

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses accurately administered prescribed medication for one resident (Resident 7) and by failing to ensure the consistent implementation of a physician-ordered therapeutic positioning device for one resident (Resident 4), for two of 36 residents reviewed. Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) the registered nurse (RN) is to carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health care team by exercising sound judgment based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) document and maintain accurate records. A review of the facility policy titled Medication Administration last reviewed by the facility on January 6, 2026, revealed that medications are administered as ordered by the physician and in accordance with professional standards of practice. The policy required staff to obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. A review of the clinical record revealed Resident 7 was admitted to the facility on [DATE], with diagnoses to include congestive heart failure (weakness of the heart that leads to a build-up of fluid in the lungs and surrounding body tissues), and chronic atrial fibrillation (an irregular heartbeat). A review of the physician's order dated January 9, 2026, directed staff to administer Midodrine HCl (medication used to treat low blood pressure) 5 mg by mouth three times a day for orthostatic hypotension (a sudden drop in blood pressure occurring within 3 minutes of standing or shifting to an upright position). The order specified to hold the medication if the systolic blood pressure was greater than 110 millimeters of mercury (mm/Hg). Systolic blood pressure is the top number in a blood pressure reading and reflects the pressure when the heart is actively pumping. A review of the January 2026 Medication Administration Record (MAR) revealed Midodrine was administered 31 times when the documented systolic blood pressure exceeded the physician-ordered hold parameter of 110 mm/Hg. The following blood pressure readings were documented at the time the medication was given: January 10, 2026 at 12:00 PM: 122/66 mm/Hg January 10, 2026 at 8:00 PM: 146/96 mm/Hg January 11, 2026 at 6:00 AM: 125/72 mm/Hg January 11, 2026 at 12:00 PM: 126/80 mm/Hg January 11, 2026 at 8:00 PM: 128/68 mm/Hg January 12, 2026 at 6:00 AM: 125/67 mm/Hg January 13, 2026 at 6:00 AM: 137/78 mm/Hg January 13, 2026 at 8:00 PM: 124/82 mm/Hg January 14, 2026 at 8:00 PM: 116/70 mm/Hg January 15, 2026 at 8:00 PM: 120/76 mm/Hg January 16, 2026 at 6:00 AM: 119/69 mm/Hg January 17, 2026 at 6:00 AM: 134/74 mm/Hg January 18, 2026 at 12:00 PM: 124/82 mm/Hg January 18, 2026 at 8:00 PM: 124/82 mm/Hg January 19, 2026 at 6:00 AM: 127/82 mm/Hg January 20, 2026 at 8:00 PM: 154/100 (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mm/HgJanuary 21, 2026 at 6:00 AM: 141/70 mm/HgJanuary 21, 2026 at 8:00 PM: 135/78 mm/HgJanuary 22, 2026 at 6:00 AM: 123/70 mm/HgJanuary 22, 2026 at 8:00 PM: 134/84 mm/HgJanuary 23, 2026 at 6:00 AM: 124/73 mm/HgJanuary 24, 2026 at 12:00 PM: 141/98 mm/HgJanuary 24, 2026 at 8:00 PM: 125/75 mm/HgJanuary 27, 2026 at 6:00 AM: 114/76 mm/HgJanuary 27, 2026 at 8:00 PM: 134/81 mm/HgJanuary 27, 2026 at 8:00 PM: 134/81 mm/HgJanuary 28, 2026 at 8:00 PM: 118/70 mm/HgJanuary 29, 2026 at 6:00 AM: 113/68 mm/HgJanuary 30, 2026 at 6:00 AM: 117/71 mm/HgJanuary 31, 2026 at 6:00 AM: 114/69 mm/HgJanuary 31, 2026 at 8:00 PM: 122/80 mm/HgA review of the February 2026 MAR revealed Midodrine was administered eight additional times when the documented systolic blood pressure exceeded 110 mm/Hg. The following blood pressure readings were documented at the time the medication was given:February 1, 2026 at 8:00 PM: 145/96 mm/HgFebruary 3, 2026 at 6:00 AM: 124/73 mm/HgFebruary 4, 2026 at 6:00 AM: 119/69 mm/HgFebruary 5, 2026 at 6:00 AM: 129/74 mm/HgFebruary 6, 2026 at 6:00 AM: 1122/67 mm/HgFebruary 9, 2026 at 8:00 PM: 122/84 mm/HgFebruary 10, 2026 at 6:00 AM: 1120/72 mm/HgFebruary 12, 2026 at 6:00 AM: 121/74 mm/Hg These findings demonstrated the medication was repeatedly administered outside of the physician-ordered parameters, contrary to facility policy and accepted standards of nursing practice. During an interview on February 27, 2026, at 9:00 AM, the Director of Nursing reviewed the above findings and confirmed that nursing staff failed to follow the physician's order by administering the medication outside the ordered parameters. A review of the clinical record revealed Resident 4 was admitted to the facility on [DATE], with diagnoses to include right femur (thigh bone) fracture (broken bone), lumbar disc degeneration (spinal discs in lower back lose water, elasticity and height, often causing chronic pain and stiffness), and muscle weakness. A review of the physician's order dated October 20, 2025, directed staff to provide a lateral support to the right side of the resident's wheelchair to promote proper positioning and stability. A