25, 2024, at approximately 1:15 PM confirmed the facility failed to ensure that comprehensive care plans were developed to meet the residents specific needs. 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to administer medication timely in accordance with physician's orders for one resident out of 35 sampled (Resident 161). Findings include: A facility policy titled Medication Administration, last reviewed by the facility in April 2024, revealed medications are administered by licensed nurses or other staff who are legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice. The policy states that licensed nurses shall Administer medications within 60 minutes prior to or after scheduled time unless otherwise ordered by physician or resident preference. A clinical record review revealed Resident 161 was admitted to the facility on [DATE], with diagnoses that include end-stage renal disease (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs). Further clinical record review revealed Resident 161 has a physician's order for Amlodipine Besylate Tablet 10 mg (a calcium channel blocker utilized to lower blood pressure by relaxing blood vessels) with instructions to administer one tablet by mouth one time a day for hypertension initiated on August 26, 2023. The scheduled administration time for this medication is 8:00 AM. A physician's order for [NAME] Aspirin Low Dose Tablet Delayed Release 81 mg (Aspirin) with instructions to administer one tablet by mouth in the morning for atrial fibrillation (a type of irregular heartbeat) initiated on December 29, 2022. The scheduled administration time for this medication is 8:00 AM. A review of a facility Medication Administration Audit Report for Resident 161 from October 1, 2024, through October 24, 2024, revealed the facility failed to timely administer Resident 161's medications on 11 occasions. Resident 161 scheduled 8:00 AM Amlodipine Besylate Tablet 10 mg and [NAME] Aspirin Low Dose Tablet Delayed Release 81 mg were administered on the following dates late: October 1, 2024, at 9:38 AM, 1 hour and 38 minutes after its scheduled time. October 2, 2024, at 9:25 AM, 1 hour and 25 minutes after its scheduled time. October 3, 2024, at 1:31 PM, 5 hours and 31 minutes after its scheduled time. October 4, 2024, at 10:01 AM, 2 hours and 1 minute after its scheduled time. October 6, 2024, at 10:24 AM, 2 hours and 24 minutes after its scheduled time. October 7, 2024, at 9:26 AM, 1 hour and 26 minutes after its scheduled time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	October 11, 2024, at 9:20 AM, 1 hour and 20 minutes after its scheduled time. October 16, 2024, at 9:29 AM, 1 hour and 29 minutes after its scheduled time. October 17, 2024, at 10:33 AM, 2 hours and 33 minutes after its scheduled time. October 19, 2024, at 11:04 AM, 3 hours and 4 minutes after its scheduled time. October 20, 2024, at 10:15 AM, 2 hours and 15 minutes after its scheduled time. During an interview on October 25, 2024, at approximately 9:30 AM, the Director of Nursing (DON) confirmed that licensed and professional nursing staff failed to administer Resident 161's medication timely in accordance with physician's orders. 28 Pa. Code 211.5(f)(xi) Medical records. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records, and resident and staff interviews, it was determined the facility failed to ensure residents receive appropriate services and assistance to maintain or improve mobility with the maximum practicable independence for two out of 35 residents sampled (Residents 145 and 180). Findings include: A clinical record review revealed Resident 145 was admitted to the facility on [DATE], with diagnoses that included dorsopathy (diseases of the spine and vertebral tissues accompanied by pain in the back) and morbid obesity (a chronic disease that's characterized by a body mass index of 40 or higher, or a body mass index of 35 or higher with obesity-related health issues). A Physical Therapy (PT) Discharge Summary dated May 31, 2023, revealed discharge recommendations for Resident 145 to have a restorative range of motion program. Specifically, the recommendations include bilateral lower extremity range of motion in recline and sitting positions and daily out of bed to wheelchair and range of motion to bilateral feet, ankles, knees, and hips. The PT summary indicated that Resident 145 prognosis to maintain current level of functioning is excellent with consistent staff support and resident participation in the restorative nursing program. A clinical record review revealed Resident 145 has an activities of daily life (ADL) self-care deficit related to weakness and deconditioning initiated on May 31, 2022. Her goal is to have her personal ADL needs met with the assistance of staff while promoting her highest level of functioning and dignity implemented on June 15, 2024. During an interview on October 22, 2024, at 12:50 PM, Resident 145 indicated she is not receiving services to improve her mobility. She explained that she had therapy services a few months ago but has not had any rehabilitation services since being discharged from therapy. Resident 145 indicated that nursing staff are not providing any range of motion exercises with her. She explained feeling frustrated and sad because she wants to regain her independence. A clinical record review confirmed that there was no documented evidence of any restorative nursing services for Resident 145 from September 1, 2024, through October 22, 2024. During an interview on October 24, 2024, at approximately 11:00 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that Resident 145 was not currently receiving restorative nursing services. The NHA confirmed that it is the facility's responsibility and policy to ensure residents receive appropriate services and assistance to maintain or improve mobility with the maximum practicable independence. