STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395462	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookmont Healthcare and Rehabilitation Center	510 Brookmont Drive Effort, PA 18330

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** 41581 Based on observations, clinical record review and staff and resident interviews it was determined that the facility failed to provide care in a manner that maintains the personal dignity, respect, and quality of life of seven residents out of 17 sampled (Resident 3, 4, 7, 9, 11,12, 16). Findings include: A review of Resident 11's clinical record revealed the resident was admitted to the facility April 11, 2024, with diagnoses which included type 2 diabetes and muscle weakness. An interview with Resident 11 on May 23, 2024, at 9:10 AM revealed that the resident stated that staff do not answer call bells timely. The resident stated that on a good day the staff will answer the call bells in 30 minutes. The resident stated that it can take up to two hours for staff to answer his call bell. The resident further explained that he was in the bathroom recently and rang for staff because there was no toilet paper left in the bathroom. The resident stated it took 25 minutes for a staff member to come in and ask what he needed. The staff member stated she would be right back with toilet paper and then the resident waited another 26 minutes on the toilet until the staff member came back. Resident 11 stated he waited 51 minutes in total in the bathroom waiting for staff assistance. Further the resident stated that staff are very rude and talk down to him. He stated he does not feel respected and when he has brought his concerns to the director of nursing attention, she gaslights him and tells him what he is saying is not true. The resident stated that there are many staff that will yell and talk down to the residents on all shifts. A review of Resident 16's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included muscle wasting and cirrhosis of the liver. An interview with Resident 16 at 9:50 AM on May 23, 2024, revealed that the resident stated that staff take at least 30 minutes to answer his call bell when he rings for help. The resident stated this happens on all shifts. A review of Resident 7's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes and stage 3 kidney disease. (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	An observation on May 23, 2024, at approximately 10:00 AM revealed Employee 3 NA (nurse aide) interacting with Resident 7 trying to get her dressed. The employee was heard yelling at Resident 7 telling her she needed to put these pants on. The employee was heard telling the resident resident your son called and said you need to do this. The resident replied to the employee, by stating Bullsh*t. The employee was heard yelling at Resident 7, Bullsh*t, Bullsh*t, call him you will see! The resident told Employee 3 to leave her alone, that she is not getting those pants on. The resident then yelled out ouch and stated, Don't fight with me. The employee got loud with the resident and stated, You don't fight with me! Resident 7 told the employee that she was not going to do what the employee was telling her to do. The resident stated she was not putting on those pants that the employee was trying to put on her. The employee said oh, why is this not your shirt or pants or walker here. The employee continued to try to force the resident to put the pants on. The resident continued to tell the employee that she doesn't feel good and to leave her alone. Employee 3 got loud and yelled, Whatever! at the resident and exited the resident's room. An interview with Resident 7 On May 23, 2024, at 10:07 AM, revealed that the resident was upset. The resident stated she was not doing well. The resident stated that Employee 3 tried to put a pair of pants on her she did not want on. The resident stated the employee was rude and fighting with her and went to go tellon her for not getting dressed. The resident stated she just wanted to be left alone but the employee kept fighting with her. The resident stated the employee just left her in a brief uncovered and pointed down. Observation at that time revealed the resident lying with no pants on just a brief in bed exposed. The resident stated staff are always rude and disrespectful to her. She stated that the call bell wait times are terrible. She stated that she has to wait an hour at times for staff to meet her needs. She stated she will be waiting for help while staff are yapping with each other in the halls. A review of Resident 9's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included muscle weakness, and osteoarthritis. An interview with Resident 9 on May 23, 2024, at approximately 10:15 AM revealed that the resident stated that staff do not answer call bells timely. The resident stated that he has waited up to two hours for staff to answer his bell and assist him. The resident stated normal wait time is over 30 minutes and it happens on all