STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395651	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation & Healthcare Center	395 Middle Road Nanticoke, PA 18634

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of facility's abuse prohibition policy, clinical records, information submitted by the facility, and select investigative reports and staff interview it was determined that the facility failed to assure that one resident (Resident B2) out of four sampled was free from physical abuse perpetrated by another resident (Resident B1). Findings included: A review of the current facility policy titled Abuse Policy, provide by the facility on May 17, 2024, revealed it is the policy of the facility that the residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. As part of the resident abuse prevention program, the administration will protect the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. A review of Resident B2's clinical record revealed admission to the facility on [DATE],with diagnoses to include Type 2 diabetes (failure of the body to produce insulin), and shortness of breath. An annual Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated March 28, 2024, indicated that the resident was moderately cognitively impaired with a BIMS (brief interview to assess cognitive status) score of 8 (8-12 represents moderate cognitive impairment). A review of Resident B1's clinical record revealed admission to the facility on [DATE], with diagnoses to include cerebral infarction (brain damage that results from a lack of blood), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to parts of the brain, depriving them of oxygen and nutrients), and cognitive communication deficit. An admission MDS dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS score of 3 (0-7 represents severe cognitive impairment). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident B1's care plan dated March 18, 2024, indicated that the resident exhibited the following behaviors due to vascular dementia: resistant to care, sexually inappropriate behaviors and comments, makes nonsensical comments, tearful, then begins to laugh, difficulty completing thoughts, curses at staff, wandering, refuses showers at times, aggressive behaviors toward others, and easily agitated. Interventions planned were to approach the resident in a calm manner, attempt distractions and redirection, sit beside other male residents and keep within arm's length of female residents, document episodes of inappropriate behaviors and notify MD when behaviors persist, and remove from area when other residents are experiencing loud outburst. A review of ACT-13 Mandatory Abuse Report dated March 19, 2024, at 1:45 PM revealed Resident B1 was sitting in the hall when he reached over and touched a female resident's face with his right hand while putting his lips on her lips. The residents were separated and Resident B1 was placed on one-to-one supervision (1:1). Review of the facility protocol titled 1:1 Supervision Process provided by the facility during the survey of May 17, 2024, indicated that when a staff member is assigned to supervise a resident placed on 1:1 supervision, the staff member is required to remain with eyes on that resident at all times. The supervisor will assign the staff member responsible for monitoring the resident and document this on the assignment sheet. The staff member is to document on the 1:1 form the following: date, time, location of resident, activity of resident, and staff members signature. Review of nursing notes from April 2, 2024, though May 12, 2024, indicated that Resident B1 remained on one-to-one supervision. Review of a nursing note dated May 12, 2024, at 7:30 PM reported that Resident B1 was seated at the nurses station with 3 other nurse aides prior to an altercation with another resident. The LPN went down the hall to provide care to another resident and when she returned to the hallway, she witnessed Resident B1 wheeling up to Resident B2 and telling him to shut up. She witnessed Resident B1 grab B2's right arm and hold it down. Resident B1 then started closed fist hitting Resident B2 in the chest. Resident B2 then started hitting Resident B1 with his left closed fist. She separated the residents and Resident B1 went to his room with his 1:1. Review of facility provided documentation titled Birchwood Summary no date or time revealed that at approximately 7:28 PM on May 12, 2024, Resident B2 was sitting in his recliner near the nurses station, yelling out that he was uncomfortable and attempted to self-ambulate. Staff responded and repositioned for comfort. At approximately 7:30 PM, the nurse was exiting a resident's room and observed Resident B1 roll his wheelchair over to Resident B2's chair telling him to shut up. As the nurse was running toward the residents and instructing them to stop, Resident B1 held Resident B2's right arm down and