

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Brookmont Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on review of select facility policy and clinical records, and staff interview it was determined the facility failed to timely identify significant weight loss and monitor resident's weights consistently and accurately to timely identify changes in nutritional parameters and timely implement nutritional interventions for two of 24 residents sampled. (Residents 72 and 27)</p> <p>Findings include:</p> <p>Review of the facility Weight Monitoring Policy last reviewed March 2024 indicated the facility will ensure all residents maintain acceptable parameters of nutritional status. Information from the nutritional status and dietary standards are used to develop an individualized care plan. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month- 5% weight loss is significant; 3 months- 7.5% weight loss is significant; 6 months- 10% weight loss is significant.</p> <p>A review of Resident 72's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia (the loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).</p> <p>A review of the resident's weights noted the following:</p> <p>September 3, 2024, 164.1 Lbs.</p> <p>October 8, 2024, 173.5 Lbs.</p> <p>It was noted the resident refused a weight in November of 2024.</p> <p>December 5, 2024- 155.1 pounds indicating a 17.4-pound weight loss or 10% loss of body weight within sixty days.</p> <p>Review of a dietary note dated December 13, 2024 (eight days after the weight loss occurred), confirmed the weight loss and recommended discontinuing health shakes, adding Boost twice daily, and initiating weekly weight monitoring.</p> <p>(continued on next page)</p>

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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of the clinical record revealed no documented evidence that weekly weights were obtained as ordered. Resident 72's care plan was reviewed, and her nutritional care plan was not updated after the significant weight loss was noted on December 13, 2024, as directed in the facility's policy and as noted in the Registered Dietician's dietary note dated December 13, 2024.</p> <p>Interview with the Registered Dietitian (RD) on February 27, 2025, at approximately 11:30 AM confirmed the resident's weekly weights were not obtained following the weight loss on December 5, 2024, and failed to provide documented evidence the resident's care plan was updated to address the residents weight loss.</p> <p>A review of a facility policy entitled Weight Assessment and Intervention that was last reviewed by the facility March 2024, indicated that the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss. The nursing staff will measure resident's weights upon admission times two, then weekly for 4-weeks, then monthly thereafter if no further weight concerns. Any weight change of 5% or more since the last weight assessment will be retaken for confirmation. The dietitian will review the weight records. Negative trends will be evaluated by the treatment team whether the criteria for significant weight change have been met.</p> <p>Further review of a facility policy Nutritional Assessment, last reviewed by the facility March 2024, indicated as a part of the comprehensive assessment, a nutritional assessment, included current nutritional status and risk factors for impaired nutrition shall be conducted for each resident. The dietitian, in conjunction with the nursing staff and health care practitioners, will conduct a nutrition assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition.</p> <p>A review of Resident 27's clinical record revealed the resident was initially admitted to the facility on [DATE], and most recently readmitted from the hospital to the facility on [DATE], with diagnoses that included congestive heart failure (CHF a progressive heart disease that affects pumping action of the heart muscles and causes fatigue, fluid accumulation, and shortness of breath), chronic kidney disease (involves a gradual loss of kidney function and impacts the kidneys ability to filter wastes and remove excess fluids from the blood, which are then removed in urine. Advanced chronic kidney disease can cause dangerous levels of fluid, electrolytes and wastes to build up in your body), hemodialysis (a treatment to filter wastes and water from blood and helps control blood pressure and balance important minerals, such as potassium, sodium, and calcium, in blood), Clostridium difficile (C. diff a type of bacteria that can cause colitis, a serious inflammation of the colon and infections from C. diff often start after taking antibiotics and can sometimes be life-threatening), and moderate protein calorie malnutrition (an imbalance of nutrients from food and drinks that are needed to keep the body healthy and functioning properly). Additionally, Resident 27 had moderate cognitive impairment with a BIMS score of 9 (brief interview for mental status, a tool to assess the resident's attention, orientation and ability to register and recall new information, a score of 08-12 equates to moderate impaired cognition).</p> <p>Further review of Resident 27's clinical record revealed that he was hospitalized on [DATE], and readmitted to the facility on [DATE], with diagnosis nontraumatic intracerebral hemorrhage (a type of stroke that causes blood to pool between the brain and skull and prevents oxygen from reaching the brain) and actively being treated for C. Diff.