shifts. A clinical record review revealed that Resident 3 was admitted to the facility on [DATE], with diagnoses that include neurogenic bladder and the need for assistance with personal care. Interview with Resident 3 on May 23, 2024, at approximately 10:16 AM, the resident stated that staff do not answer call bells timely and has experienced very long waits for staff to answer the call bells and this happens on a regular basis. It just happened this morning, waited over 30 minutes. Some waits are up to two hours. The resident states what if it was a true emergency, I would be dead. The resident mentioned complaining to staff and the administration is aware but the more they complain the more rude staff becomes when they finally come in to assist. The resident stated waits results in sitting in their own urine and feces while waiting for someone to come help them. A clinical record review revealed that Resident 4 was admitted to the facility on [DATE], with diagnoses that include lack of coordination, muscle weakness, gait and mobility abnormalities and repeated falls. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident 4 on May 23, 2024, at approximately 10:23 AM, revealed that she often waits up to an hour for staff to assist after ringing the call bell. The resident stated that she suffers from constipation and if she feel like having to hold a bowel movement ends up making this worse and becomes embarrassed when she becomes incontinent and requires total assistance to get cleaned up. An interview with Resident 12 (who wishes to remain anonymous in fear of retaliation) on May 23, 2024, at approximately 10:45 AM revealed the resident has to wait 30 minutes for the call bell to be answered. The resident stated it happens on all shifts. The resident further indicated that staff are rude and have bad attitudes. The resident stated some staff are disrespectful to the residents. The resident stated some employees speak very nasty to this resident and to other residents and tell them this is the way it is. The resident stated it is sometimes just the employee's demeanor and presence alone that make the resident uncomfortable. The resident stated employees are fighting with each other in that halls and residents can hear them. The resident reiterated please not to identify me for feat the staff will retaliate against the resident. During an interview on May 23, 2024, at approximately 1:15 PM with the Nursing Home Administrator (NHA) verified that it is the facility's expectation that all residents be treated with dignity and respect. The NHA was unable to explain why multiple residents are reporting untimely staff response times, resulting in the residents' feelings that the facility is not adequately staffed, which was negatively affecting the residents' quality of life in the facility. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident rights 28 Pa Code 211.12 (d)(5) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to provide housekeeping and maintenance services to maintain a clean and safe resident environment. Findings include: An observation on May 23, 2024, at approximately 9:00 AM revealed a strong urine smell when entering the facility. An observation on May 23, 2024, at 9:10 AM revealed a strong urine smell emanated from resident room [ROOM NUMBER]. There were gouges in the paint on the wall behind the residents' beds. Paper and debris was observed on the floor. A used glucose monitoring strip was observed lying on the baseboard heater. The light at the first bed did not turn off. The light switch was broken and does not turn the light off. The handle was broken off the nightstand. An observation on May 23, 2024, at 9:26 AM, in the Nourishment Room in the Center Hallway revealed the hinges broken off the cabinet door. An observation on May 23, 2024, at approximately 10:00 AM revealed resident room [ROOM NUMBER]'s door was cracked and chipped. Dirt, debris, and food crumbs were observed on the floor and fall mats. In Resident room [ROOM NUMBER] dirt and debris was observed on the floor. The room had a strong odor of feces. The bedroom door was cracked and chipping. [NAME] spots were observed splattered on the privacy curtains. An observation on May 23, 2024, at 10:03 AM, in resident room [ROOM NUMBER] revealed a dark brown water stain in the bowl of bathroom toilet. The surface of the wall to the right upon entering the room was cracked, crumbling and flaking. An observation on May 23, 2024, at 10:43 AM, in resident room [ROOM NUMBER] revealed a used wet washcloth in shared resident bathroom hanging on the top of the toilet seat. Upon entering the to right of the room, several black marks were observed on the wall. Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 23, 2024, at approximately 1:00 PM confirmed that the facility is to be maintained daily to provide a clean and sanitary environment for the residents. 28 Pa. Code 201.18 (e)(2.1) Management

