

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on observations and resident and staff interviews, it was determined that the facility failed to provide housekeeping and maintenance services to maintain a clean and orderly environment in one of the two nursing halls (First floor nursing unit).</p> <p>Findings include:</p> <p>An observation on October 24, 2024, at 11:00 AM, in room [ROOM NUMBER] revealed food, dirt, and debris on the floor around and under the resident's bed. The floor was noted to be sticky.</p> <p>During an interview on October 24, 2024, at the time of the observation Resident 2 was asked how often her floor is swept and mopped. The resident replied, not too often, once in a blue moon.</p> <p>An observation on October 24, 2024, at 11:10 AM, in room [ROOM NUMBER] revealed the floor was dirty with dirt and paper debris. Further it was noted the garbage can overflowing with trash.</p> <p>An observation on October 24, 2024, at 11:15 AM, in room [ROOM NUMBER] revealed the floor was dirty with dirt and paper debris. The tube feeding pole in the room had dried tube feeding solution on the bottom of the pole. The wall under the wall mounted television was gouged and had multiple black marks on it.</p> <p>An observation on October 24, 2024, at 11:20 AM, in room [ROOM NUMBER] revealed the floor was dirty with dirt and paper debris.</p> <p>An observation on October 24, 2024, at 11:25 AM, in room [ROOM NUMBER] revealed the garbage can to be overflowing with trash. The floor was noted to have dirt and paper debris. The fall mat on the floor beside the right side of the bed was dirty with food and dried liquid stains.</p> <p>An observation on October 24, 2024, at 11:30 AM, in room [ROOM NUMBER] revealed the floor was dirty with dirt and paper debris. The heating unit located under the window had a protective grate which was broken and approximately 6 inches of the grate was missing, exposing the inner unit. The overbed unit was dirty with food and liquid stains.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on October 24, 2024, at 11:35 AM, in the hallway outside room [ROOM NUMBER] revealed a wheelchair with a chair pad which was dirty with food and liquid stains. An additional chair pad was also noted to be dirty with food and liquid stains. The arms of the chair and chair pad were ripped. There was no resident identification on the wheelchair at the time of the survey.</p> <p>An observation on October 24, 2024, at 11:40 AM, in room [ROOM NUMBER] revealed the floor was dirty with dirt and paper debris.</p> <p>An observation on October 24, 2024, at 11:45 AM, in room [ROOM NUMBER] revealed the floor was dirty with dirt and paper debris. The floor under the tube feeding pole was noted to have dried up tube feeding solution on it.</p> <p>During an interview on October 24, 2024, at approximately 2:00 PM, the Nursing Home Administrator (NHA) confirmed that the facility is to be maintained in a manner that supports the resident's right to a clean and orderly environment.</p> <p>28 Pa. Code 201.18 (e)(1)(2.1) Management</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on clinical record review, review of a facility investigation, and staff interview, it was determined the facility failed to implement planned interventions to prevent a fall with injury, resulting in a facial fracture for one resident (Resident 1) out of 5 reviewed.</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnosis to include critical illness myopathy (a common neuro-muscular complication of intensive care treatment associated with increased morbidity and mortality), chronic respiratory failure (a condition in which your blood doesn't have enough oxygen), and Langerhans Cell Histiocytosis (a rare disorder that can damage tissue or cause lesions to form in one or more places in the body).</p> <p>A quarterly MDS assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 23, 2024, revealed the resident was severely cognitively impaired and required maximum assistance for activities of daily living.</p> <p>A review of the resident's plan of care initially dated June 25, 2024, revealed the resident was at risk for falls. A review of interventions initiated on July 7, 2024, indicated staff were to monitor and report for new signs and symptoms of pain, bruising, change in mental status, new onset of confusion, sleepiness, inability to maintain posture, and agitation.</p> <p>A review of the resident's plan of care initially dated June 25, 2024, revealed a care plan for ADL (activities of daily living) self-care performance deficit related to generalized weakness and impaired mobility. A review of interventions initiated on August 9, 2024, indicated the resident was to have a mechanical lift (device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) used for transfers with assist of two staff members and the resident required two person total assistance with toileting.</p> <p>A review of a facility investigation report and nursing documentation dated October 1, 2024, at 7:30 AM, revealed Resident 1 was assisted to the toilet with the assistance of two staff members and the apex lift (a sit to stand lift, assists a resident from a sitting to standing position). While on the toilet, the resident started to lean. The nurse aide (Employee 1) yelled for assistance. At that time no staff answered the nurse aide's calls. The nurse aide stuck her head out of the door to call the nurse, and then she heard Resident 1 fall to the floor.</p> <p>A review of a nursing note dated October 1, 2024, at 07:45 AM, revealed, the resident was found on the floor in front of the toilet with her head facing sink and feet facing the toilet, her slipper socks, brief and pants were on at her knees. The resident had complaints of pain to her nose and a small amount of bleeding. The physician was notified a new order was noted for facial X-ray.</p> <p>A review of the resident's clinical record revealed the resident was not sent to the hospital to be evaluated after the fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facial bones x-ray result dated October 2, 2024, revealed a fixator seen along the right temporal bone extending up to zygomatic-temporal arch with nondisplaced fracture (facial bone fracture).</p> <p>A review of a witness statement dated October 1, 2024, (no time indicated) revealed Employee 1 NA (nurse aide) stated Resident 1 was transferred with the APEX lift by Employee 2 LPN (license practical nurse) and herself. The Employee 1 indicated the nurse, Employee 2 LPN then left the bathroom. Employee 1 stated while the resident was on the toilet, she seemed unsteady and was leaning off the toilet. Employee 1 indicated she called for help but could not find anyone to answer. The employee stated at that time she peeked her head out of the resident's room to call for help and heard the resident fall.</p> <p>There was no witness statement from Employee 2 LPN available at the time of the survey.</p> <p>During an interview October 24, 2024, at 2:30 PM, Employee 1 NA stated that she and Employee 2 LPN transferred Resident 1 with the sit to stand lift from the bed to the toilet. Employee 1 stated Employee 2 then left the bathroom. Employee 1 indicated she saw the resident start to lean off the toilet. She stated that the resident looked bad. Employee 1 stated when the resident started to lean off the toilet, she panicked, left the bathroom, stepped outside of the resident's room, and yelled for help. Employee 1 indicated during that time the resident fell to the floor. Employee 1 stated that she was aware that Resident 1 was an assist of two staff for toileting and should not have left the resident alone in the bathroom.</p> <p>During an interview October 24, 2024, at 2:35 PM, Employee 2 LPN stated that she assisted Employee 1 to transfer the resident with the sit to stand to the toilet. Employee 2 stated she left the resident on the toilet with Employee 1 and left the resident's room. Employee 2 stated that she was aware that Resident 1 was an assist of two for toileting and should not have left the resident and Employee 1 in the bathroom alone prior to the fall.</p> <p>During an interview October 24, 2024 at 2:45 PM, the Director of Nursing confirmed staff failed to provide the proper supervision with toileting as indicated in the resident's plan of care resulting in a fall with a facial fracture.</p> <p>28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing Services</p>		