

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Dr Arthur Clifton McKinley Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 133 Laurelbrooke Drive Brookville, PA 15825	
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to initiate a baseline care plan and provide a written summary of the baseline care plan and order summary to the resident and/or representative for five of five residents reviewed (Residents R2, R6, R9, R10, and R13). Findings include: Review of facility policy entitled Care Plans - Baseline dated 11/4/25, revealed that A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission. The policy further stated The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality of care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: Initial goals based on admission orders and discussion with the resident/representative, physician orders, dietary orders, therapy services, social services, and PASARR recommendations if applicable. The policy further stated that The resident and/or representative are provided a written summary of the baseline care plan, and provision of the summary to the resident and/or representative is documented in the medical record. Resident R2's clinical record revealed an admission date of 8/2/25, with diagnoses the included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Stroke (occurs when blood flow to the brain is blocked or a blood vessel inside or on the surface of the brain bursts causing brain cells to die often times leading to permanent disabilities), and Diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R2's clinical record lacked evidence that a baseline care plan was initiated and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. Resident R6's clinical record revealed an admission date of 4/25/25, with diagnoses that included Diabetes, Benign Prostatic Hyperplasia (BPH - a noncancerous enlargement of the prostate gland, which can result in frequent urination, difficulty starting or stopping urination and a weak urine stream), and Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications). Resident R6's clinical record lacked evidence that a baseline care plan was initiated and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. Resident R9's clinical record revealed an admission date of 11/6/25, with diagnoses that included Atrial Fibrillation, Dementia (loss of cognitive functioning affecting a person's memory and behaviors), and Diabetes. Resident R9's clinical record lacked evidence that a baseline care plan was initiated and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. Resident R10's clinical record revealed an admission date of 11/14/25, with diagnoses that included Diabetes, Atrial Fibrillation, and Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Resident R10's clinical record lacked evidence that a baseline care plan was initiated and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. R13's clinical record revealed an admission date of 8/20/25, with diagnoses that included Parkinson's Disease (a movement disorder of the nervous system that may (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	result in tremors, stiffness, slowing of movement, and trouble with balance that worsens over time), Benign Prostatic Hyperplasia, and Gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn). Resident R13's clinical record lacked evidence that a baseline care plan was initiated and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. During an interview on 12/3/25, at 3:09 p.m. the Nursing Home Administrator confirmed that the clinical records for Residents R2, R6, R9, R10, and R13 lacked evidence that a baseline care plan was initiated, and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10(c) Resident care plan 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy and manufacturer's guidelines, observation, and staff interview, it was determined that the facility failed to appropriately discard outdated medications for one of two medication rooms reviewed (Rehabilitation Unit). Findings include: Review of facility policy entitled Medication Labeling and Storage dated 11/4/25, revealed that Multi-dose vials that have been opened or accessed (example - needle punctured) are dated and discarded within 28-days unless the manufacturer specified a shorter or longer date for the open vial. Review of manufacturer's guidelines revealed that an open vial of Tubersol (a solution used for tuberculosis testing upon admission and employment) should be discarded within 30-days after opening. Observation of drug storage on 12/2/25, at 12:13 p.m. of the Rehabilitation Unit medication storage room refrigerator revealed an open vial of Tubersol with an open date of 10/28/25, making the discard date 11/27/25. During an interview at the time of observation, Licensed Practical Nurse Employee E1 confirmed that the open vial of Tubersol vial was past 30 days and should have been discarded 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services		