struck him in the torso. Resident B2 responded with his left arm and struck back at Resident B1. Residents were immediately separated. Skin checks performed on both residents with no injuries noted. MD and RP notified. The report stated that prior to the incident, Resident B1 was last observed sitting in his wheelchair near the nurses station and calmly talking with another resident at approximately 7:29 PM. His mood had been pleasant thus allowing his supervision level to be decreased. However, there was no evidence at the time of the survey ending May 17, 2024, that Resident B1 was removed from 1:1 supervision on May 12, 2024, prior to him physically abusing Resident B2, as noted on the above summary (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on May 17, 2024, at 1:05 PM confirmed that Resident B1 should have remained 1:1 during the shift of May 12. 2024, and that the facility failed to prevent the physical abuse of Resident B2 perpetrated by Resident B1, during which Resident B1 was punching Resident B2 in the chest. The facility was aware of the physically aggressive behavior of Resident B2 but failed to demonstrate sufficient supervisory measures of this resident to monitor his activities and whereabouts to prevent the physical abuse of another resident. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (c) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records and staff interview it was determined that the facility failed to develop a person-centered comprehensive plan of care to meet the specific supervision needs of one resident out of 12 sampled (Resident B1). Findings included: A review of Resident B1's clinical record revealed admission to the facility on [DATE], with diagnoses to include cerebral infarction (brain damage that results from a lack of blood), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to parts of the brain, depriving them of oxygen and nutrients), and cognitive communication deficit. An admission MDS dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS score of 3 (0-7 represents severe cognitive impairment). A review of ACT-13 Mandatory Abuse Report dated March 19, 2024, at 1:45 PM revealed Resident B1 was sitting in the hall when he reached over and touched a female resident's face with his right hand while putting his lips on her lips. The residents were separated and Resident B1 was placed on one-to-one supervision (1:1) Review of nursing notes from April 2, 2024, though May 12, 2024, indicated that Resident B1 remained on one-to-one supervision. Review of a nursing note dated May 12, 2024, at 7:30 PM reported that Resident B1 was seated at the nurses station with 3 other nurse aides prior to an altercation with another resident. The LPN went down the hall to provide care to another resident and when she returned to the hallway, she witnessed Resident B1 wheeling up to Resident B2 and telling him to shut up. She witnessed Resident B1 grab B2's right arm and hold it down. Resident B1 then started closed fist hitting Resident B2 in the chest. Resident B2 then started hitting Resident B1 with his left closed fist. She separated the residents and Resident B1 went to his room with his 1:1. Review of Resident B1's care plan dated March 18, 2024, and revised May 17, 2024, indicated that the resident exhibited the following behaviors due to vascular dementia: resistant to care, sexually inappropriate behaviors and comments, makes nonsensical comments, tearful, then begins to laugh, difficulty completing thoughts, curses at staff, wandering, refuses showers at times, aggressive behaviors toward others, and easily agitated. Interventions planned were to approach the resident in a calm manner, attempt distractions and redirection, sit beside other male residents and keep within arm's length of female residents, document episodes of inappropriate behaviors and notify MD when behaviors persist, and remove from area when other residents are experiencing loud outburst. Resident B1's care plan failed to identify Resident B1's need for the one-to-one (1:1) supervision and criteria for re-evaluation for the level and degree of supervision necessary to maintain resident safety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing on May 17, 2024, at approximately 1:00 PM confirmed that the resident received 1:1 supervision and that facility failed to fully develop and implement the comprehensive care plan to include Resident B1's 1:1 supervision requirement. Refer F600 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of select facility policy, clinical records and documentation and staff interviews, it was determined that the facility failed to demonstrate the implementation of ongoing QAPI programs, to include the use of systems for investigating and analyzing the root cause of adverse events as evidenced by one resident out of 12 sampled (Resident A1). Findings include: Review of the facility policy entitled Quality Assurance/Performance Improvement last reviewed [DATE] revealed, the facility shall develop, implement and maintain an ongoing, facility wide data driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI program are to: 1. provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. provides a means to establish and implement performance improvement projects to correct identified negative and problematic indicators. 