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	12/19/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of selected facility policies, clinical records, and staff interviews, the facility failed to show documented clinical justification for the administration of psychoactive medications for two residents out of five sampled residents for unnecessary medication prescribing practices (Residents 5 and 18).Findings included: A review of a facility policy entitled Psychotropic Medication Use last reviewed by the facility August 6, 2025, indicated that residents do not receive psychotropic medications that are not clinically indicated (a written explanation of why a medication is needed) and necessary to treat a specific condition documented in the medical record. The policy defined psychotropic medication as any medication that affects brain activity associated with mental processes and behavior. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless contraindicated, to determine whether the continued use of the medication in benefiting the resident, to find an optimal dose, or in an effort to discontinue the medication. When efforts to decrease one psychotropic medication are implemented, other psychotropic medications (for example, hypnotics) are not increased without documented clinical rationale. Further review of the policy indicated that residents on psychotropic medication receive gradual dose reductions (a step-by-step taper of a medication to see if a lower dose or stopping the medication is safe and effective) coupled with non-pharmacological interventions (non medication approaches use to address symptoms or behaviors) unless clinically contraindicated to determine whether the continued use of the medication is benefiting the resident, to find an optimal dose, or to discontinue the medication. Review of Resident 5's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included unspecified dementia, severe with mood disturbance (decline in cognitive function that interferes with daily activities and experiences mood disturbances) and bipolar disorder (mental health disorder characterized by severe mood swings). Review of a quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated September 11, 2025, indicated the resident had a BIMS (brief interview mental status that aids in detecting cognitive impairment) score of 3. A score of 3 indicates significant cognitive impairment suggesting Resident 5 required additional support and monitoring. Observation of Resident 5 on December 17, 2025, at 11:30 AM revealed Resident 5 was seated in a wheelchair at the nurse's station. Resident 5 did not verbalize any thoughts and did not respond to questions. Another observation of Resident 5 was conducted on December 18, 2025, at 1:05 PM in the common dining area. Resident 5 was observed seated in a wheelchair, at a table with her meal in front of her, her neck was flexed. Resident 5 was not alert, unable to feed herself or respond to any questions. Employee 1, a NA (nurse aide), was observed helping feed Resident 5 and attempted to awaken Resident 5 by rubbing her back and her arm. Employee 1 reported Resident 5 could not feed herself or propel her wheelchair in and out of the common dining area. A review of the clinical record revealed a medication order for Ziprasidone HCL (Geodon, a medication used to treat schizophrenia and manic symptoms of bipolar disorder and works by correcting chemical imbalances in the brain) 40 mg capsule by mouth twice a day. The medication order was initiated on December 17, 2021. A review of Resident 5's December 2025 Medication (continued on next page)

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Record (MAR) revealed the resident was administered Ziprasidone HCL 40 mg capsule at 8:30 AM and 4:30 PM every day in the month of December 2025. Review of the clinical record review titled, Documentation Survey Report, for August through December 2025 noted that Resident 5 was exhibiting no behaviors (such as restlessness, fearfulness, agitation, irritability, or mood disturbance) from August 2025 through December 2025 that would support the continued use of the medication. Further review of the clinical record review, Psychiatric Evaluation & Consultation, documented Resident 5 was confused but calm and cooperative and experienced a stable mood with no sleep or appetite changes, and no psychosis (loss of contact with reality) on evaluations dated December 14, 2025, November 23, 2025, September 28, 2025, September 2, 2025, and August 3, 2025. A review of the clinical document titled Note to Attending Physician/Prescriber, dated September 23, 2025, stated that a gradual dose reduction of Ziprasidone was considered contraindicated due to the potential for increased symptoms. The clinical record did not contain additional documentation explaining the clinical reasoning for continuing the current dose over the four-year period, in the absence of documented symptoms. The clinical record did not include an updated assessment of Resident 5's condition, identify current therapeutic goals, or show evidence of attempts at non-pharmacological interventions or other treatment approaches to evaluate whether a reduction or discontinuation of Ziprasidone 40 mg twice a day was appropriate. The above information was reviewed with the Director of Nursing and the Nursing Home Administrator on December 18, 2025, at 1:05 PM. At the time of review, no additional documentation was provided that explained the basis for continuing the current dose of Ziprasidone or the clinical rationale for not attempting a gradual dose reduction A review of Resident 18's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included unspecified psychosis (psychotic symptoms that do not match a specific condition),, recurrent