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	09/17/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of the facility's abuse prohibition policy and procedures, report of alleged abuse, clinical record review, and staff interviews, it was determined the facility failed to fully implement its abuse prohibition procedures to identify potential sexual abuse, ensure timely notification of administration and the State Survey Agency, notify the resident's representative and physician, and promptly investigate an allegation of sexual abuse for one of seven sampled residents (Resident 2).Findings include: A review of the facility policy titled Abuse Policy last reviewed by the facility on August 14, 2025, revealed all allegations of abuse must be reported immediately to the Director of Nursing (DON). In the absence of the Director of Nursing such reports may be made to the Nurse Supervisor on duty. The Nursing Home Administrator (NHA) or Director of Nursing must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the NHA and DON must be called at home or must be paged and informed. The facility's abuse policy defines sexual abuse as non-consensual sexual harassment, sexual coercion, contact or sexual assault. Further review of the policy revealed that any covered individual, which means the owner, operator, employee, manager, agent or contractor must report to the state survey agency and one or more law enforcement entities for the political subdivision in which the facility is located. Any alleged violations must be reported 1. Immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury. 2. Not later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment or misappropriation of resident property and does not result in serious bodily injury. Review of a report of an allegation of abuse dated September 2, 2025, revealed the alleged incident occurred on August 26, 2025, at 11:30 AM involving Resident 2 and Resident 2's visitor. Review of a witness statement provided by Employee 1 NA (nurse aide) dated August 28, 2025, (no time indicated) revealed that the alleged incident occurred on August 26, 2025, at 11:30 AM. Employee 1 reported she heard what sounded like a kissing noise in Resident 2's room. The curtain was pulled. Employee 1 stated she did not see anything, just heard the noise and reported it to Employee 3 LPN (licensed practical nurse). Review of a witness statement provided by Employee 2 (nurse aide) dated August 28, 2025, (no time indicated) revealed on August 26, 2025, she heard talk about sexual abuse to a resident and reported it to Employee 3 LPN. Review of a witness statement provided by Employee 3 LPN dated August 28, 2025, (no time indicated) revealed Employee 1 the nurse aide reported to him that she walked into Resident 2's room and heard moaning noises. Employee 3, LPN indicated he reported it to the RN Supervisor (Employee 4). The exact date of the incident on Employee 3's witness statement was illegible. Review of a witness statement provided by Employee 4 (RN Supervisor) dated August 28, 2025, (no time indicated) revealed that she was notified on August 28, 2025, by Employee 3 that he was told the day before by the nurse aide that she heard inappropriate noises coming from Resident 2's room while her visitor was in the room. Employee 4 reported it to the NHA. A review of Resident 2's clinical record revealed no documentation of the alleged sexual abuse had occurred. There was no documentation the facility NHA, DON, attending physician, or the resident's responsible party were made aware of the alleged sexual abuse at the time of the incident. Review of the facility's internal investigation revealed the facility did not initiate an investigation until August 28, 2025, two days after the alleged incident. Review of reports submitted to the State Survey Agency revealed the facility failed to notify the agency within the required two-hour timeframe following the allegation of sexual abuse. During an interview with the Assistant Director of Nursing on September 17, 2025, at 10:15 AM, it was confirmed that Employee 3 did not report the allegation of abuse in accordance with facility policy, resulting in delayed identification, notification, and investigation. The facility failed to implement its abuse prohibition procedures by not promptly identifying the alleged sexual abuse of Resident 2, not ensuring timely notification of administration, physician, responsible party, and State Survey Agency, and by delaying the initiation of an investigation into the allegation. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a)(c) Resident Rights. 28 Pa. Code 201.14(a)(c) Responsibility of Licensee. 28 Pa. Code: 211.12 (c)(d)(1)(3)(5) Nursing Services. 28 Pa. Code: 211.10 (c)(d) Resident care policies.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility investigative reports, and staff interviews, it was determined the facility failed to adequately investigate resident falls and timely develop and implement effective safety interventions to prevent falls for residents with a known history of falls and unsafe behaviors. This deficient practice resulted in repeated falls for one resident (Resident 3) and a serious injury (fracture of knee) requiring hospitalization for another resident (Resident 1), affecting two of the seven sampled residents.Findings include: A review of Resident 3's clinical record revealed admission to the facility on May 7, 2025, with a diagnosis to include hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke), legal blindness, and end stage heart disease (advanced and irreversible stage of heart failure, where the heart is severely weakened and unable to pump blood effectively). The resident expired on September 5, 2025. A review of a quarterly MDS (Minimum Data Set- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 15, 2025, revealed Resident 3 was moderately cognitively impaired with a BIMS score of 11 (BIMS-Brief Interview for Mental Status is a tool to screen and identify the cognitive condition of long-term care residents. A score of 8-12 represents moderate cognitive impairment). Resident 3 required substantial to maximal assistance of staff for activities of daily living. A review of the plan of care initiated May 12, 2025, identified Resident 3 was at risk for falls due to decreased strength, endurance, generalized weakness, and hemiplegia. Planned interventions included: educate the resident and family to call for assistance before transferring, keep call light, food/fluids and personal belongings within reach, keep bed in low position (not the lowest), keep environment free of clutter, provide activities that promote exercise and strength, and