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	04/05/2024

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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility policy CMS guidance and facility documentation, and resident, resident representative, and staff interviews, it was determined that the facility failed to ensure that resident Medicare beneficiaries were only disenrolled from Medicare health plans with the beneficiary's or the beneficiary's representative's request, consent, knowledge, and/or complete understanding for four out of the 23 residents sampled (Residents 82, 95, 168, and 269). Findings include: A review of a CMS guidance titled Memo to Long Term Care (LTC) Facilities on Medicare Health Plan Enrollment dated October 2021 revealed CMS continues to hear reports of the unacceptable practice of nursing facilities or skilled nursing facilities (collectively, long-term care or LTC facilities) disenrolling beneficiaries from Medicare health plans (Medicare Advantage plans with and without Part D, Medicare-Medicaid plans, or Programs of All-Inclusive Care for the Elderly (PACE) without the beneficiary's or the beneficiary's representative's request, consent, knowledge, and/or complete understanding. Only a Medicare beneficiary, the beneficiary's authorized or designated representative, or the party authorized to act on behalf of the beneficiary under state law can request enrollment in or voluntary disenrollment from a Medicare health or drug plan. Further it is indicated changes in a beneficiary's health care coverage generally must be initiated by the beneficiary or their representative. If a beneficiary or their legal representative requests assistance from the LTC facility in changing the beneficiary's health care coverage, the LTC facility should take the following steps to help ensure changes to a beneficiary's health care coverage comply with regulations regarding enrollment/disenrollment and resident rights: 1) Explain orally and in writing the impact to the beneficiary if they change coverage (e.g., to a stand-alone prescription drug plan (PDP) and Original Medicare, or to a different Medicare health plan). (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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record revealed Resident 95 was admitted to the facility on [DATE], with diagnoses that included protein-calorie malnutrition, gastro-esophageal reflux disease (GERD), end-stage renal disease, and dependence on renal dialysis. An admission MDS assessment dated [DATE], revealed that Resident 95 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status - a tool to assess cognitive function - a score of 13-15 indicates cognitively intact). Upon admission, Resident 95's primary insurance payer was noted to be [NAME] Quality Options Medicare Plan. On March 1, 2024, the resident's primary insurance payer was changed to traditional Medicare. A review of a facility form entitled Disenrollment Form dated February 28, 2024, revealed a request to disenroll Resident 95 from her [NAME] Medicare Plan so that the resident may be covered under original Medicare benefits. During an interview on April 4, 2024, at approximately 10:05 AM, Resident 95 stated that she was aware of the change in her insurance, but stated that she did not ask or initiate the request and did not ask the facility for assistance in changing her insurance. The resident stated that the facility approached her to initiate the change. Resident 95 stated she did not sign anything authorizing the change. The state surveyor shared the facility form entitled Disenrollment Form dated February 28, 2024, and the resident, who was alert and oriented resident stated, That's not my signature. In further interview, Resident 95 stated that her son, her identified emergency contact #1, had called her and informed her that the facility staff had reached out to him regarding her insurance. She said that her son had stated, This is what they do, meaning change insurance. A telephone interview with Resident 95's son, emergency contact #1, on April 5, 2024, at approximately 1:05 PM, revealed that the facility's Director of Marketing called him regarding changing his mother's Medicare insurance. He further stated that he believes the call was on February 28, 2024, and was late in the day. He explained that the facility informed him that his mother's Medicare insurance plan would be cutting her from therapy services, but if they changed her insurance, she will receive additional paid days in therapy. Resident 95's son stated the facility did not fully inform him of the pros and cons of switching, including specific pharmacy changes, co-pays, physician choices, re-enrollment in her prior plan, deadlines, and potential penalties or loss of any additional coverage or benefits. Resident 95's son further stated he felt pressured by the facility to decide because the facility stated it was the end of the month and they needed to make the change now so his mother would receive more services. Resident 95's son further stated he called back the next day to further the conversation with the facility about potentially making a change in Medicare plans and the facility told him, It's done; your mother already signed it. He further stated that he never gave his permission nor signed anything to allow this change, and that his mother would most certainly know her signature when she saw it. A review of Resident 95's clinical record revealed no documented evidence of the date or time the resident, or her son, initiated their wish or desire to change, nor the circumstances surrounding the request to disenroll from her [NAME] Medicare Plan. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on April 4, 2024, at approximately 12:15 PM, the facility's Director of Marketing explained that she assists residents with the Medicare disenrollment process. The Director of Marketing explained that the facility does not have a specific policy or procedure that details under what circumstances the facility can assist a beneficiary with an insurance plan change. The Director of Marketing stated that she approaches residents when they are eligible for additional days of Medicare Part A stay, if they disenroll from a Medicare Advantage Plan and switch to Original Medicare. She confirmed during interview that she was not aware of the need to assess and document the residents' cognitive abilities prior to asking the residents to sign disenrollment forms to ensure the residents were fully capable of making an informed decision and possessed the functional abilities to understand the potential implications of disenrolling from their Medicare plans. The Director of Marketing provided the surveyors, an information packet that is provided to residents, when the facility approaches them to disenroll from a Medicare insurance plan. The packet failed to include the information indicated in the facility's Medicare Enrollment/Disenrollment policy to ensure that residents and residents' representatives are able to make fully informed decisions on disenrollment. Specifically, the packet failed to include an explanation regarding deductible costs, copays, and loss or lack of supplemental coverage specific to the beneficiary. Also, the packet did not include the specific name of the drug plan that will cover the beneficiary's medication, including the deductible and co-pays or coinsurance. The Director of Marketing confirmed that the facility does not provide residents information from www.medicare.gov for information on locating a Medicare-approved agent or education regarding Medicare disenrollment, as indicated in the facility policy. Residents are directed and provided with a third-party health insurance agent that represents many major health insurance carriers. During an interview on April 5, 2024, at approximately 10:00 AM, the Nursing Home Administrator (NHA) confirmed that the facility's policy does not explain under what circumstances the facility can assist a beneficiary with a Medicare insurance plan change. The NHA was unable to provide documentation that the Director of Marketing was aware of the resident's cognitive assessment prior to disenrolling residents' Medicare plans. The NHA was was also unable to state why some residents stated that they did not understand or authorize the facility to make changes to their healthcare insurance coverage. During the interview, the NHA confirmed that it is the facility's responsibility to ensure that resident Medicare beneficiaries are only disenrolled from Medicare health plans with the beneficiary's or the beneficiary's representative's request, consent, knowledge, and/or complete understanding. During an interview with the Nursing Home Administrator (NHA) on April 5, 2024, at approximately 1:28 PM, a request was made for documented evidence of resident 95's [NAME] insurance indicating that the resident was being released-cut from therapy services. In response, the NHA stated that he was not aware of the notification letter and that the information communicated to the resident and her resident representative may have been presented hypothetically not factually. 28 Pa. Code 201.18 (b)(1)(2)(e)(1) Management 28 Pa. Code 201.29 (a) Resident rights

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48277 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 April 2, 2024, at 11:10 AM , in resident room E-58 revealed multiple dark brown water stains in the bowl of bathroom toilet. Interview with Resident 33, a cognitively intact resident with a BIMS score of 13 (BIMS-brief interview to assess cognitive status. A score of 13-15 indicates intact cognitive responses), indicated that the previous housekeeper used a special cleaner to remove the stains, but the new housekeeper does not use the same cleaner and the toilet looks dirty all the time. Further observation of resident room E-58, bed A, revealed light brown stains on the Resident 33's fitted sheet and a yellow stain on the pillowcase. Resident 33 stated that he makes his bed every day. He also stated that his bed linens are the same sheets since I came back (from the Covid isolation room). I've been back over a month. Resident 33 further stated that he chooses to bathe at the sink and does not like to take showers. He stated that he performs his own bathing at the sink without assistance from staff. Continued observation on April 2, 2024, at 11:25 AM, in resident room E-58, bed B, revealed soiled bed linens on Resident 88's bed. Two pillowcases were stained yellow, and the fitted sheet was stained with multiple light brown stains in the middle of the mattress and a large brown stain at the foot of the bed. Interview during the observation with Resident 88, a cognitively intact resident with a BIMS score of 15, revealed that her bed linens are not changed regularly. Resident 88 stated that she chooses not to take a shower but prefers to bathe at the sink in the bathroom. Resident 88 state that she performs her own bathing at the sink, without assistance from staff. A second observation of the above areas in Room E-58 on April 3, 2024, at 10:35 AM, revealed the above findings remained as initially observed and in the same condition as previously observed during the initial observation conducted on April 2, 2024. Interview with Employee 7 (nurse's aide) on April 3, 2024, at 10:45 AM revealed that bed linens are changed on shower days or as needed. When asked about bed linen changes for residents who do not take showers, Employee 7 indicated that the bed linens are changed on their scheduled shower day even if the resident does not receive a shower. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 33's April 2024 Documentation Survey Report v2 indicated that he was scheduled to receive a shower on Mondays and Thursdays during the day shift. The report also indicated that Resident 33 received a shower on April 1, 2024, the day before the surveyor's observation and interview. Review of Resident 88's April 2023 Documentation Survey Report v2 indicated that she was scheduled to receive a shower on Mondays and Thursdays during the evening shift. The report also indicated that Resident 88 refused a shower on April 1, 2024, the day before the surveyor's observation and interview. Interview with the Director of Nursing (DON) on April 4, 2024, at approximately 11:35 AM confirmed that it is the facility's expectation that bed lines are changed upon soilage and on the residents' bed bath and shower days. She also confirmed that Resident 33 and 88's bed linens should have been changed on their scheduled shower day, April 1, 2024. An observation on April 2, 2024, at 11:50 AM , in resident room E-56 