depressive disorders (a mental health condition characterized by repeated episodes of deep sadness, hopelessness, and loss of interest in daily activities), anxiety (a feeling of worry, nervousness, or unease about something with an uncertain outcome), and unspecified dementia with agitation (memory loss with restlessness or irritability). A review of Resident 18's physician orders revealed the resident was prescribed multiple psychoactive medications (medications that affect brain activity, mood, or behavior). An order dated January 22, 2022, at 8:30 AM directed Sertraline 50 mg (antidepressant used for mood-related conditions) by mouth one time daily for depression. An order dated March 8, 2022, at 9:30 AM directed Lorazepam 0.5 mg (a benzodiazepine used for anxiety that carries dependence and withdrawal risks) by mouth every 12 hours for anxiety. An order dated October 9, 2024, directed Seroquel 25 mg (Quetiapine an antipsychotic used for psychosis and bipolar disorder and is generally not recommended for behavioral symptoms in dementia) by mouth at bedtime for unspecified psychosis. An additional order dated January 10, 2025, directed Seroquel 12.5 mg by mouth one time daily for unspecified psychosis. A monthly pharmacy review completed by the consultant Pharmacist (PharmD) on September 23, 2025, documented that Resident 18 was receiving Quetiapine 25 mg in the morning and 50 mg at bedtime, Sertraline 50 mg daily, and Lorazepam 0.5 mg every 12 hours. The pharmacist noted that CMS (Center for Medicare/Medicaid Services) expects routine review of psychoactive medications and consideration of a gradual dose reduction (GDR), to determine if a lower dose or discontinuation is safe, unless there is documented medical reasoning that a reduction is not appropriate. The pharmacist requested clinical rationale if a GDR could not be attempted.A review of the attending physician/prescriber response dated October 6, 2025, disagreed with attempting a GDR and stated the resident continues with occasional symptoms, but no additional clinical rationale was documented to explain why the medication should continue at the current doses, what symptoms were being treated, or why a dose reduction would be unsafe. The record did not show current symptoms to support continued use, did not identify treatment goals, and did not document non-pharmacological interventions (non-medication approaches such as reassurance, calming activities, or environmental adjustments tried before or along with medications). No documentation was provided to show why a (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	GDR was medically contraindicated. The above information was reviewed with the Director of Nursing on December 19, 2025, at 12:15 PM. No additional documentation was provided at that time to show a clinical basis for continuing the current psychoactive medication regimen. 28 Pa. Code 211.2 (d) (3) Medical Director 28 Pa. Code 211.5 (f) (ix)Medical records 28 Pa. Code 211.9 (k) Pharmacy Services 28 Pa Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (d)(1)(3) Nursing Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, select policy review, and staff interviews, it was determined the facility failed to ensure the resident environment remained free from potential accident hazards for one resident (Resident 10) of 24 sampled residents when medications were left accessible at the bedside without documented clinical assessment for safety or authorization to self-administer.Findings included: A review of a facility policy titled Medication Policy, last reviewed August 6, 2025, revealed medications are to be administered by licensed nurses, or by other legally authorized staff to do so, as ordered by the physician and in accordance with professional standards of practice in a manner that prevents contamination or infection. The policy also stated the licensed nurse will observe resident consumption of medication. This was listed as number 16 in the policy explanation and compliance guidelines. A clinical record review revealed Resident 10 was admitted to the facility on [DATE], with diagnoses that include cerebrovascular disease (conditions which affect blood flow to the brain. A review of Resident 10's quarterly Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 20, 2025, revealed a Brief Interview for Mental Status (BIMS, an assessment tool that is used to assess the resident's attention, orientation, and ability to register and recall new information) score of 11 indicates moderate cognitive impairment, meaning the resident may require additional support, monitoring, and supervision to maintain safety. During an observation on December 17, 2025, at 11:25 AM, in Resident 10's room, two circular tablets (one yellow and one green) were observed sitting unattended on the bedside table in a clear plastic 30 milliliter cup. Resident 10 was seated on the side of the bed near the table where the medications were located. A review of Resident 10's clinical record review did not contain documented evidence that Resident 10 had been assessed or deemed safe to self-administer medications. Further review of the electronic medication record revealed a physician order for Tums Oral Tablet Chewable 500 milligrams (Calcium Carbonate Antacid) to be given by mouth, two tablets every two hours as needed for indigestion. The electronic medication administration record documented the medication was last administered on December 16, 2025, at 8:07 PM. During an interview on December 17, 2025, at 12:30 PM, the Director of Nursing and the Nursing Home Administrator were made aware of the observations and the clinical record findings. They acknowledged there was no documented assessment in the clinical record indicating that Resident 10 had been evaluated or determined safe to self-administer medication, and no additional documentation supporting self-administration was presented at that time. The facility failed to maintain an environment free from potential accident hazards by leaving medications accessible at the bedside without documented assessment or authorization for self-administration and the potential for accidental consumption by others. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and select facility policy, and staff interviews, it was determined the facility failed to monitor a resident's weight and timely identify significant weight loss and assure timely assessment of a resident's nutrition status to timely develop and implement nutritional approaches addressing significant weight and notify a resident's attending physician and responsible party of significant weight loss for one resident out of four residents sampled for nutrition (Resident 9). Findings included: A review of a facility policy entitled Weight Assessment and Intervention last reviewed August 6, 2025, indicated any weight change of five percent (5%) or more since the last weight assessment will be retaken for confirmation. The Dietitian will review the Weight Records and negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change had been met. The threshold for significant unplanned and undesirable weight loss will be based on the following criteria, one month 5% weight loss is significant and greater than five percent is severe, in three months 7.5% weight loss is significant and greater than 7.5% is severe, and in six months 10% weight loss is significant and greater than 10% is severe. The physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia (loss of appetite), weight loss, or increasing the risk of weight loss. A review of the clinical record revealed Resident 9 was admitted to the facility on [DATE], with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (an ischemic stroke caused by interrupted blood flow to the brain), affecting the right dominant side; dysphagia (difficulty swallowing); and cognitive communication deficits (impairments in thinking and communication). A review of the comprehensive person-centered plan of care, initiated February 20, 2020, identified that Resident 9 was at risk for altered nutritional status due to a history of cerebrovascular accident (CVA, also referred to as stroke), underweight status with moderate protein-calorie malnutrition (a condition caused by inadequate intake of calories and protein), and a history of significant weight loss. Planned interventions included notifying the attending physician and responsible party of significant weight changes, providing a fortified diet (a diet enhanced with additional calories and protein to promote weight gain or maintenance), providing a regular texture diet, obtaining laboratory studies as ordered and notifying the physician of results, and obtaining weights as ordered.A review of Resident 9's weight records revealed the following documented weights documented in the electronic clinical record: September 1, 2025, at 11:19 AM, 119.2 pounds; and October 2, 2025, at 2:19 PM, 106.3 pounds. This reflected a weight loss of 12.9 pounds, representing a 10.8 percent decrease in one month, meeting the facility's policy definition of severe weight loss. Further review of the weight record revealed an additional weight was obtained on October 10, 2025, at 2:08 PM, nine days after the documented severe weight loss, with a recorded weight of 112.2 pounds. The record further showed the October 2, 2025, weight of 106.3 pounds was later stricken out on October 10, 2025, at 2:13 PM, by the facility's Registered Dietitian with a notation of reweight. A review of progress notes revealed a Weight Warning Nutrition Note dated October 10, 2025, at 2:21 PM, completed by the Registered Dietitian, which identified significant weight loss of 7.0 pounds or 5.9 percent in approximately 40 days, significant weight loss of 9.3 pounds or 7.7 percent in approximately 100 days, and non-significant weight loss of 6.4 pounds or 5.4 percent over 180 days. The note indicated the resident remained on a fortified regular texture diet with thin liquids, desserts twice daily, and health shakes (a high-calorie oral nutritional supplement) three times per day, with reported meal intake generally greater than 76 percent but variable. The Registered Dietitian documented the resident's body mass index (BMI, a calculation using height and weight to estimate body fat) as 19.3, indicating an underweight status for the resident's age, and noted weight loss was not desirable. Recommendations included discontinuing health shakes three times daily and adding a nutritional drink which provided essential vitamins, minerals and protein, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	twice daily to increase daily caloric intake by approximately 120 calories, with continued monitoring of intake, weights, and laboratory values. The plan of care was noted as updated. The facility was unable to provide documented evidence that Resident 9's weight loss occurring between September 1, 2025, and October 2, 2025, was timely addressed by the Registered Dietitian or that timely revisions to the resident's care plan and timely development and implementation of nutritional interventions were completed. Additionally, the facility was unable to provide documented evidence that Resident 9's attending physician and responsible party were notified of the weight loss. During an interview with the Nursing Home Administrator on December 18, 2025, at 10:45 AM, the above findings were reviewed. No additional documentation was provided to demonstrate that Resident 9's weight loss was timely addressed or that the attending physician and responsible party were notified. 