lateral support is a padded L-shaped positioning device attached to the wheelchair to provide lateral stability, help maintain a neutral upright sitting position, and improve posture by supporting the torso. It prevents side-to-side leaning and fatigue. Observation on February 24, 2026, at 12:30 PM revealed Resident 4 seated in her wheelchair at the entrance to her room. She was leaning significantly over the right side of her wheelchair. The ordered lateral support was not attached to the wheelchair. The device was observed in a laundry basket on a chair in the resident's room. A second observation on February 26, 2026, at 1:10 PM, conducted in the presence of Employee 2 (Licensed Practical Nurse), confirmed the physician ordered lateral support was not in place on the resident's wheelchair. These findings demonstrated the facility failed to ensure nursing services were provided in accordance with physician orders and professional standards of practice. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations of resident pantry areas and staff interview, it was determined the facility failed to maintain equipment and environmental surfaces in a clean and sanitary condition in areas used for food and ice service to prevent the potential for microbial growth in food and beverages, increasing the risk of foodborne illness and waterborne pathogens in four of four resident pantry areas (East, North, Spruce and [NAME] pantries). Findings include: Observation on February 26, 2026, at 10:25 AM of the resident food pantry located on the East Wing nursing unit revealed the ice machine's condensation drain hose (a hose that transports moisture produced by the ice machine to a floor drain) was visibly soiled with a black substance. The ice dispenser contained a buildup of orange and gray substance and white mineral deposits (hard residue left behind from water) within and around the dispenser opening where ice is dispensed. The pantry sink contained a used food thermometer that was visibly soiled with an orange substance. Observation on February 26, 2026, at 10:40 AM of the resident food pantry located on the North Wing nursing unit revealed the ice machine's dispenser contained a thick white build-up of white substance around the dispenser opening. Observation on February 26, 2026, at 10:47 AM of the resident food pantry located on the Spruce nursing unit revealed the ice machine's condensation hose DrainGap fitting device (a component designed to create an air gap, which is an open space between the end of the drain hose and the floor drain that prevents contaminated water, sewage, or bacteria from flowing backward into equipment that produces ice) was in direct contact with the floor drain, eliminating the protective separation intended to prevent contamination. The floor drain and surrounding tiles were visibly covered with a wet black substance, and several floor tiles were broken and cracked. The pantry microwave contained an eight-inch rust-like area along the top left interior wall and two 1.5-inch rusted areas on the interior ceiling. Observation on February 26, 2026, at 11:01 AM of the resident food pantry located on the [NAME] nursing unit revealed the ice machine's condensation hose DrainGap fitting device was in direct contact with the floor and not aligned with the floor drain, eliminating the protective separation intended to prevent contamination. Evidence of water damage was observed to six floor tiles surrounding the drain area. The DrainGap condensation hose end piece and surrounding floor tiles were visibly soiled with a black substance. During an interview on February 26, 2026, at 1:45 PM the Nursing Home Administrator confirmed that the ice machines and microwave were not maintained in a sanitary manner. 28 Pa. Code 201.18 (e)(2.1) Management 28 Pa. Code 211.6 (f) Dietary Services		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, clinical records, and staff interviews, it was determined the facility failed to afford a resident and their designated representative the right to participate in the development of the resident's plan of care for one resident out of 36 sampled residents (Resident 11). Findings include: A review of the facility policy titled Care Planning-Resident Participation, last reviewed by the facility on January 6, 2026, revealed it is the facility policy to support the resident's right to be informed of and participate in their care planning and treatment (implementation of care). The policy indicates the facility will notify the resident and/or resident representative of the risks and benefits of proposed care, treatment, and treatment alternatives or options. The facility will honor requests for care plan meetings and acknowledge requests for revisions to the person-centered plan of care. A clinical record review revealed Resident 11 was admitted to the facility on [DATE], with diagnoses that include acute respiratory failure (a condition where the lungs fail