revealed that the wall behind/above the heating and cooling unit was cracked, crumbling and flaking. Further observation in room E-56 revealed the front corner of bedside nightstand veneer to be peeling, leaving an exposed rough edge. Interview with the Nursing Home Administrator (NHA) on April 5, 2024, at approximately 11: 00 AM 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 0622 Level of Harm - Potential for minimal harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the necessary resident information was communicated to the receiving health care provider for five residents out of 23 residents sampled with facility inititiated transfers (Residents 29, 46, 64, 80, and 269). The findings include: A review of Resident 29's clinical record revealed that the resident was transferred to the hospital on October 1, 2023, and returned to the facility on [DATE]. A review of Resident 80's clinical record revealed that the resident was transferred to the hospital on October 11, 2023, and returned to the facility on [DATE]. A review of Resident 46's clinical record revealed that the resident was transferred to the hospital on February 23, 2024, and returned to the facility on [DATE]. A review of Resident 64's clinical record revealed that the resident was transferred to the hospital on February 25, 2024, and returned to the facility on [DATE]. A review of Resident 269's clinical record revealed that the resident was transferred to the hospital on March 26, 2024, and returned to the facility on [DATE]. There was no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals and all information necessary to meet the resident's specific needs at the receiving facility. Interview with the Director of Nursing (DON) on April 4, 2023, at approximately 11:30 AM, confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer. 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on 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 for one resident (Resident 82) and prescribed medication therapy for three residents out of 23 sampled residents (Resident 48, 80, and 53). Findings include: A review of the clinical record revealed Resident 82 was admitted to the facility January 24, 2024, with diagnoses of viral hepatitis C without hepatic coma, and cirrhosis of the liver. A review of Resident 82's care plan, conducted during the survey ending April 5, 2024, revealed that the resident's comprehensive care plan did not include the resident's medical condition, viral hepatitis or cirrhosis of the liver and the necessary care and services necessary to manage those conditions. Interview with the Director of Nursing (DON) on April 5, 2024, at approximately 9:10 AM, confirmed the absence of Resident 82's medical condition, viral hepatitis, and cirrhosis of the liver, on his care plan. A review of the clinical record revealed Resident 48 was admitted to the facility on [DATE], with diagnoses of congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). A review of a physician order initially dated August 15, 2023, revealed that the resident was receiving Xarelto (anticoagulant medication to thin your blood) 20 mg (milligram) in the evening. A review of the current resident's plan of care, conducted during the survey ending April 5, 2024, revealed that the resident's anticoagulant therapy was not addressed on the resident's care plan to include necessary monitoring for potential side effects, including bleeding risks. A review of the clinical record revealed Resident 80 was admitted to the facility on [DATE], with a diagnosis of type 2 diabetes. A review of a physician order initially dated January 11, 2024, revealed that the resident was receiving Insulin Glargine Subcutaneous Solution 100 UNIT/ML inject eight unit subcutaneously in the morning for diabetes. A review of the current resident's plan of care, in effect at the time of the survey ending April 5, 2024, revealed that the resident's care plan failed to identify the resident's insulin use for diabetes and interventions to monitor for signs and symptoms of hypo or hyperglycemia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record revealed Resident 53 was admitted to the facility on [DATE], with diagnoses to include type 2 diabetes and atrial fibrillation. A review of a physician order initially dated January 11, 2024 revealed that the resident was receiving Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML inject eight unit subcutaneously in the morning for diabetes and Apixaban Oral Tablet 2.5 MG give every morning and at bedtime dated January 23, 2024. A review of the current resident's plan of care, in effect at the time of the survey, revealed that the resident's care plan 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. Interview with the Nursing Home Administrator and Director of Nursing on April 5, 2024, at approximately 1:30 PM confirmed the facility 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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on observation, a review of clinical records and interviews with staff it was determined that the facility failed to consistently provide a functional communication system to maintain the resident's ability to communicate for one of one resident sampled with communication needs/deficit (Resident 318). Findings include: A review of Resident 318's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include dementia, depression, and anxiety. A review of Resident 318's nursing progress notes revealed a nursing note dated March 29, 2024, at 10:21 PM, indicating that the resident's first language is Spanish. Further review revealed that the resident exhibited increased agitation and was approached by several staff members who were unable to redirect her behaviors. A Spanish speaking nurse approached resident, engaged her in conversation, and eventually was able to calm the resident down. The nurse encouraged the resident to take her medications with coffee at which the resident replied that coffee upsets her stomach at night and medications were refused. A review of resident's clinical record during survey ending March 5, 2024, revealed the resident's care plan, initiated March 29, 2024, identified the resident as only Spanish speaking with a goal to make her basic needs known on a daily basis. Intervention was to refer to Speech therapy for evaluation and