3. reinforce and buildup effective systems and processes related to the delivery of quality care and services. 4. establish systems through which to monitor and evaluate corrective actions. Clinical record review revealed that Resident A1 was admitted to the facility on [DATE], with diagnosis to include, Dementia, cerebral infarction (stroke) and atrial fibrillation. A review of a significant change minimum data set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated [DATE], revealed that the resident had a BIMS score of 12, indicating that the resident was moderately cognitively impaired, required set-up assistance for meals and staff assistance for activities of daily living including ambulation, transfers and toileting. The resident's care plan, initiated [DATE], revealed that Resident A1 had impaired cognitive function related to Vascular Dementia, Bipolar Disorder and Cerebral Infarction (stroke) with moderate, cognitive function. According to the resident's care plan the resident was at risk for altered nutritional status related to a history of aspiration (aspiration occurs when contents such as food, drink, saliva or vomit enters the lungs. The lungs are guarded by protective reflexes such as coughing and swallowing. This condition occurs if these reflexes are diminished) and chewing difficulty requiring modified texture diet. Planned interventions were to provide a Mechanically soft diet, ground texture and provide feeding/dining assistance as needed. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident had a physician order dated [DATE], for a regular diet, mechanical soft, ground meat texture, with thin liquids. A review of the facility menu for [DATE], dinner meal revealed that mechanically soft diets were to receive a ground breaded chicken patty on a bun, canned diced tomatoes, cheese puffs and chopped pear halves with whipped topping. A review of the resident's meal tray ticket dated [DATE], for the dinner meal indicated that the resident was to be served a dental soft (mechanical soft) texture foods. A review of a change in condition note dated [DATE] at 5:52 P.M. revealed Called to {Resident A1's} room by staff, noted resident sitting on toilet, color pale, clammy, foaming at the mouth, and sweaty. Resident unresponsive to stimuli. Resident assisted onto chair then into the bed. oxygen applied, resident mouth was suctioned . Vital signs as followed, Blood pressure ,d+[DATE], pulse 82, Respirations 34, o2 sat 97% (out of one hundred) with o2 on. 911(emergency response) called and Physician called and made aware of resident's status order received to transfer resident to the emergency room . By the time 911 arrived resident is awake alert and oriented x 3. A nurses note dated [DATE] at 02:30 A.M. revealed {Resident A1} returned from ER diagnosis, syncope (fainting or passing out, is a loss of consciousness and muscle strength characterized by a fast onset, short duration, and spontaneous recovery) via ambulance without incident. Transferred to bed, incontinent care delivered. RN Supervisor notified. Resident requested drink, had difficulty swallowing with coughing spell at that time. Liquid consistency downgraded to nectar, food texture to puree until evaluated by speech. An interview conducted on [DATE], at 12 P.M. revealed that Employee 1 (LPN) stated that on Saturday [DATE], during the 3 PM to 11 PM shift she was on duty on the first floor. At the time of Resident A1's incident she was seated at the nurses station, watching the residents seated in their wheelchairs. She called 911 for the ambulance. She stated that she did not go into the resident's room. An interview [DATE] at 12:10 P.M., Employee 2, nurse aide, stated that she was working Saturday [DATE], 3 PM to 11 PM on the first floor at the time of the incident. She stated that she and Employee 3, nurse aide, passed dinner trays on the west hall. Employee 3 served Resident A1's dinner tray to him in his room. Employee 2 stated that we finished passing trays on that hallway and began passing trays on the east hallway. Resident A1's call bell was going off. The employee stated I went to {Resident A1's} room, he was choking on a sandwich. He got the wrong sandwich, it should have been ground up. Employee 3 had her finger in the resident's mouth, trying to get the food out. He bit down on her finger, trying to get food out of Resident A1's mouth. Resident A1 was blue and gurgling. Resident A1 bit Employee 3's finger and it was bleeding. We called for the crash cart and began CPR on the resident. By the time the ambulance got to the facility, the resident woke up. All the staff on the floor new what was going on. Multiple attempts were made to contact Employee 3 at the time of the survey ending [DATE], but the employee did not answer or return the telephone calls. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview [DATE] at 11:30 AM Employee 4 (agency RN Supervisor) stated that she was the facility RN supervisor on Saturday [DATE] 3 PM to 11 PM shift. She stated that she was on the second floor and was called to the first floor in response to Resident A1's incident. She stated that nursing had called her due to an unresponsive resident (Resident A1). Further stating that the resident was on the toilet, skin gray and clammy, foaming from the mouth, unresponsive. She stated that this resident had a habit of attempting self-transfers in the past and probably self transferred to the toilet. Employee 4 (agency RN) stated that the resident had responded when staff transferred him back to bed and was awake when emergency services arrived at the facility. She stated that the crash cart was taken to the resident room, but not used. She stated that she did not know anything about Resident A1 receiving the wrong texture diet, staff ordering an additional tray that evening meal from dietary or this resident receiving CPR. She stated that she did not call the Director of Nursing (DON) after the event to inform her as didn't think it was necessary to call the DON. A telephone interview [DATE] at 12:30 P.M. with a staff member who wished to remain anonymous due to retaliation stated that on [DATE] at around 5:30 PM, {Resident A1} was served the wrong consistency dinner tray, a regular consistency dinner tray to include a whole chicken breast sandwich (instead of a chopped meat sandwich). She stated that Employee 3, nurse aide, served him the tray in his room. He began to eat the sandwich before Employee 3 realized that it was the wrong consistency. She put her finger in his mouth in an attempt to remove the food. The resident bit down on her finger, causing it to bleed. The resident began to choke and became unconscious. A code was called. Nursing staff brought the crash cart into the room and CPR was initiated. This staff member stated that the resident was then placed onto the toilet. She stated that he was blue and gurgling from the mouth.+ The interview continued with the anonymous facility employee stating that nursing staff on duty that evening were very upset over the event and not informing the DON. She stated that the Nursing Home Administrator (NHA) was in the building at that time and several nursing staff members confronted her in the nursing supervisors office concerning the event. The employee stated that the NHA called the DON at that time and neither was concerned about the event. An interview [DATE] at 9:30 A.M, the Certified Dietary Manager stated that nursing staff had contacted the kitchen during the dinner meal on [DATE], to ask for a new tray for Resident A1. She was unable to state why the new tray was requested and she was not in the building at that time. During an interview [DATE] at approximately 2:30 P.M., the NHA stated that she was in the building on Saturday [DATE] at approximately 5:45 P.M. She stated that she was making a spot check of the facility. She stated that she was not on the first floor but in her office and the nursing supervisor's office. She stated that she was aware of some kind of incident involving Resident A1, however stated that she does not get involved in medical issues with residents. She stated that staff were in the office concerning Resident A1's incident and she did call the DON at that time. During an interview [DATE] at 2:45 P.M. the DON stated that neither nursing staff nor the NHA called her on [DATE], 3 PM to 11 PM shift regarding Resident A1 and his need to go out to the hospital. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of the survey ending [DATE], the facility had not investigated this adverse event, and Resident A1's possible choking incident as the result of being served the wrong consistency diet. There was no evidence that the facility had identified the underlying cause or contributing factors to this incident and was able to provide the surveyor with a factual and accurate representation of the events surrounding Resident A1's potential choking incident, change in condition necessitating hospital transfer. There was no evidence at the time of the survey that the facility demonstrated an effective QAPI program to include outcomes of quality of care and quality of life by investigating alleged incidents and thorough documentation to support their analysis of the data collected and any corrective actions developed and implemented. 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(4) Management 28 Pa. Code 211.12(c) Nursing Services