to adequately oxygenate the blood or remove carbon dioxide, leading to insufficient oxygen to meet the body's needs). A review of Resident 11's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 8, 2026, revealed that Resident 11 was cognitively intact with a BIMS score of 14 (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 through 15 indicates cognition is intact). During an interview on February 24, 2026, at 12:02 PM Resident 11 explained that she would like to receive more therapy and restorative services (nursing based exercises to help maintain or improve strength and movement) to address her deficits related to ambulation. Resident 11 indicated that she has not addressed the concern with the facility. A progress note dated February 25, 2026, at 1:42 PM indicated a care plan meeting was held on February 25, 2026, with the resident. No family present. The note indicated social services reviewed Resident 11's code status, diet, weights, meal consumption, transfer status, assistance with activities of daily living care, therapy status, and psychosocial needs. During a follow-up interview on February 26, 2026, at 10:10 AM, Resident 11 had no knowledge of a care plan meeting and was not invited to participate in a care plan meeting on February 25, 2026. She indicated that she has not discussed her therapy status, activities of daily care, and/or preferences of daily care with facility staff. She indicated that she has not had the opportunity to discuss her preferences for more therapy and restorative services to address her deficits related to ambulation. A clinical record review revealed no documented evidence the resident was notified that a care plan meeting was scheduled to occur on February 25, 2026. Also, a clinical record review revealed no documentation that Resident 11 was provided an opportunity to fully participate in establishing her expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. During an interview on February 27, 2026, at approximately 10:30 AM, the nursing home administrator (NHA) confirmed there was no documented evidence that Resident 11 or Resident 11's representative was invited to participate in the resident's care plan development. The NHA was unable to provide documented evidence the interdisciplinary team and Resident 11 met and provided Resident 11 an opportunity to fully participate in establishing her expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. The NHA was unable to provide a list of facility staff that met on February 25, 2026, as part of Resident 11's care plan meeting. The facility failed to ensure a person-centered care planning process was completed by failing to invite or include Resident 11 in the development of her goals and frequency of services, resulting in the resident's concerns regarding services for ambulation not addressed. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(3) 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** Based on review of the Resident Assessment Instrument (RAI) Manual, clinical records, resident observation, and staff interviews, it was determined the facility failed to complete an accurate Minimum Data Set for one of 36 sampled residents (Resident 199). Findings include: A clinical record review revealed resident 199 was admitted to the facility on [DATE], with a diagnosis of urinary incontinence (the loss of control over one's urine). A review of a significant change Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 30, 2025, revealed that Resident 199 did not experience any limitation in range of motion (ROM) (referring to the full movement of a joint) in the upper extremities. MDS section GG-0115 (section related to functional abilities, the ability to perform tasks and activities necessary for daily living) indicated Resident 199 did not experience any limitation in moving one's shoulders, arms, elbows, wrist, hands, and fingers. Clinical record review revealed an evaluation by occupational therapy (certification period August 4, 2025, to October 25, 2025) and indicated Resident 199 had limited ROM in the right and left upper extremities including shoulders, elbows, wrists, and fingers. The therapy evaluation identified Resident 199 had bilateral hand contractures (permanent tightening of muscles, tendons, ligaments, or skin, which severely impacts joint mobility and function). The therapy evaluation revealed Resident 199 had a mobility performance score of 0. The mobility function score ranges from 0-12, 0 indicated the lowest level of function. Observation of Resident 199 while in bed, on February 24, 2026, at 10:45 AM revealed bilateral upper extremities (including elbows, wrists and fingers) with obvious joint deformities. The resident's elbows were observed in a fixed flexed position (permanently bent and unable to be straightened) held close to the chest. Both hands were observed in a closed, flexed position with the fingers tightly bent toward the palm. When asked, the resident