treatment as ordered. The care plan failed to develop interventions to address the resident's communication deficit and primary language and identify ways to make her basic needs know on a daily basis. The care plan failed to include the minimum healthcare information to properly care for the resident's immediate needs. The care plan failed to support the resident's communication deficit. Interview with Employee 2 (RN) on April 3, 2024, at approximately 9:50 AM revealed that non-Spanish speaking staff do not have a way to communicate with Resident 318 in her own language. Employee 2 verified that there was no communication board bedside or in the resident's room. Interview with the Director of Nursing on (DON) April 4, 2024, at approximately 11:35 AM confirmed that the facility failed to develop interventions to address Resident 318's language and communication deficit and had not provided the resident with any other means of communication to facilitate continuous communication between the resident and staff at all times. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 201.18 (e)(1) Management

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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** 41581 Based on a review of clinical records and staff interview, it was determined that the facility failed to provide nursing services consistent with professional standards of practice by failing to demonstrate consistent monitoring and thorough assessment of one resident displaying constipation (Resident 116) and by failing to follow physician orders for bowel protocol prescribed for two residents out of 23 sampled (Residents 36 and 48) to promote normal bowel activity to the extent practicable. Findings include: According to the American Academy of Family Physicians {The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine}the primary goal of constipation management should be symptom improvement, and the secondary goal should be the passage of soft, formed stool without straining at least three times per week). According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient ' s designated support person and other third parties. A review of the clinical record revealed that Resident 116 was admitted to the facility on [DATE], with diagnoses that included heart failure, pneumonia, severe protein-calorie malnutrition, and atrial fibrillation (irregular heart rate). Review of Resident 116's report of bowel activity from the Documentation Survey Report v2 for January 2024, revealed that the resident did not have a bowel movement on January 2, 3, 4, 5, and 6, 2024 (5 days or 15 shifts of nursing duty). Review of Resident 116's Medication Administration Record (MAR) for January 2024, revealed no physician orders to follow to promote normal bowel activity for this resident or to treat constipation in effect at the time of the resident's period of constipation (January 2nd thru January 6th). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders were subsequently noted on January 13, 2024, for Colace Oral Capsule 100 MG, (Docusate Sodium) give 1 capsule by mouth two times a day for constipation hold for loose stools, and Senna Oral Tablet 8.6 MG (Sennosides) give 1 tablet by mouth at bedtime for constipation hold for loose stools and orders noted for Milk of Magnesia (MOM) Suspension 400 MG/5ML (Magnesium Hydroxide) give 30 ml by mouth as needed for constipation administer if no BM by the third day/9 shifts document effectiveness. Dulcolax Suppository (Bisacodyl) insert 1 suppository rectally as needed for constipation for no Bowel movement within 24 hours after administration of Milk of Magnesia (MOM). Fleet Enema 7-19 GM/118 ML (Sodium Phosphates) insert 1 applicatorful rectally as needed for constipation for no bowel movement by the end of the following shift after administration of suppository. Notify MD if ineffective. There was no documented evidence that nursing staff consulted with the physician during the resident's five days of bowel inactivity or of a documented nursing assessment of the resident's physical status during the period of constipation, including any pain or discomfort the resident was experiencing and additional physical assessment of the resident's bowel function and status. A review of the clinical record revealed that Resident 48 was admitted to the facility on [DATE], with diagnoses to include congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). The resident had physician orders dated August 7, 2023, for the following bowel regimen: Milk of Magnesia 400 MG/5 ML. Give 30 ml by mouth as needed for constipation. Administer if no BM (bowel movement) by the third day/9 shifts. Document effectiveness. Dulcolax Suppository. Insert 1 suppository rectally as needed for constipation. For no bowel movement within 24 hours after administration of MOM. Fleet Enema 7-19 GM/118 ML. Insert 1 applicatorful rectally as needed for constipation. For no bowel movement by the end of the following shift after administration of suppository. Notify MD is ineffective. Review of Resident 48 's report of bowel activity from the Documentation Survey Report v2 for the month of March 2024, revealed that the resident did not have a bowel movement on March 23, 24, 25, 26, 27, 2024 (five days - 15 shifts). Review of Resident 48's Medication Administration Record (MAR) for March 2024, revealed no documented evidence that nursing administered the prescribed bowel protocol during the period without a bowel movement to promote bowel activity. There was no documented evidence that the physician was notified of the five (5) consecutive days, March 23, 24, 25, 26, 27, 2024, without a bowel movement. A review of the clinical record revealed Resident 36 was admitted to the facility on [DATE], with diagnoses to include hemiplegia (paralysis of one side of the body) following cerebral infarction (disrupted blood flow to the brain). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of physician's orders initially dated December 21, 2023, revealed the following bowel regimen: Milk of Magnesia 400 MG/5 ML. Give 30 ml by mouth as needed for constipation. Administer if no BM (bowel movement) by the third day/9 shifts. Document effectiveness. Dulcolax Suppository. Insert 1 suppository rectally as needed for constipation. For no bowel movement within 24 hours after administration of MOM. Fleet Enema 7-19 GM/118 ML. Insert 1 applicatorful rectally as needed for constipation. For no bowel movement by the end of the following shift after administration of suppository. Notify MD is ineffective. Review of Resident 36 's report of bowel activity from the Documentation Survey Report v2 for the month of February 2024, revealed that the resident did not have a bowel movement on February 12, 13, 14, 15, 2024 (four days - 12 shifts). Review of Resident 36's Medication Administration Record for February 2024 revealed no documented evidence that nursing administered the prescribed bowel protocol during the period without a bowel movement to promote bowel activity. Review of Resident 36 's report of bowel activity from the Documentation Survey Report v2 for the month of March 2024, revealed that the resident did not have a bowel movement on March 11, 12, 13, 14, 15, 2024 (15 shifts) and again on March 22, 23, 24, 25, 26, 2024 (15 shifts). Review of Resident 36's Medication Administration Record for February 2024 revealed no documented evidence that nursing administered the prescribed bowel protocol during the period without a bowel movement to promote bowel activity. There was no documented evidence that the physician was notified of the five consecutive days the resident went without a bowel movement. During an interview with the Director of Nursing (DON) on April 5, 2024, at approximately 12:15 PM, the DON was unable to provide evidence that nursing staff assessed and consulted with the physician regarding potential treatment of Resident 116's constipation and that nursing staff had followed physician orders for the prescribed bowel protocol for Residents 48 and 36 during the period without bowel activity or had notified the physician of the extended days without a bowel movement. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.5 (f) Medical records

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records, and staff interview, it was determined that the facility failed to implement individualized approaches to restore normal bladder function to the extent possible and provide maintenance incontinence care for two out of 23 sampled residents (Resident 36 and 64). Findings include: A review of Resident 36's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it) and epilepsy (seizure disorder). A review of the resident's plan of care for mixed bladder incontinence related to disease process revealed an intervention dated January 5, 2024, for the resident to have a scheduled toileting program for bowels only. The resident was to be toileted between 8:00 AM and 8:30 AM, 11:00 AM and 11:30 AM, 2:00 PM and 2:30 PM, 6:00 PM and 6:30 PM, 10:00 PM and 10:30 PM, and 11:30 PM and 12:00 AM. A review of the documented evidence of the implementation of the resident's scheduled toileting plan for January 2024 and February 2024, revealed that the facility failed to toilet the resident as scheduled on 34 occassions during the month of Janaury 2024 and on 36 occassions during the month of February 2024. A review of Resident 64's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of type 2 diabetes and heart failure. A review of the resident's plan of care for urinary incontinence related to impaired mobility revealed an intervention dated August 12, 2021, for the resident to have an incontinence care and comfort toileting program (check and change every two hours). A review of the documented evidence of the facility's provision of the resident's incontinence comfort and care during the months of January 2024, February 2024, and March 2024 revealed that the facility failed to provide the resident's every two hour check and change 90 times for the month of January 2024, 73 occassions during the month of February 2024, and . 52 times during the month of March 2024. Clinical record review revealed that Resident 301 was admitted to the facility on [DATE], with diagnoses to include 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 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). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 22, 2024 revealed that Resident 301 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 13-15 indicates cognition is intact). MDS Section GG - Functional Abilities and Goals indicates that the resident usually requires caregivers to do more than half the effort when toileting. The resident's care plan, when reviewed at the time of the survey ending April 5, 2024, indicated that Resident 301 has a problem with urinary incontinence related to a cardiovascular accident {diagnosis not listed in resident medical diagnosis tab} initiated on May 25, 2021. Interventions in place were to establish toileting times, ask if toileting is needed and reminding resident that it is time to use the toilet, providing assistance with toileting or providing incontinent care as needed, and including the resident in the facility's incontinence comfort and care program {two-hour incontinence check and change if needed}. The resident's care plan also noted that Resident 301 has a self-care deficit related to immobility and deconditioning was initiated on March 10, 2021, with interventions in place include toileting the resident with the assistance of one staff member. During interview with Resident 301 on April 4, 2024, the resident stated that she waits long periods of time for staff assistance with toileting and often sits in her wet brief for long periods of time. Resident 301 explained that even yesterday she wanted to leave the facility because she did not get timely assistance with toileting from the nursing staff. The resident stated that she often waits over 20 minutes for staff to respond to her call-bell rings for assistance. The resident stated that she has brought this concern up with the facility in the past, but nothing has changed. A review of the facility Incontinence Comfort and Care Program logs revealed that the facility staff will check {the resident for incontinence} and change resident every two hours {if applicable}. A review of Resident 301's Incontinence Comfort and Care Program logs from March 6, 2024 through April 5, 2024 revealed that facility staff failed to indicate if the resident was checked every two hours for incontinence and changed if necessary as care planned and according to the facility's incontinence comfort