STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395917	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brinton Manor Nursing and Rehabilitation Center	549 Baltimore Pike Glen Mills, PA 19342

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's policy, clinical records, and staff interview, it was determined that the facility failed to comprehensively assess and timely provide treatment to a wound for one of two residents reviewed (Resident CL1).Findings: A review of the facility's policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, undated, revealed that the staff will examine the skin of a new admission for ulcerations or alterations in skin. The nurse shall describe and document/report the full assessment of pressure sore, including location, stage, length, width, and depth, presence of exudates (a protein-rich fluid that leaks from blood vessels into surrounding tissues commonly seen in wounds, inflammation, or infection) or necrotic (dead, non-viable) tissue. A review of Resident CL1's hospital records Assessment and Plan dated December 28, 2025, revealed the resident had a sacral (The triangular bone just below the lumbar vertebrae), unstageable wound (Obscured full-thickness skin and tissue loss. A wound VAC (Also known as Negative Pressure Wound Therapy- is a medical device that uses continuous or intermittent suction to accelerate healing in complex or chronic wounds) treatment was made, and dressing was changed three times weekly. A review of Resident CL1's admission skin assessment dated [DATE], revealed the following assessment: sacrum (The triangular bone just below the lumbar vertebrae), pressure, unstageable (Obscured full-thickness skin and tissue loss). The same assessment review failed to reveal the wound measurements, slough (is non-viable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed) presence/percentage and presence of exudate. A review of the physician's progress notes dated January 6, 2026, revealed: holding wound vac at this time as patient has a lot of slough. A review of the physician's order dated January 6, 2026, revealed an order to discontinue the wound vac and cleanse the resident's sacrum with normal saline solution (NSS) apply medical honey (An ointment/cream that aids and support debridement and a moist wound healing environment in acute and chronic wounds and burns) to wound base cover with dry dressing everyday shift. A review of Resident CL1's January 2026 Treatment Administration Records (TAR) failed to reveal that the wound vac order was initiated from admission. The same TAR revealed the resident's sacral wound was not treated until January 7, 2026, two days after an unstageable sacral ulcer was identified on admission [DATE]). A review of Resident CL1's wound consults dated January 7, 2026, revealed the resident's sacral wound was assessed as unstageable, measuring 6.8 x 7.7 x 1.0 cm. with 60% slough, 6 o' clock - 7 o'clock undermining (A wound complication where tissue destruction occurs under intact skin at the wound edge, creating a shelf or pocket). A new treatment to cleanse the sacral wound: Dakins solution (An antiseptic solution used to treat and prevent skin/tissue infections in wounds), apply Santyl (A topical medication used for removing damaged or burned skin to allow for wound healing and growth of healthy skin), and cover with a dry dressing. An interview was conducted with the Director of Nursing on March 16, 2026, at 1:00 p.m. The DON confirmed that Resident CL1's unstageable sacral wound, identified upon admission, was not comprehensively assessed until seen by the wound doctor on January 7, 2026. The DON also confirmed that there was no documented evidence that Resident CL1's sacral wound was provided with treatment until (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395917	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brinton Manor Nursing and Rehabilitation Center	549 Baltimore Pike Glen Mills, PA 19342

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	January 7, 2026, two days after the wound was identified on admission [DATE]). The facility failed to ensure Resident CL1's unstageable wound was comprehensively assessed and provided with treatment in a timely manner. 28 Pa Code 211.10(c) Patient care policies 28 Pa. Code 211.12(c)(1)(3)(5) Nursing services