</p> <p>A review of Resident 27's weight record revealed the following recorded weights:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>January 17, 2025, at 5:08 PM, 205.5 - pounds post dialysis</p> <p>January 29, 2025, at 8:21 PM, 189.2 - pounds with use of a mechanical lift (post hospitalization but not confirmed as per the facility policy)</p> <p>January 31, 2025, at 7:57 PM, 194.7 - pounds post dialysis</p> <p>February 1, 2025, at 2:53 PM, 181.1 - pounds with use of a mechanical lift</p> <p>The RD completed a nutrition progress note for a 5-day MDS (Minimum Data Set assessment-a federally mandated standardized assessment conducted at specific intervals to plan resident care) assessment dated [DATE] (5-days post readmission from the hospital) indicated a diet order for a CHO controlled (carbohydrate controlled diet is a diet that provides consistent amounts of carbohydrates to manage diabetes), NAS (no added salt diet involves restricting sodium intake to less than 4 grams, or 4,000 milligrams per day and is usually prescribed to decrease water retention for people who have high blood pressure), regular texture, thin consistency fluids, with an 1800 mL fluid restriction daily (the limitation of oral fluid intake to a prescribed amount for each 24-hour period. This therapeutic measure is indicated in patients who have edema associated with kidney disease). Additionally, the RD's progress note indicated that Resident 27 had a new Stage 2 pressure ulcer (partial thickness loss of skin without true ulceration) to sacrum as per wound care CRNP (certified registered nurse practitioner) note from January 30, 2025. This progress note documented a significant weight loss and a new Stage 2 sacral pressure ulcer but did not initiate immediate nutritional interventions.</p> <p>The dietitian recommended providing liquid protein (30 mL daily) for wound healing; however, the intervention was not implemented until February 4, 2025 (six days post-readmission and post-identification of the pressure ulcer) as per a review of the Medication Administration Record (MAR). The facility did not provide documented evidence of a timely comprehensive nutritional assessment related to the weight loss and pressure ulcer.</p> <p>During an interview with the Registered Dietitian (RD) on February 28, 2025, at 11:00 AM, it was reported a nutrition progress note was completed for Resident 27's 5-Day MDS and that it was within the set ARD (assessment reference date). Additionally, the RD confirmed that the nutrition progress note was not completed until 5-days after Resident 27 returned from the hospital with a significant weight loss of 24.4 lbs. or 11.9% in approximately 2 weeks and a significant loss of 29.2 lbs. or 13.9% in 30 days intervention was not put into place until 6-days post identification of a pressure ulcer.</p> <p>An interview with the Nursing Home Administrator on February 28, 2025, at 1:00 PM, confirmed the facility failed to timely assess and implement nutritional interventions for Resident 27.</p> <p>28 Pa Code 211.5(f)(ii)(ix) Medical records</p> <p>28 Pa Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on a review of select facility policies and clinical records and staff interview, it was determined the facility failed to administer pain medication as prescribed by the physician on an as needed basis for one of 24 residents reviewed. (Resident 10).</p> <p>Findings include:</p> <p>A review of the facility policy entitled Pain Assessment and Management last reviewed March 2024, indicated the purpose of the procedure is to help staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain.</p> <p>Review of Resident 10's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include post-surgical care for fracture of right tibia (leg bone), acute pain due to trauma, and hypertension.</p> <p>A review of current physician orders revealed that Resident 10 was prescribed pain medications based on a pain scale to guide appropriate administration. The pain scale categorizes pain levels as mild (1-3), moderate (4-7), and severe (8-10), with corresponding medications ordered to manage each level of pain effectively.</p> <p>Starting with the physician orders dated January 29, 2025, the resident was prescribed Acetaminophen 325 mg, two tablets every 4 hours as needed for mild pain (1-3).</p> <p>On January 30, 2025, additional pain medications were ordered to address increasing levels of pain:</p> <p>For moderate pain (4-7):</p> <p>Oxycodone HCL 5 mg - 0.5 (half) tablet every 4 hours as needed</p> <p>Tramadol HCL 50 mg - one tablet every 6 hours as needed</p> <p>For severe pain (8-10):</p> <p>Oxycodone HCL 5 mg - one tablet every 4 hours as needed (valid for 10 days, through February 9, 2025).</p> <p>Further review of the clinical record revealed that after February 9, 2025, there were no active physician orders for pain medication to treat severe pain (8-10). Despite this, Resident 10 continued to experience severe pain, and staff failed to notify the physician or obtain further pain management orders.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Director of Nursing (DON) on February 27, 2025, at approximately 1:30 PM confirmed that the facility failed to provide effective pain management and did not administer pain medication in accordance with physician orders. The DON acknowledged that the incorrect pain medication was given for severe pain, and no action was taken to update the physician or obtain additional orders after February 9, 2025.</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on a review of clinical records and staff interview, it was determined the facility failed to implement procedures to ensure accurate documentation of the disposition of controlled medications upon discharge for one (1) of three (3) discharged residents reviewed (Resident 109).</p> <p>Finding include:</p> <p>Review of Resident 109's clinical record revealed the resident was admitted to the facility on [DATE], and was discharged to the hospital on November 27, 2024.</p> <p>Review of controlled substance receipts indicated that 30 tablets of Tramadol 50 mg (dispensed as half tablets, totaling 60 tablets of 25 mg each) were delivered to the facility on [DATE], for Resident 109.</p> <p>Review of the Medication Administration Record (MAR) for November 2024 documented the resident was administered three (3) doses of Tramadol during the month.</p> <p>Further review of the resident's closed record revealed no documentation of the disposition of the remaining 57 tablets of Tramadol 25 mg at the time of the resident's discharge to the hospital on November 27, 2024.</p> <p>In an interview on February 27, 2025, at approximately 11:00 AM, the Nursing Home Administrator confirmed there was no documentation regarding the disposition of the remaining Tramadol upon the resident's discharge.</p> <p>The facility's failed to maintain accurate records of controlled substance disposition upon discharge of a resident.</p> <p>28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services.</p> <p>28 Pa Code 211.5 (f)(x) Medical records</p> <p>28 Pa Code 211.9(a)(1)(k) Pharmacy services.</p>