and care program on the following date and times: March 6, 2024, from 8:30 PM through 12:00 AM March 9, 2024, from 2:30 PM through 10:00 PM March 10, 2024, from 6:30 AM through 4:00 PM March 11, 2024, from 6:30 AM through 4:00 PM March 16, 2024, from 2:30 PM through 12:00 AM March 17, 2024, from 2:30 PM through 12:00 AM March 18, 2024, from 2:30 PM through 10:00 PM March 19, 2024, from 4:30 PM through 12:00 AM (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	March 20, 2024, from 2:30 PM through 10:00 PM March 23, 2024, from 2:30 PM through 12:00 AM March 25, 2024, from 8:30 PM through 12:00 AM March 27, 2024, from 2:30 PM through 12:00 AM March 28, 2024, from 8:30 PM through 12:00 AM March 29, 2024, from 8:30 PM through 12:00 AM March 30, 2024, from 8:30 PM through March 31, 2024 at 8:00 AM March 31, 2024, from 8:30 PM through April 1, 2024 at 8:00 AM April 3, 2024, from 10:30 PM through April 4, 2024 at 8:00 AM April 4, 2024, from 8:30 PM through 12:00 AM Interview with the Director of Nursing on April 5, 2024, at approximately 2:00 PM confirmed that the facility failed to demonstrate consistent implementation of scheduled toileting plans an the incontinence comfort and care programs 28 Pa. Code 211.12 (d)(5) Nursing services 28 Pa. Code 211.10 (a)(d) Resident care policies

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and select facility policy, and a staff interview, it was determined that the facility failed to provide person-centered pain management consistent with professional standards of practice for one out of the 23 residents sampled (Resident 23). Findings include: A review of facility policy titled Pain Assessment and Management, last reviewed by the facility on March 25, 2024, revealed that it is the facility's policy to identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs that address the underlying causes of pain. The policy indicates that non-pharmacological interventions for managing residents' pain may be appropriate alone or in conjunction with medications. Also, the policy indicates that pharmacological interventions (i.e., analgesics medications) may be prescribed to manage pain; however, they do not usually address the cause of the pain and can have adverse effects on the resident. A clinical record review revealed that Resident 23 was admitted to the facility on [DATE], with diagnoses that included lumbar radiculopathy (a pinched nerve that may result in frequent pain, weakness, numbness, or tingling) and spondylosis (a weakness or stress fracture in one of the bony bridges that connect the upper and lower facet joints of the spine). The resident's care plan indicated that Resident 23 has acute right hip and shoulder pain after experiencing a fall initiated on February 21, 2024, with planned interventions to administer fentanyl patches as per physician orders, and the resident prefers to have pain controlled by fentanyl patches, lidocaine patches, and tylenol. The resident's care plan failed to identify any non-pharmacological interventions to be attempted to reduce or alleviate Resident 23's pain. A physician's order was initiated on February 26, 2024, for Resident 23 to receive a fentanyl transdermal patch 72 hours at 12 mcg/hr, which was discontinued on March 1, 2024. A physician's order was initiated on February 21, 2024, for Resident 23 to receive Hydrocodone-Acetaminophen Oral Tablet 10-325 mg (an opioid pain medication) with orders to give 2 tablets by mouth every 8 hours as needed for severe pain (7-10). A physician's order was initiated on February 21, 2024, for Resident 23 to receive Acetaminophen Oral Tablet 325 mg with orders to give 2 tablets by mouth every 4 hours as needed for mild pain (1-3). There was no physician order to treat moderate pain rated from (4-6). A review of the resident's Medication Administration Records (MARS) for March 2024 and April 2024 revealed that staff administered two tablets of Hydrocodone-Acetaminophen 10 -325 mg to the resident 55 times from March 1, 2024, through April 5, 2024. There was no documentation that any non-pharmacological interventions were attempted prior to any administration of the prn opioid pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident MARs for March and April 2024 revealed that staff administered Hydrocodone-Acetaminophen 10 -325 mg outside the parameters of the physician's order (as needed for severe pain, level 7-10) on the following dates: March 15, 2024, at 2:47 AM for pain level 5 March 16, 2024, at 4:23 AM for pain level 6 March 25, 2024, at 3:21 AM for pain level 6 March 27, 2024, at 5:15 AM for pain level 6 March 30, 2024, at 9:25 PM for pain level 4 During an interview on February 5, 2024, at approximately 09:30 AM, the Director of Nursing (DON) was unable to provide evidence that the facility developed resident-centered non-pharmacological interventions for Resident 23's pain management. The DON was unable to provide evidence that the facility attempted non-pharmacological interventions prior to administering the prn opioid pain medication. The DON was unable to provide evidence that staff adminstered the opioid pain medication in accordance with physician's orders on the identified dates in March 2024. The DON confirmed that the facility failed to provide person-centered pain management consistent with professional standards of practice. 28 Pa. Code 211.12 (d)(1)(5) Nursing services 28 Pa. Code 211.5 (f) Medical records