28 Pa Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure the availability of required emergency dialysis supplies and failed to provide person-centered care related to hemodialysis for one resident out of two residents reviewed who received hemodialysis (Resident 88).Findings include: According to the National Kidney Foundation, individuals receiving hemodialysis, (a life-sustaining treatment for individuals with kidney failure that removes waste and excess fluids from the blood) must have access to emergency supplies, such as clamps and pressure dressings, in the event of complications such as hemorrhage (bleeding) or catheter dislodgement. A review of the policy Care of Resident with End-stage Regal Disease last reviewed August 6,2025, indicated that staff caring for residents with ESRD (End Stage Renal Disease) including residents receiving dialysis care outside of the facility shall be trained in the care and special needs of these residents, including the ability to recognize and intervene in medical emergencies such as hemorrhage or infection. The policy also indicated emergency supplies are to be maintained and accessible for residents with dialysis access sites. A review of the clinical record revealed that Resident 88 was admitted to the facility on [DATE], with diagnoses to include end-stage kidney disease with dependence on kidney dialysis (process of removing waste products and excess fluid from the body when the kidneys cannot adequately filter the blood). The clinical record revealed the resident had a left upper arm arteriovenous (AV) fistula (a surgically created connection between an artery and a vein used for dialysis access). Current physician orders dated December 3, 2025, indicated the resident was to attend dialysis on Monday, Wednesday, and Friday at 6:30 AM; staff were to follow specific instructions related to the left upper extremity AV fistula including limb alert precautions, monitoring for signs and symptoms of infection and/or bleeding, maintaining an emergency fistula kit at the bedside, and documenting a progress note when the resident left the facility for dialysis and upon the resident's return. During an observation on December 17, 2025, at 1:35 PM, no emergency dialysis supply kit, clamps, pressure dressings, or other fistula-related emergency equipment were present at the bedside, mounted to the wall, or otherwise visible within Resident 88's room. An interview with Employee 2, Licensed Practical Nurse, on December 17, 2025, at 1:42 PM, confirmed that an emergency kit containing clamps and pressure dressings should have been present and immediately accessible in the resident's room based on the resident's dialysis access needs. A continued review of the resident's current care plan, initiated December 3, 2025, revealed the care plan did not include individualized interventions addressing the resident's hemodialysis treatment, AV fistula, required monitoring, or emergency measures for hemorrhage or dislodgement. There were no documented interventions regarding fistula care or emergency response planning. On December 18, 2025, at 12:15 PM, the above information was reviewed with the Nursing Home Administrator. 28Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that necessary behavioral health care and services were provided to attain or maintain the highest practicable mental and psychosocial well-being for one of 24 residents reviewed for behavioral health needs (Resident 94). Findings include: A review of Resident 94's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including a personal history of suicidal behavior (defined as documentation of past suicidal actions or attempts, indicating increased risk for future suicidal thoughts or behaviors and the need for clinical monitoring). Further review of Resident 94's clinical record revealed a history and physical from the hospital prior to admission to facility dated [DATE], indicating he had been admitted to the hospital due to being found by a family member with self-inflicted lacerations to the left wrist and scissors present in the bed. The resident denied suicidal intent at that time; however, the documented history indicated the need for ongoing assessment and behavioral health monitoring. A review of the resident's care plan, initiated [DATE], revealed no individualized interventions or goals to address the resident's history of suicidal attempts or suicidal ideation (a term referring to thoughts or plans of self-harm or suicide). The care plan did not address documented behaviors, risks, or the need for behavioral health monitoring based on presented history. Further review of the clinical record revealed the resident's son died by suicide on [DATE]. The resident was evaluated by an outside psychiatric provider on [DATE]; however, review of the care plan through the survey exit date of [DATE], indicated there were no updates reflecting this significant psychosocial event or the resident's increased risk for mental health decline following the loss of a child. There was no evidence that the facility developed or implemented person-centered interventions or additional services to address the resident's ongoing behavioral health needs, psychosocial stressors, or potential for further suicidal ideation following the traumatic loss. During an interview with the Director of Nursing (DON) on [DATE], at 10:00 AM, the DON was unable to provide evidence that the care plan had been updated to address the resident's history of suicidal behavior, recent loss of a family member, or the need for behavioral health interventions to maintain the resident's highest practicable level of mental and psychosocial well-being. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(5) Nursing services.