was unable to open either hand or extend the arms. Dressings were observed in both hands and between the fingers. These observations were consistent with significant limitations in movement of the upper extremities (arms and hands). However, a review of the resident's Significant Change Minimum Data Set (MDS) assessment dated [DATE], Section GG0115, Functional Abilities and Goals indicated the resident did not have limitations with movement of the upper extremities. The observed physical limitations and therapy evaluation did not correspond with the MDS coding indicating no limitation. A review of the same significant change MDS dated [DATE], Section GG0120, Mobility Device (addressing devices used to assist with mobility such as walking), revealed Resident 199 uses a walker for mobility and ambulation. This information was inconsistent with the coding in Section GG0170, Mobility (which documents how a resident performs movement activities such as rolling in bed, sitting, standing, and transferring). Section GG0170 indicated the resident was dependent (helpers perform all of the effort, the resident does none of the effort to complete the activity) for multiple mobility activities, including rolling from left to right, sitting to lying, sitting to standing, and transferring from the bed to a chair. The coding in Section GG0170 further indicated the resident was unable to walk or move independently. The documentation indicating the resident used a walker for ambulation did not correspond with the resident's documented dependence for mobility and inability to walk. During an interview on February 25, 2026, at 1:45 PM, the Director of Nursing reviewed the above information and confirmed the MDS assessment data was inaccurate and did not accurately reflect Resident 199's limited upper extremity movement or the resident's mobility status. 28 Pa. Code 211.5(f)(iii) Medical records. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of pre-admission records, facility clinical records, select facility policy, and staff interviews, it was determined the facility failed to develop a baseline care plan that documented interim, person-centered approaches to address the resident's identified fall risk for one of 36 sampled residents (Resident 14). Findings include: A review of the clinical record revealed Resident 14 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure with hypoxia (lungs cannot deliver oxygen to the body). A review of Resident 14's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 6, 2025, revealed Resident 14 was 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; score between 0 and 7 indicate severe cognitive impairment). A review of Resident 14's pre-admission medical records revealed the resident experienced two falls in the weeks prior to admission. Documentation indicated a fall occurred at home on October 12, 2025, at 2:15 AM, and another fall occurred at home on October 16, 2025, at 3:00 AM. A review of the facility's Baseline Care Plan Policy, reviewed January 6, 2026, indicated the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality of care. The policy explanation and compliance guidelines revealed that initial goals shall be established that reflect the resident's stated goals and objectives. The interventions shall be initiated that address the resident's current needs including any health and safety concerns to prevent decline or injury such as elopement, fall, or pressure injury risk as well as any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. The baseline care plan must be developed within 48 hours of the resident's admission. A review of nursing documentation dated November 4, 2025, at 1:43 AM revealed Resident 14 was observed in the hallway without clothing on the lower half of the body. The documentation indicated the resident wandered into other residents' rooms and went through other residents' belongings. Nursing staff attempted to redirect the resident using snacks, drinks, and activities such as coloring and folding laundry. The documentation indicated the resident required one-to-one supervision (continuous monitoring by a staff member assigned to observe the resident at all times) and returned to bed at approximately 5:00 AM. A review of nursing documentation dated November 8, 2025, at 7:00 AM revealed Resident 14 remained restless throughout the night. Documentation indicated that both non-medication interventions (such as activities, food, and providing a calm environment) and medication were not effective in reducing the resident's restlessness. The note indicated the resident required staff supervision for most of the night. A review of the clinical record revealed Resident 14 experienced a fall without injury on November 8, 2025, at 7:45 AM. Nursing documentation indicated the resident was confused and looking for socks at the time of the fall. The note further indicated the resident was wearing properly fitting, non-skid