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and staff interviews, it was determined that the facility failed to develop and implement an individualized person-centered plan to provide trauma informed care to a resident with a history of trauma for one out of 23 residents reviewed (Resident 23). Findings include: A clinical record review revealed that Resident 23 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder (a mental health disorder that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of an Admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 26, 2024 revealed that Resident 23 was moderately cognitively impaired with a BIMS score of 11 (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 8-12 indicates moderate cognitive impairment). The resident's care plan identified that Resident 23 had a mood problem related to anxiety, bipolar disorder, and depression, initiated on February 21, 2024, with planned interventions in place for administering psychiatric medication as ordered, monitoring for side effects and effectiveness, and providing behavioral health consultations as needed. A physician order was noted on February 23, 2024, for an outside behavioral health provider care to evaluate and treat the resident. The behavioral health services psychological evaluation report dated February 29, 2024, revealed that Resident 23 has the cognitive ability and verbal capacity to participate in and benefit from psychotherapy. The evaluation indicated that Resident 23's condition will deteriorate if the patient does not participate in psychotherapy. The report included a comprehensive trauma screening, indicating that Resident 23 has decreased social interaction, withdrawing behavior, and a persistent negative mood state related to a history of sexual assault and sexual abuse as a child. The report also includes a session summary in which the clinician indicates that the resident may have post-traumatic stress disorder (PTSD- mental health disorder that develops after exposure to a traumatic event. Symptoms may include persistent, frightening thoughts and memories, sleep problems, and feeling detached or numb). Following this psychological evaluation, there was no evidence that the facility had developed a resident-specific trauma-informed plan of care to meet Resident 23's needs for identifying and minimizing triggers or re-traumatization. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of the survey ending April 5, 2024, there was no evidence that the facility provided Resident 23 with any additional psychological services or behavioral health provider consultations following the session on February 29, 2024. During an interview on April 3, 2024, at 9:00 AM, Resident 23 stated that she is afraid when she utilizes her bathroom. She explained that she shares a bathroom with male residents and indicated that sometimes they jiggle the {door} handle. Resident 23 explained that it makes her upset and scared because she is worried that men will walk in on her when she is in the bathroom. During an interview on April 4, 2024, at approximately 1:15 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to provide evidence that the facility provided trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of Resident 23. The DON and NHA were unable to provide evidence that Resident 23 received any further behavioral health services following the psychological evaluation on February 29, 2024. 28 Pa Code 211.12 (d)(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. 39235 Based on review of select facility policy and controlled drug shift count records, observations, and staff interview, it was determined that the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs on three of five medication carts (Center, North, and West). Finding include: A review of the facility policy Controlled Substances last reviewed by the facility March 25, 2024, indicated that nursing staff must count controlled medications at the end of each shift. The nurse coming on duty, and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. A review of the Inter Shift Drug Record sheet for April 2024, for the Center medication cart on April 3, 2024, at approximately 8:57 AM, revealed that the on-coming nurse and/or off-going nurse failed to sign the sheets during shift change on the following date to verify completion of the task to count the controlled drugs in the respective medication cart April 1, and 2, 2024. Interview with Employee 1 (LPN), on April 3, 2024, at approximately 8:57 AM, confirmed the observation and acknowledged the licensed nurse signatures are expected to be signed at change of shift. A review of the Inter Shift Drug Record sheet for April 2024, for the [NAME] medication cart on April 3, 2024, at approximately 9:05 AM, revealed that the on-coming nurse and/or off-going nurse failed to sign the sheets during shift change on the following date to verify completion of the task to count the controlled drugs in the respective medication cart April 1, 2024. Interview with Employee 2 (RN), on April 3, 2024, at approximately 9:05 AM, confirmed the observation and acknowledged the licensed nurse signatures are expected to be signed at change of shift. A review of the Inter Shift Drug Record sheet for April 2024, for the North medication cart on April 3, 2024, at approximately 9:10 AM, revealed that the on-coming nurse and/or off-going nurse failed to sign the sheets during shift change on the following date to verify completion of the task to count the controlled drugs in the respective medication cart April 1, 2024. Interview with Employee 3 (LPN), on April 3, 2024, at approximately 9:10 AM, confirmed the observation and acknowledged the licensed nurse signatures are expected to be signed at change of shift. Interview with the Director of Nursing (DON) on April 3, 2024, at approximately 12:10 PM, confirmed that it is her expectation that nursing staff signs the Control Substance logs, Inter Shift Drug Record, at change of shift to demonstrate that they completed the count of the controlled drugs to identify potential discrepancies. 28 Pa. Code 211.19(a)(1)(k) Pharmacy services 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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	04/05/2024

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