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 180's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included ALS (amyotrophic lateral sclerosis (ALS) is a progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord that results in muscles weakening and wasting away), cognitive communication deficit, muscle weakness and atrophy (is a progressive and degeneration or shrinkage of muscles or nerve tissues), and dysphagia (difficulty swallowing). A Review of the resident's comprehensive person-centered plan of care that was initiated on April 1, 2024, and revised on July 23, 2024, identified that Resident 180 had ADL (activities of daily living) self-care performance deficits related to ALS with hospice services and a goal for the resident to maintain current level of function in ADL's. Planned interventions included assistance of two-persons with transfers and toilet use, required assist of staff participation to reposition and turn in bed, dependent on staff for eating, and PT/OT evaluation and treatment as per MD orders. A review of the resident's Physical Therapy (PT) Discharge Summary dated May 31, 2024, revealed discharge recommendations for twenty-four-hour care and a restorative program for restorative range of motion and assisted active and passive range of motion (AA-PROM) bilateral lower extremities (BLE). Further review of Resident 180's clinical record failed to reveal documented evidence that the recommended restorative program for assisted active and passive range of motion to the bilateral lower extremities were performed by staff from June 1, 2024, through survey ending October 18, 2024. An interview with the NHA and DON on October 18, 2024, at 11:00 AM, confirmed that the facility could not provide documented evidence that Resident 180's recommended restorative program was implemented and confirmed that the facility failed to assure that the restorative nursing program was implemented as per PT's recommendations to maintain the resident's highest practicable function. 28 Pa. Code: 211.12(d)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on review of clinical records, select facility policy and incident reports, and staff interviews, it was determined that the facility failed to implement adequate safety measures, including sufficient staff supervision, for a resident identified as at high risk for falls to prevent falls for one resident out of 35 sampled (Resident 115). Findings include: A facility policy titled Falls Prevention Program, last reviewed by the facility in April 2024, revealed that each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy indicates the facility will provide interventions as directed by the resident's assessment, including but not limited to assistive devices, increased frequency of safety monitoring rounds, scheduled ambulation or toileting assistance, and therapy services referrals. A clinical record review revealed Resident 115 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder (a condition in which excessive worry causes clinically significant distress or impairment in social, occupational, or other areas of functioning) and insomnia (a sleep disorder that makes it hard to fall or stay asleep) and a history of falling. A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 4, 2024, revealed that Resident 115 is severely cognitively impaired with a BIMS score of 3 (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 0-7 indicates severe cognitive impairment). A care plan revealed the resident has delirium or acute confusional episodes at times initiated on July 1, 2024, with a goal that she will be free from signs or symptoms of delirium (changes in behavior, cognitive function, communication level of consciousness, restlessness). Further clinical record review revealed Resident 115 is at risk for falls related to a history of falling, initiated on June 29, 2024. Her care plan indicates she will be free from injury with facility interventions including checking the resident every 15 minutes, anticipating the resident's needs, motion alarms, bilateral floor mats, and a position alarm to the resident's chair and bed to qalert staff of unsafe transfers. A clinical record review revealed Resident 115 experienced nine falls during her first month at the facility from June 29, 2024, through July 29, 2024. A Fall Risk assessment dated [DATE], identified Resident 115 as a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed Resident 115 experienced seven additional falls from August 26, 2024, through October 18, 2024. A review of facility investigations revealed that six of these falls were unwitnessed. A progress note dated August 26, 2024, at 12:15 AM, indicated Resident 115 was found on the floor of her room lying on her right side, incontinent, without complaints of pain or discomfort. The resident was assessed without injury. A progress note dated September 1, 2024, at 1:40 AM, indicated Resident 115 was found on the floor in her room. The note indicated that the resident was assessed without injury and assisted to the nursing station for monitoring. A progress note dated September 9, 2024, at 11:27 PM indicated Resident 115 was found on the right side of her bed on her buttocks with her back against the wall. The note indicated that the resident was assessed without injury, assisted into her wheelchair, and brought to the nursing station for monitoring. A progress note dated September 12, 2024, at 5:29 PM indicated Resident 115 was found on the floor near the nurse's station in front of her wheelchair. A small amount of blood was noted on the resident's hand and forehead. An additional progress note dated September 12, 2024, at 5:30 PM indicated Resident 115 was assessed with noted skin tears to her left temple measuring 0.1 cm x 3.0 cm x 0.1 cm and left posterior hand measuring 0.1 cm x 2.0 cm x 0.1 cm. The note indicated the resident reported striking her head against the floor during the event. The resident denied pain and was assessed without further injuries. A progress note dated September 22, 2024, at 11:45 AM, indicated Resident 115 fell out of her chair while sitting in front of the nurse's station. The note explained that her previous skin tear on her left hand began to bleed. The resident had no complaints of pain and was assessed without further injury noted. A progress note dated September 28, 2024, at 10:10 AM, indicated Resident 115 was found on the floor, laying on her right side by the nursing station. The note indicated the resident was assessed, and injuries noted included a skin tear to her right forearm and an abrasion on her right knee. Further clinical record review revealed no additional documented evidence describing Resident 115's right forearm skin tear or right knee abrasion. A progress note dated October 18, 2024, at 3:25 AM, indicated Resident 115 was found on the floor. The resident was assessed without injury and had no complaints of pain or discomfort. The facility failed to implement effective interventions and provide adequate supervision to prevent the resident's reoccurring falls. During an interview on October 25, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed it is the facility's responsibility to ensure each resident receives adequate safety measures, including sufficient staff supervision to prevent falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(3)(5) Nursing services.