socks. Interventions initiated after the fall included checks by staff every 15 minutes from 7:00 PM through 9:00 AM for 72 hours, an evaluation by therapy, and neurological checks (assessments performed by staff to monitor a resident after a fall such as level of consciousness, alertness and the ability to move) in accordance with facility policy. A review of the baseline care plan initiated on October 31, 2025, indicated Resident 14 had safety risks, including falls, and documented the resident experienced multiple falls at home prior to admission. However, the baseline care plan lacked specific, resident-centered fall prevention interventions to reduce the resident's risk for falls during nighttime hours, despite documented falls occurring during nighttime hours prior to admission and observations of nighttime wandering and unsafe behaviors after admission. During an (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on February 27, 2026, at 10:15 AM, the Director of Nursing confirmed the baseline care plan for Resident 14 did not include individualized fall prevention interventions consistent with the resident's identified nighttime behaviors and fall risk and was not consistent with the facility's baseline care plan policy. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.5(f)(iii) Medical records.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, investigative documentation provided by the facility, select facility policy, manufacturer guidelines, and staff interview, it was determined the facility failed to ensure appropriate prevention and management of a pressure injury for one of 36 sampled residents (Resident 9). Findings include: Review of the facility's Pressure Injury Prevention and Management policy, reviewed January 6, 2026, revealed that the facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce, or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. Interventions could include, but are not limited to, redistribution of pressure, minimizing exposure to moisture, and providing appropriate, pressure-redistributing support surfaces. Clinical record review revealed that Resident 9 had diagnoses including chronic kidney disease (a long-term medical condition in which the kidneys gradually lose the ability to filter waste and excess fluid from the blood) and a history of pressure injuries (damage to the skin and underlying tissue caused by prolonged pressure on the skin, most often over bony areas of the body). The resident also had an unstageable pressure ulcer (the wound is covered by dead tissue or scabbing that prevents healthcare staff from determining the full depth and severity of the wound until the tissue covering the wound is removed) on the coccyx (tailbone area located at the lower end of the spine). A review of Resident 9's quarterly Minimum Data Set assessment, MDS, a federally mandated standardized assessment process conducted periodically to plan resident care dated January 10, 2026, revealed that Resident 9 was severely cognitively impaired with a BIMS score of 1, (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 indicates a score of 0-7 indicates severe cognitive impairment). The MDS indicated the resident required staff assistance with mobility in bed and when transferring between bed and chair and had a Stage III pressure ulcer (a full thickness loss of skin where the underlying fat tissue may be visible and dead tissue may be present, although the depth of the wound can still be determined). Investigative documentation provided by the facility dated December 28, 2025, at 8:00 PM revealed staff identified a pressure ulcer on Resident 9's coccyx that measured 1 centimeter by 0.5 centimeter. However, the investigation failed to document the depth of the wound and failed to determine the stage of the pressure ulcer, which is a clinical method used to classify the severity and depth of a pressure injury. The investigation indicated the resident had a history of pressure injuries in the same location and that the previously healed area had reopened after healing on November 24, 2025. The facility identified potential contributing factors including immobility, incontinence (inability to control bowel or bladder function), and fragile skin. The investigative report included a staff statement indicating the resident was incontinent of bowel and bladder and that staff had attended to the resident two hours earlier. The report also indicated the resident spent time in both a chair and bed during the shift. However, the investigation did not include documentation describing the condition of the coccyx area prior to the identification of the pressure ulcer, did not describe the condition of the skin surrounding the wound, and did not determine whether preventative interventions identified in the resident's care plan were consistently implemented. The investigation also failed to determine whether a change in the resident's condition or care contributed to the reopening of the previously healed pressure injury. A Braden Scale assessment (a standardized assessment tool used to determine a resident's risk for developing pressure injuries by evaluating factors such as mobility, (continued on next page)		