therapy evaluation. Nursing documentation revealed the resident exhibited increased anxiousness, self-ambulation, physical and verbal aggression toward staff, disruptive behaviors such as turning off roommate's air mattress, pushing roommate's belongings onto the floor, yelling obscenities and racial slurs, and removing oxygen tubing. Nursing documentation and facility investigative documentation from August 2, 2025, to September 3, 2025, revealed Resident 3 experienced ten falls: 7 unwitnessed falls and 3 witnessed falls. The incidents were as follows: August 2, 2025, at 1:15 PM: Resident 3 was found sitting on floor in his room with bruising and raised area to the left side of his head. The resident stated he slipped when going to the bathroom. Neurological checks (at a minimum assessment of pulse, respiration, and blood pressure measurements; assessment of pupil size and reactivity; and equality of hand grip strength following a head injury) were initiated. August 7, 2025, at 10:00 AM: Resident 3 was found sitting on the left side of bed on his buttocks. The housekeeper witnessed the fall. Resident 3 reported he was sitting on the side of the bed and tried reaching for his soda on the floor and fell forward onto his knees. Incontinence care provided. August 8, 2025, at 2:10 AM: Resident 3 attempted to self-ambulate and his legs gave out. The resident reported he had a cramp in his leg and tried to walk it off. He stated his legs gave out and he fell. Neurological checks initiated. August 12, 2025, at 1:56 AM: Resident 3 was found sitting on the floor at the foot of his bed. Neurological checks initiated. The care plan revised to provide tap bell. August 24, 2025, at 7:30 AM: Resident 3 was found sitting on the floor in front of the nightstand. Noticeable red marks on his mid to upper right side of his back. Skin tears noted to the right lower extremity from scab removal from fall. Neurological checks initiated and treatment to right lower extremity provided. August 25, 2025, at 1:30 AM: Resident 3 was found sitting on the floor near his closet with both legs extended in front of him. The bedside table was knocked over. The resident reported that he did not want to wait. Neurological checks initiated. Resident encouraged and reminded to activate call bell for assistance. August 29, 2025, at 9:15 PM: Resident 3 found lying on the floor on the left side of the bed with his blanket covering him and holding his pillow. The resident reported he rolled out of bed. August 30, 2025, at 9:50 AM: Resident 3 attempted to stand near the wall/corner of hallway and fell on his right side. Small abrasion on his forehead. Neurological checks initiated. Care plan revised to offer toileting after meals. September 1, 2025, at 8:00 AM: Resident 3 heard yelling out and was found lying on the floor on his left side with his head towards the foot of the bed. The resident reported he slid out of bed. September 3, 2025, at 7:00 PM: Resident 3 observed throwing arms and legs over wheelchair armrest, fell as staff approached. The care plan revised September 3 to add fall mats while in bed; revised again September 4 to provide mattress on floor when agitated and unable to remain seated. Despite documented interventions, the facility failed to identify root causes or implement adequate enhanced

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, and staff interviews, it was determined that the facility failed to implement individualized, person-centered interventions identified in the care plan to address dementia-related behaviors for one of seven sampled residents (Resident 4). Findings include: A review of a facility policy for Dementia-Clinical Protocols, reviewed August 2025 revealed, for residents with a confirmed dementia diagnosis, the interdisciplinary team will develop and implement a resident-centered care plan designed to maximize remaining function and quality of life. Clinical record review revealed that Resident 4 was admitted to the facility on [DATE], with diagnosis to include dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 3, 2025, revealed Resident 4 to be severely, cognitively impaired with a BIMS score of 3 (brief interview for mental status, is a cognitive screening tool that helps nursing staff measure how well residents can remember, process and recall information. A score of 0 to 7 indicates severe cognitive impairment) and required assistance of staff for activities of daily living.A care plan addressing behaviors, including yelling out and resistance with care, initiated July 24, 2024, directed staff to approach the resident in a calm manner to avoid frustration and escalation of behaviors. The care plan further instructed that if the resident became agitated and showed signs of escalation, staff were to stop the activity and re-approach the resident later to complete care when she was calmer. Review of facility investigative documentation and nursing notes dated August 30, 2025, at 7:30 PM, revealed Employee 5 (nurse aide) reported to Employee 6 (RN Supervisor) that she heard a noise from Resident 4's room that sounded like a muffled human voice. Employee 5 stated she suspected staff inside the room were holding their hand over Resident 4's mouth to prevent her from yelling. Employees 7 and 8 (nurse aides) were providing care to Resident 4 at the time. Both staff members were suspended and sent home pending the outcome of a facility investigation. A review of a witness statement dated August 30, 2025, revealed Employee 8 (nurse aide) stated, I did not cover Resident 4's mouth at any point. I understand the seriousness of this allegation, but it is not true. At the time of me changing Resident 4, she was very combative, screaming, and she was angry. A review of a witness statement dated August 30, 2025, from Employee 7 (nurse aide) indicated, I walked into Resident 4's room to assist Employee 8 (nurse aide) to put Resident 4 in her chair. At no time did either of us cover Resident 4's mouth. The resident was combative and screaming. At no point did anyone stop her from screaming. Although the facility's investigation did not substantiate abuse, there was no evidence that staff implemented the care-planned dementia interventions when Resident 4 became agitated. Specifically, there was no documentation or evidence that staff stopped the care and re-approached the resident at a later time as directed by the care plan. During an interview conducted on September 17, 2025, at 3:00 PM, the Assistant Director of Nursing and the Corporate Nurse Consultant confirmed that the individualized dementia care plan interventions were not implemented for Resident 4. 28 Pa Code 211.12 (d)(5) Nursing services.