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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. 41581 Based on clinical record review and staff interviews, it was determined that the facility failed to develop person-centered care plans that addressed a resident's medical needs and prescribed medication therapy for one resident out of 17 sampled residents (Resident 13). Findings include: A review of the clinical record revealed Resident 13 was admitted to the facility April 29, 2024, with diagnoses of type two diabetes (a condition from insufficient production of insulin causing high blood sugar), sarcoidosis (a condition where there is an abnormal collection of inflammatory cells that form clumps in the skin or lymph nodes that result in dry cough and shortness of breath), and long-term use of anticoagulants (blood thinning medication) and insulin (injectable medication to treat diabetes). A review of a physician order initially dated April 29, 2024, revealed that the resident was receiving Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/milliliter (ml) inject 17 unit subcutaneously in the afternoon for diabetes and Apixaban (Eliquis) Oral Tablet 5 milligrams (mg) give every morning and at bedtime to prevent blood clots related to Atrial Fibrillation. A review of Resident 13's care plan, conducted during the survey ending May 23, 2024, revealed that the resident's comprehensive care plan did not include the resident's medical condition, type two diabetes and sarcoidosis, and the necessary care and services needed to manage those conditions and failed to identify the resident's daily insulin use for diabetes and interventions to monitor for signs and symptoms of hypo or hyperglycemia. The resident's plan of care failed to identify the resident's anticoagulant therapy and interventions to monitor for bleeding and related side effects. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 23, 2024, at approximately 1:15 PM confirmed the absence of Resident 13's medical conditions and failed to ensure that comprehensive care plans were developed in manner to meet the resident's medical and treatment needs. 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on select facility policy, observation, and staff interview, it was determined that the facility failed to ensure adherence to medication expiration/use by dates for one of 15 residents (Resident 15) and failed to properly label medication in one of five medication carts (Center Cart). Findings include: A review of facility policy entitled Storage of Medications indicated that the pharmacy dispenses medications in containers that meet legal requirements including standards established, medications are maintained in the dispensed packaging. Medications outdated are disposed of according to disposal guidelines. A review of facility policy entitled Medication Administration indicated that the individual administering medications must verify the resident's identity before giving the medication verifying the name and date of birth, checking identification band, checking photograph and medical record. The manufacturer's expiration/beyond use date on the medication label must be checked prior to administering. An Observation on [DATE], at 9:41 AM, of the Center Hall medication cart in the presence of Employee 1 Licensed Practical Nurse (LPN), revealed an opened Hemorrhoid (Phenylephrine-Mineral Oil) 0XXX[DATE].9 % Ointment (hemorrhoid pain and discomfort relief ointment used rectally) and X-[NAME] Freeze (pain relieving cold therapy gel) 16-ounce bottle without a label identifying the resident or instructions of use. A clinical record review revealed that Resident 15 was admitted to the facility on [DATE], with diagnoses that include glaucoma (a condition where the eye's optic nerve is damaged with or without raised intraocular pressure and could cause gradual vision loss if untreated). A review of Medication Administration Record (MAR) for the month of May, revealed that Resident 15 was ordered Xalatan Solution (Latanoprost) with instructions to instill one drop in both eyes at bedtime for glaucoma with a start date of [DATE], and to be discontinued on [DATE]. An observation on [DATE], at 10:17 AM of the East Hall medication cart in the presence of Employee 2, LPN revealed an opened Latanoprost Ophthalmic (eye) drop medication with an open date of [DATE], and without an expiration date noted on the bottle. According to the product manufacturer storage instructions Latanoprost eye drops are to be thrown away and not used after six weeks of opening. The Latanoprost eye drops were opened on [DATE], and would have expired on [DATE] (six weeks after opening). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Director of Nursing (DON) and Nursing Home Administrator (NHA) on [DATE], at 1:00 PM it was confirmed that the eye drops should be dated when opened and discarded six weeks after the initial date opened and medications in use should have a proper label present prior to administering. 28 Pa. Code 211.9 (a)(1)(k)(1) Pharmacy Services 28 Pa Code 211.12 (d)(3)(5) Nursing services