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activity level, moisture exposure, and nutritional status) had been completed for Resident 9 on December 28, 2025. The assessment indicated Resident 9 was at very high risk for developing pressure injuries due to being chairfast, having limited mobility, and being constantly moist due to urinary incontinence. A review of the resident's care plan dated January 28, 2026, revealed interventions to prevent pressure injury development and promote wound healing. These interventions included staff repositioning the resident regularly while in bed and while seated in a chair to relieve pressure from vulnerable areas of the body. Staff task documentation for February 2026 indicated Resident 9 was to be repositioned every hour as part of pressure injury prevention measures. However, a review of staff task documentation from February 1, 2026, through February 26, 2026, revealed the repositioning documentation was blank and lacked evidence that staff completed or documented the required repositioning interventions. A review of Resident 9's February 2026 weight record revealed that on February 19, 2026, the resident weighed 99 pounds and on February 26, 2026, at 8:53 AM the resident weighed 98.5 pounds. The clinical record indicated the resident utilized a specialty therapeutic mattress identified as the Med-Aire Melody Alternating Pressure Low Air Loss Mattress to assist with pressure redistribution and wound healing to the resident's coccyx area. Manufacturer guidelines for the Med-Aire Melody Alternating Pressure Low Air Loss Mattress indicated the mattress is designed to distribute a resident's body weight across the support surface in order to reduce pressure on vulnerable areas and promote healing of pressure injuries. The manufacturer instructions indicated the mattress must be set according to the resident's current weight in order to ensure proper pressure redistribution and therapeutic function for wound healing. Observation of Resident 9's therapeutic mattress on February 26, 2026, at 9:15 AM and 2:15 PM, and again on February 27, 2026, at 10:20 AM, revealed the mattress weight setting was adjusted to 150 pounds. This setting was inconsistent with the resident's documented weight of 98.5 pounds. The mattress manufacturer indicated the system could accommodate residents weighing as little as 80 pounds. A review of a wound assessment dated [DATE], revealed the pressure ulcer on Resident 9's coccyx measured 2.0 cm by 1.0 cm by 0.20 cm and was identified as unstageable. During an interview on February 27, 2026, at 9:15 AM, the Director of Nursing was unable to provide evidence that the facility conducted a thorough investigation to determine whether pressure injury prevention interventions were consistently implemented. The Director of Nursing was also unable to provide documentation demonstrating that the resident's repositioning schedule had been followed or that the incorrect therapeutic mattress weight setting had been identified and corrected to ensure appropriate pressure redistribution and promote healing of the pressure injury. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
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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** Based on clinical record review, review of select facility policy, and resident and staff interviews, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility to the extent possible for one resident out of 36 residents sampled (Resident 13). Findings include: A review of the facility policy titled Restorative Nursing Program, last reviewed by the facility on January 6, 2026, revealed it is the policy of the facility to provide maintenance services (ongoing nursing support intended to preserve a resident's current physical abilities and prevent decline) and restorative services (structured nursing interventions designed to help a resident regain or improve functional abilities such as walking, transferring, or performing daily activities) designed to maintain or improve a resident's abilities to the highest practicable level. The policy indicates that residents, as identified during the comprehensive assessment process, will receive services from restorative aides (trained nursing assistants who provide restorative maintenance care under the supervision of licensed nursing staff) when they are assessed to have a need for restorative nursing services. A clinical record review revealed Resident 13 was admitted to the facility on [DATE], with diagnoses that include multiple sclerosis (a chronic autoimmune disease in which the body's immune system attacks the protective covering of nerves in the brain and spinal cord, which