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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. 39235 Based on observation, a review of select facility policy, and staff interview, it was determined that the facility failed to adhere to acceptable storage and use by dates for multi-dose medication on one of three medication carts observed (Center medication cart - Resident 40). Findings include: A review of facility policy entitled Administering Medications last reviewed by the facility March 25, 2024, indicated the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. Observation of medication administration pass beginning at approximately 8:47 AM, on April 3, 2024, revealed Employee 1, Licensed Practical Nurse (LPN), on the center hall medication cart. One (1) Lantus Solostar (medication used for diabetes) belonging to Resident 40, was observed to be opened and available for use but not dated when initially opened. Employee 1, licensed practical nurse (LPN), confirmed the medication belonged to Resident 40, and that the insulin was not dated when first opened for resident use to determine acceptable storage time. Interview with the Director of Nursing (DON) on April 3, 2024, at approximately 12:10 PM, confirmed the that the facility failed to date multi-dose medications when opened to assure acceptable storage times. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing 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 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. 48277 Based on observations of the resident pantry areas, review of select facility policy, and staff interview, it was determined that the facility failed to maintain a sanitary environment and acceptable practices for the storage and service of food to prevent the potential for microbial growth in foods and conditions, which increased the risk of food-borne illness in two of two resident pantry areas. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Review of the facility policy titled Foods Brought by Family/Visitors last reviewed by the facility March 25, 2024, indicated that non-perishable foods will be stored in re-sealable containers with tight-fitting lids. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item, and the use by date. Nursing staff will discard perishable foods on or before the use by date. Observation of the resident food pantry located on Side 2 nursing unit on April 2, 2024, at 1:25 PM, revealed three Styrofoam Wawa bowls containing food without a name, leftover food wrapped in aluminum foil without a date or name, a clear plastic container of fruit without a date or name, a wheat germ container without a date or name, a 20 ounce strawberry lemonade beverage without a date or name, and a reusable bag containing an opened one-half gallon Silk almond milk, and a Tupperware container with leftover food without a date or name. Observation of the freezer revealed an opened blue Gatorade bottle without a date or name, a 16-ounce Styrofoam cup with an opened straw inserted in the lid without a date or name, ice bits scattered throughout the freezer and freezer door, and an aluminum soda can lid dislodged from the soda can on the freezer door shelf. Interview with Employee 5 (Concierge) on April 2, 2024, at 1:30 PM confirmed the observations of the Side 2 resident food pantry. Observation of the resident food pantry located on Side 1 nursing unit on April 2, 2024, at 1:45 PM, revealed two Styrofoam take-out containers without a date. Observation of the freezer revealed an opened one-half gallon of dark chocolate ice cream without a name and dated March 12, a Smart Ones frozen dinner without a name and dated March 5. Observation of the upper cabinet revealed an opened bag of honey barbecue Lays potatoe chips without a name. Interview with Employee 6 (RN) on April 2, 2024, at 1:50 PM confirmed the observations of the Side 1 resident food pantry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further observation of the Side 2 resident food pantry on April 4, 2024, at 1:35 PM, in the presence of the Nursing Home Administrator (NHA) revealed the ice machine's condensation drain hose (hose which transports condensation from the ice machine to the floor drain) and the floor drain was visibly soiled with a black substance. Inside the cabinet supporting the ice machine, there was a black substance on the walls of the interior cabinet and on the floor tiles under the cabinet. Interview with the NHA on April 4, 2024, at 1:40 PM confirmed that the ice machine condensation drain hose, floor drain and cabinet were not maintained in a sanitary manner. He confirmed that the food in the resident pantry was to be labeled with a use by date and the name of the resident and that acceptable practices for food storage were to be followed. 28 Pa. Code 201.18 (e)(2.1) Management 28 Pa. Code 211.6 (f) Dietary Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observation and staff interviews it was determined that the facility failed to ensure the consistent implementation of infection control procedures designed to prevent the spread of infection during the medication administration for one out of two residents observed (Resident 170) and one of three medication administration carts (center hall) sampled. Findings include: Observation of medication administration pass beginning at approximately 8:45 AM, on April 3, 2024, revealed Employee 1, Licensed Practical Nurse (LPN), on the center hall medication cart. Employee 1 was observed in the process of administering medications to Resident 170, who resided, in room [ROOM NUMBER]-B. The resident had a physician order dated March 22, 2024, for Mucinex (an expectorant medication to help loosen congestion) oral tablet extended release 12 hour, 600 milligram (mg), give 1 tablet by mouth every 12 hours for congestion. Employee 1, LPN, removed the medications from the medication cart. After removing the medications, which included Mucinex 400 mg, she proceeded to prepare the medications for administration. During this process, Employee 1 removed 2 tablets of the Mucinex and placed 1 in the medication cup and placed the other tablet directly on top of the surface of the medication cart, without placing a protective barrier, and or cleaning the top of the cart. Employee 1, LPN, then used hand sanitizer, and split the Mucinex tablet in half and placed it in the medication cup. She entered the resident's room and administered the medications including the Mucinex tablets. During the above observation of medication administration pass to resident 170, on April 3, 2024, a cell phone was observed inside the top drawer of the medication cart. Interview with Employee 1, LPN, at approximately 8:57 AM, on April 3, 2024, confirmed the observations stated above, and acknowledged it was her own personal cell phone placed in the med cart. Employee 1, LPN, confirmed she had not adhered to infection control procedures during this medication pass. Interview with the Nursing Home Administrator (NHA) on April 4, 2024, at approximately 1:05 P.M., confirmed the facility failed to ensure the consistent implementation of infection control procedures designed to prevent the spread of infection in the facility during medication administration. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.