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	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Brook Rehabilitation and Healthcare Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of clinical records, resident council meeting minutes, and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by three residents out of 35 residents sampled (Residents 47, 48, and 140) and five out of nine residents interviewed during a resident group interview (Residents 10, 31, 49, 72, and 142). Findings include: A review of Resident Council meeting minutes dated February 11, 2025, revealed residents in attendance raised concerns regarding not being assisted out of bed to participate in activities. The residents indicated there was an issue with receiving staff assistance to get out of bed promptly. Also, residents in attendance raised concerns indicating call bells are not answered when residents ring for assistance. During a resident council meeting on March 19, 2025, at 10:00 AM, Residents 10, 31, 49, 72, and 142 expressed concerns about the timeliness of staff assistance when using their call bells. Resident 49 stated she rang her call bell for assistance the night before but did not receive help for over two hours. She needed medication for not feeling well and noted that this concern had been raised repeatedly in previous Resident Council meetings without improvement Resident 142 stated that staff often enter her room, turn off her call bell light, and leave without providing care. She recalled an incident where she soiled her bed and was left waiting for at least an hour after her call bell was silenced. She noted that delays are more frequent during the night shift Resident 10 stated he routinely waits 20 to 30 minutes for assistance and finds the prolonged delays frustrating. He reported that waiting excessive times for help has become a daily occurrence and it causes him frustration. Resident 72 and his roommate both reported 30-minute wait times for staff to respond to call bells. Resident 72 stated that these delays cause frustration and sadness and make him feel as though staff do not care about the residents (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 31 indicated he frequently waits 30 minutes or more for care after using his call bell. He reported that staff sometimes respond after 15 minutes, turn off his call bell, and leave without assisting him, forcing him to ring for help multiple times before receiving care. A clinical record review revealed Resident 140 was admitted to the facility on [DATE], with diagnoses that included dementia (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), and difficulty in walking. A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 14, 2024, revealed that Resident 140 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). During an interview on March 18, 2025, at 12:05 PM, with Resident 140's Responsible Party, she indicated she has concerns regarding the timeliness of staff assisting Resident 140 with her toileting needs. She expressed that Resident 140 is frequently soiled upon arrival when she visits and that the staff may not be checking and changing Resident 140 as often as needed. She reported that Resident 140's husband, Resident 149, reported utilizing the call bell to obtain assistance for his wife, but that they wait an extended period of time, up to an hour, for staff to provide assistance. She continued to report the delay in care is most noted during the evening and night shifts. A clinical record review revealed Resident 48 was admitted to the facility on [DATE], with diagnoses that included stage 4 chronic kidney disease (severe kidney damage leading to waste and fluid buildup), and dependence on renal dialysis (process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). A review of an annual MDS dated [DATE], revealed that Resident 48 is cognitively intact with a BIMS score of 14 (a score of 13-15 indicates intact cognition). Interview on March 18, 2025, at 12:30 PM: Resident 48 reported excessive wait times for staff assistance. He recounted waiting 1.5 hours to be placed on a bedpan and another 1.5 hours to be removed from it. He also stated that because he requires assistance from two staff members, staff often respond to his call bell, say they will find a second staff member, and then never return. He reported these delays are most frequent during the second shift A clinical record review revealed Resident 47 was admitted to the facility on [DATE], with diagnoses that included chronic heart failure (a condition that occurs when the heart can't pump enough blood to meet the body's needs). A review of an annual MDS dated [DATE], revealed that Resident 47 is moderately cognitively impaired with a BIMS score of 12 (a score of 8-12 indicates moderate cognitive impairment). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on March 19, 2025, at 11:00 AM, Resident 47 indicated she experiences long wait times for care. She indicated she often waits 20 to 30 minutes or longer for staff to respond to her call bell after she rings for assistance. Resident 47 stated the long wait often occurs when she is ready to get out of bed in the morning. During an interview on March 21, 2025, at approximately 9:30 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 and provided care in a manner that promotes each resident's quality of life. The NHA and DON were unable to explain why multiple residents continued to report delayed response times and unmet care needs. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(4) Nursing services.