can cause weakness, problems with movement, balance, and coordination). A review of Resident 13's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 1, 2026, revealed that Resident 13 was cognitively intact with a BIMS score of 14 (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 through 15 indicates cognition is intact). An occupational therapy Discharge summary dated [DATE], revealed discharge recommendations for Resident 13 to have a restorative range of motion program established, which includes bilateral upper extremities active range of motion (AROM, movement of a joint performed by the resident using their own muscle strength to move the body part through its normal range of movement) through all planes as tolerated, two sets of 10 repetitions daily to improve range of motion and maintain strength and joint integrity. A physical therapy Discharge summary dated [DATE], revealed discharge recommendations for Resident 13 to have a restorative nursing program, which includes bilateral lower extremity active range of motion and passive range of motion (PROM, movement of a joint performed by another person, such as nursing staff, who moves the resident's body part through its normal range of movement when the resident is unable to move it independently), manual stretches for improved range of motion, strength for bilateral lower extremities, and reducing the resident's risk for contractures. A review of the resident's care plan revealed that Resident 13 required a nursing maintenance program initiated on August 28, 2025. Interventions implemented for Resident 13 were to maintain or improve the present level of functioning include discussing nursing maintenance appropriateness and progress in interdisciplinary department meetings and active range of motion upper and lower body exercises daily. During an interview on February 24, at 11:36 AM, Resident 13 indicated that she is not receiving any therapy or restorative nursing services and is not encouraged or offered exercise daily. Resident 12 confirmed that she has a problem with her upper and lower body range of motion (ROM, the full, measurable distance and direction a joint or body part can move, ranging from bending to straightening). During an interview on February 24, at 11:40 AM, Resident 13's representative indicated that she was concerned the facility was not consistently implementing range of motion exercises with the resident. A review of the documentation survey report for January 28, 2026, through February 25, 2026, revealed Resident 13 refused or was not applicable for bilateral upper extremity active range of (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	motion exercises on 17 occasions during the 30-day period. A review of the documentation survey report for January 28, 2026, through February 25, 2026, revealed Resident 13 refused or was not applicable for bilateral lower extremity active range of motion exercises on 17 occasions during the 30-day period. A review of the documentation survey report dated February 25, 2026, revealed that Resident 13 actively participates in bilateral lower and upper active range of motion exercises with Employee 1, Nurse Aide (NA). The documentation indicated Resident 13 completed 30 repetitions and spent 15 minutes completing the upper body exercises. Also, the documentation indicated Resident 13 completed 30 repetitions and spent 15 minutes completing the lower-body exercise. During an interview on February 26, 2026, at 10:02 AM, Resident 13 indicated that she did not receive or was offered 15 minutes of active upper body range of motion exercises or lower body range of motion exercises yesterday. Resident 13 reiterated she is not receiving any therapy or restorative nursing services and is not encouraged or offered exercise daily. Also, the resident confirmed that she is not refusing and did not refuse participation in these activities over the last 30 days. During an interview on February 26, 2026, at 10:50 AM, Employee 1, Nurse Aide (NA), confirmed that she documented Resident 13 received 15 minutes of active upper body range of motion exercises and lower body range of motion exercises on February 25, 2026. Employee 1, NA, indicated that the range of motion exercises occur when the resident is assisted with activities of daily life. Employee 1, NA, could not confirm that Resident 13 completed 30 repetitions and spent 15 minutes completing the lower body exercises and completed 30 repetitions and spent 15 minutes completing the upper body exercises. During an interview on February 26, 2026, at 12:05 PM, the above information was reviewed with the director of nursing (DON). The DON was unable to explain why the documentation survey report indicated that Resident 13 refused or was not applicable for bilateral lower and upper extremity active range of motion exercises on 17 occasions during the 30-day period. The facility failed to consistently provide restorative nursing services as planned to maintain mobility to the extent possible for Resident 13. 