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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** 48276 Based on a review of clinical records, the Resident Assessment Instrument (RAI), and staff interviews, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of two residents out of 35 sampled (Residents 2 and 183). Findings include: According to the Resident Assessment Instrument (RAI) User's Manual (an assessment tool utilized to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan, and the RAI also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status) dated October 2024, Section A2105: Discharge Status indicates to review the medical record, including the discharge plan and discharge orders, for documentation of discharge location. This section indicates that if the resident is discharged to a private home, apartment, board and care, assisted living facility, group home, transition living, or adult foster care, then Code 01, home and community, should be encoded. Also, RAI Section I Active Diagnoses indicates to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. A clinical record review revealed Resident 2 was admitted to the facility on [DATE]. A review of the annual Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) Section I, Active Diagnoses, dated January 9, 2025, indicated Resident 2 has a psychotic disorder (other than schizoaffective and schizophreniform) diagnosis. A clinical record review revealed no documented evidence of a psychotic disorder other than schizoaffective disorders. During an interview on March 21, 2025, at approximately 9:30 AM, the Director of Nursing confirmed Resident 2's MDS dated [DATE], was not accurate. The DON confirmed there was no documented evidence Resident 2 had psychotic disorder diagnosis (other than schizoaffective disorder). A clinical record review revealed Resident 183 was admitted to the facility on [DATE], and discharged home to the community on February 4, 2025. A review of the discharge return not anticipated MDS, dated [DATE], Section A Identification Information; Subsection A2105 Discharge Status indicated Resident 182 was discharged to a short-term general hospital (acute hospital). A progress note dated February 7, 2025, at 4:41 PM revealed Resident 183 was discharged to home with belongings and medications by way of wheelchair through an external transport company. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on March 21, 2025, at approximately 9:30 AM, the DON confirmed Resident 183's discharge return not anticipated MDS dated [DATE], was not accurate. The DON confirmed Resident 183 was discharged to home and not transferred to a community hospital. 28 Pa. Code 211.5 (f)(vi) Medical records. 28 Pa. Code 211.12(d)(3) 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** 48276 Based on observations, a review of clinical records and staff interviews, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included specific and individualized interventions to address a resident's involuntary movements for one out of five residents sampled for unnecessary medication (Resident 10). Findings include: A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder (a condition in which an individual has a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania, and a milder form of mania called hypomania). A clinical record review revealed an Abnormal Involuntary Movement Scale (AIMS- assessment tool used to screen for and assess the severity of tardive dyskinesia (TD), a movement disorder that can occur as a side effect of certain medications, particularly antipsychotics) dated September 23, 2024, indicated Resident 2 has an overall moderate level of severity of abnormal movements and mild incapacitation due to these abnormal movements. The assessment also indicates Resident 2 experiences moderate distress because of the involuntary movements. A clinical record review revealed Resident 2 has a physician's order to receive a Quetiapine Fumarate tablet (an antipsychotic medication that works by affecting the balance of certain chemicals in the brain, such as dopamine and serotonin) 50 mg, with directions to give 50 mg by mouth three times a day related to schizoaffective disorder initiated on January 9, 2025. A physician's order for hydroxyzine HCl oral tablet 10 mg with direction to give 10 mg by mouth every 6 hours as needed for anxiety or motor restlessness was initiated on March 17, 2025. A physician's order for lorazepam 0.5 oral tablet 0.5 mg with directions to give 1.5 tablets by mouth every 8 hours related to generalized anxiety disorder was initiated on July 16, 2024. During an observation on March 19, 2025, at 11:02 AM, Resident 2 was lying in bed, displaying an erratic rolling motion between her left and right sides. Concurrently, her arms were moving irregularly and unpredictably, with abrupt, jerky movements. Resident 2 did not appear to be in control of these movements. A clinical record review revealed no documented evidence the facility developed a care plan to include the resident's involuntary movements and the psycho-social distress the resident reported as a result of the involuntary movements as identified from the September 23, 2024, AIMS assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following questions asked during the survey, Resident 2's care plan was updated to include a care plan focus that indicates she has a behavioral problem and mood problem related to medication-induced akathisia (a movement disorder characterized by an intense, subjective feeling of inner restlessness and an uncontrollable urge to move, often manifesting as pacing, fidgeting, or an inability to sit still, and is frequently a side effect of certain medications, particularly antipsychotics). During an interview on March 21, 2025, at approximately 9:30 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure each resident's comprehensive person-centered care plan includes identified problems and services that are to be provided to assist the resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being. The DON and NHA confirmed Resident 2's comprehensive person-centered care plan did not identify a problem with medication-induced involuntary movements or the psychosocial distress caused by the movements prior to inquiries made during the survey ending on March 21, 2025. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa Code 211.12 (d)(1)(3) 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** 21738 Based on observation, review of clinical records, select facility policy, and staff interview it was determined the facility failed to consistently administer Oxygen (O2) as ordered for one out of 35 sampled residents (Resident 14). Findings included: Review of the facility Oxygen Administration Policy last reviewed April 17, 2024, indicated that oxygen is administered to residents who need it, consistent with professional standards, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under the orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. A review of the clinical record of Resident 14 revealed admission to the facility on [DATE], with diagnoses that include congestive heart failure (the heart muscle does not pump blood as well as it should). The resident had a current physician order initially dated December 16, 2024, for O2 at 2 liters per minute (L/min) continuous via nasal cannula for shortness of breath. An observation on March 19, 2025, at 10:15AM revealed Resident 14's O2 concentrator (machine delivering oxygen therapy) was turned on and running at 3 L/min which was not consistent with physician's orders. An observation on March 21, 2025, at 9:05 AM revealed Resident 14's O2 was turned on and again running at 3 L/min failing to follow physician's orders. Employee 1 (LPN) confirmed this observation. Interview with the director of nursing on March 21, 2025, at approximately 9:30 AM confirmed the physician's order for supplemental oxygen was not followed for Resident 14. 