28 Pa. Code: 211.5(f)(ii) Medical records. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa Code 211.12(d)(3)(5) Nursing services.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and staff interviews, it was determined the facility failed to ensure that a resident's drug regimen was free of unnecessary antibiotics for one out of 36 residents sampled (Resident 141). Findings include: A review of Resident 141's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include mild neurocognitive disorder with behavioral disturbance (a slight, noticeable decline in cognitive abilities that does not significantly interfere with daily independence and is accompanied by agitation, irritability or mood changes) and cerebral infarction (stroke). A nursing progress note dated January 20, 2026, indicated staff notified the physician of Resident 141's increased confusion and incontinence (the inability to control bladder or bowel function). The physician ordered STAT (immediate) laboratory testing, including a complete blood count (CBC, a blood test that measures the number and types of blood cells and can help identify infection or inflammation), a basic metabolic panel (BMP, a blood test that measures electrolytes, kidney function, and blood sugar levels), a urinalysis (UA, a laboratory test that examines the appearance and chemical composition of urine to detect signs of infection or other medical conditions), and a urine culture and sensitivity test (C&S, a laboratory test that attempts to grow bacteria from a urine specimen to determine whether bacteria are present and, if so, which antibiotics would effectively treat the bacteria). A physician's order dated January 21, 2026, directed staff to administer Ceftriaxone Sodium Injection (a powerful, long-acting antibiotic used to treat severe bacterial infections). The order instructed staff to administer 1 gram intramuscularly (injection of medication into a large muscle to allow the medication to be absorbed into the bloodstream) once daily for three days. A laboratory report dated January 21, 2026, indicated the urine culture showed no significant growth, meaning the urine specimen did not contain enough bacteria to indicate an active urinary tract infection. Review of Resident 141's January 2026 Medication Administration Record (MAR, the clinical document used by staff to record medications administered to a resident) revealed staff administered one dose of Ceftriaxone on January 21, 2026, despite the urine culture showing no significant bacterial growth. The physician discontinued the Ceftriaxone order on January 22, 2026. A physician's order dated February 19, 2026, directing staff to obtain another urinalysis and urine culture and sensitivity test. An additional order dated February 20, 2026, directed staff to administer Ceftriaxone Sodium Injection 1000 milligrams intramuscularly once daily for a suspected urinary tract infection (UTI) followed by 500 milligrams intramuscularly on the second day and 500 milligrams intramuscularly on the third day. A laboratory report dated February 20, 2026, indicated the urine specimen showed multiple flora suggesting contamination (the presence of several different types of bacteria that likely entered the specimen during collection, which means the test result may not accurately represent bacteria present in the bladder) or colonization (bacteria present in or on the body without causing illness, symptoms, or tissue damage). The report recommended repeating the test if symptoms worsened. Review of the February 2026 MAR revealed staff administered Ceftriaxone on February 20, 2026, and again on February 21, 2026. Review of physician's orders indicated the medication was discontinued on February 20, 2026; however, staff administered an additional dose on February 21, 2026. During an interview on February 27, 2026, at 10:45 AM, the Infection Preventionist (IP) confirmed the resident's symptoms did not meet the McGeer Criteria (a standardized surveillance guideline used in long term care facilities to determine whether a resident has a true, symptomatic infection requiring treatment). The IP explained that the criteria help distinguish a true urinary tract infection from asymptomatic bacteriuria (the presence of bacteria in the urine without symptoms of infection). The IP acknowledged that the administration of Ceftriaxone was not clinically indicated and confirmed the resident received unnecessary antibiotic therapy that was not consistent with evidence-based infection control practices or antimicrobial stewardship principles (programs designed to ensure antibiotics are used only when medically necessary to reduce (continued on next page)		

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotic resistance and prevent avoidable medication exposure). 28 Pa. Code 211.2(d)(3)(5) Medical Director 28 Pa. Code 211.12(d)(3)(5) Nursing services		