28 Pa. Code 211.10 (c) Resident Care Policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48277 Based on review of clinical records and controlled drug records, and staff interview, it was determined the facility failed to implement procedures to promote accurate accounting and administration of controlled medications for two of 35 residents sampled (Residents 64 and 92). Finding include: A review of Resident 92's clinical record revealed a physician's order dated December 21, 2024, for Morphine Sulfate 15 mg (an opioid pain medication used to treat moderate to severe pain), with instructions to administer one tablet by mouth every four hours as needed for severe pain. A review of the controlled substance record for Resident 92's Morphine Sulfate 15 mg (schedule II opiate narcotic medication; schedule II drugs have a high potential for abuse) showed that nursing staff signed out doses of the medication on the following dates and times: February 2, 2025, at 4:15 PM February 4, 2025, at 4:00 PM February 5, 2025, at 2:00 PM February 18, 2025, (time illegible) February 21, 2025, at 5:50 PM March 3, 2025, at 4:40 PM However, a review of Resident 92's Medication Administration Record (MAR) revealed there was no documentation indicating that the medication was administered to the resident on these dates and times A review of the clinical record revealed a physician's order dated for January 17,2025, for Resident 64 to receive Oxycodone HCL 5 mg. (Oxycodone is in a schedule II opiate narcotic medication) with instructions to administer one tablet every six hours as needed for moderate pain. A review of the controlled substance record for Resident 64's Oxycodone HCL 5 mg showed that nursing staff signed out doses of the medication on: March 4, 2025, at 8:15 PM March 5, 2025, at 5:00 PM However, the administration of the controlled drug to the resident was not recorded on the resident's Medication Administration Record (MAR) on those dates and times. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on March 21, 2025, at 9:30 AM, the Director of Nursing confirmed the discrepancies in the accounting and administration of opioid pain medications for Residents 64 and 92. 92. 28 Pa Code 211.5 (f)(xi) Medical records 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa Code 211.9(a)(1)(k) Pharmacy services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and resident and staff interviews, it was determined the facility failed to timely follow up with required dental services for one Medicaid payor source resident out of 35 residents sampled (Resident 10). Findings include: A clinical record review revealed Resident 10 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and mild protein malnutrition (inadequate intake of food, particularly protein and calories, resulting in a deficit in expected weight for age or height). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 3, 2025, revealed that Resident 10 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). A review of the facility's census information revealed Resident 10 receives benefits through Medicaid (a social assistance program providing individuals comprehensive health and long-term care coverage). A progress note dated December 22, 2024, at 3:00 PM revealed that Resident 10 stated he has been missing his lower dentures for two months. A room search revealed the dentures were not able to be located. A progress note dated December 23, 2024, at 7:05 AM revealed Resident 10's representative contacted the facility and wished to speak with the facility about the resident's missing dentures. A progress note dated January 3, 2025, at 11:37 PM revealed an X-ray full series was performed regarding missing dentures. A review of Resident Council meeting minutes dated January 14, 2025, revealed Resident 10 indicated it is very hard for him to eat due to not having his new dentures. During an interview on March 19, 2025, at 10:30 AM, Resident 10 indicated he has not had dentures for three to four months. He expressed that he is upset the facility staff threw his dentures in the garbage. Resident 10 explained he has brought this issue up a few times with staff, but nothing has been done to help him get his new dentures. A clinical record review revealed no documented evidence the facility provided Resident 10 further assistance in attaining dental services to replace his missing dentures until inquiries made during the week of the survey ending on March 21, 2025. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on March 21, 2025, at approximately 9:30 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were not able to provide evidence the facility ensured Resident 10 received dental services to replace his missing dentures. Following inquiries made during the survey, Resident 10 was scheduled for an appointment to receive additional dental services. The DON and NHA confirmed it is the facility's responsibility to ensure residents receive required dental services. 28 Pa. Code 211.12 (d)(3) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and staff interview, it was determined the facility failed to offer and/or provide the influenza immunization, unless the immunization was medically contraindicated or the resident had already been immunized, for one out of the five residents sampled (Resident 58). Findings include: A review of the clinical record revealed that Resident 58 was admitted to the facility on [DATE], with diagnoses to include chronic atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 6, 2025, revealed that Resident 58 is severely cognitively impaired with a BIMS score of 03 (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 01-07 indicates severe cognitive impairment). A review of Resident 58's influenza immunization informed consent revealed Resident 58's resident representative acknowledged receiving information and education on the benefits and potential side effects of the influenza vaccine. Resident 58's representative authorized consent for Resident 58 to receive an influenza vaccine on January 29, 2025. A review of the clinical record revealed no documented evidence indicating Resident 58 received the influenza vaccine. During an interview on March 21, 2025, at approximately 9:30 AM, the Director of Nursing (DON) confirmed the facility failed to administer Resident 58's influenza vaccination. The DON confirmed it is the facility's responsibility to ensure residents are offered and/or provided the influenza immunization, unless the immunization was medically contraindicated or the resident has already been immunized. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(3) Nursing Services