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	06/05/2026

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on clinical record reviews, resident interviews and staff interviews, it was determined that the facility failed to properly assess two of twenty-three residents reviewed (Resident 3 and Resident 66). Review of Resident 3's quarterly MDS assessment (MDS - periodic assessment of resident care needs) dated April 22, 2026, Section H0100 - Bowel and Bladder indicated that the resident had an indwelling foley catheter (a flexible tube inserted into the bladder to continuously drain urine.)No current, discharged , or completed orders for an indwelling foley catheter were observed in Resident 3's physician orders.Review of resident 3's care plan revealed no care plan or interventions for an indwelling foley catheter. During interview conducted with Resident 3 on June 3, 2026, at 1:04 p.m., Resident 3 denied ever requiring the use of an indwelling foley catheter. Interview conducted with Director of Nursing (DON) on June 4, 2026, when the above was presented, the DON confirmed Resident 3 did not require use of an indwelling foley catheter and the MDS was inaccurately documented.Review of Resident 66's medical diagnoses revealed a diagnosis for Diabetic Retinopathy (a serious eye condition caused by damage to the blood vessels in the retina due to Diabetes Mellitus (- a condition that occurs when the body can't properly use blood sugars, leading to high sugar levels) .)Resident 66's care plan revealed a focus dated April 14, 2025, indicating the resident has impaired visual function related to Diabetes Mellitus (DM- with bilateral DM retinopathy. During interview conducted with Resident 66 on June 2, 2026, at 11:35 p.m., Resident 66 stated that he/she had a visual deficit and was only able to see shadows. Review of Resident 66's May 7, 2026, Quarterly MDS, Section B1000 indicates the resident has adequate ability to see in adequate light.Interview conducted with Director of Nursing (DON) on June 4, 2026, at 10:15 a.m. when the above was presented, the DON confirmed Resident 66 had a visual deficit and the MDS was incorrectly documented. 28 Pa. Code: 211.12(d)(1)(5) Nursing services

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of the facility's policy and clinical records, observations, and interview with staff and residents, it was determined that the facility failed to appropriately monitor and follow a fluid restriction order for four of the four residents reviewed (Residents 1, 7, 37, and 53). Findings: A review of the facility's policy titled Encouraging and Restricting Fluid, undated, revealed, Be accurate when recording fluid intake. The same policy revealed, When a resident has been placed on restricted fluids, remove the water cup from the room. If the resident refuses to have the water removed, notify the supervisor and physician. A review of Resident 1's diagnosis list includes Chronic Congestive Heart Failure (CHF- When the heart cannot pump enough blood into the body to meet the metabolic needs) and Hepatic Failure (Occurs when the liver loses its ability to function properly). A review of Resident 1's physician order dated May 13, 2026, revealed Fluid restriction: 2000 ml daily every eight hours 24 hours total: Dietary 1320 ml: Breakfast 360 ml, lunch 480ml, dinner 480 ml. Nursing 680 ml: 7-3 270 ml, 3-11 270 ml, 11-7 140 ml. A review of Resident 1's May and June 2026 Medication Administration Record revealed that the resident's total fluid intake each shift was not monitored/documented. An observation conducted on June 3, 2026, at 1:30 p.m., revealed a 16 ounce of white styrofoam cup filled with cold water on the resident's bedside table. An interview with Resident 1 was conducted on June 3, 2026, at 1:30 p.m. The resident reported that the staff provides the cup of water and refills it. The residents do not know how many fluids they're allowed to take every meals/shift. A review of Resident 7's diagnosis list includes CHF and Chronic Kidney Disease (CKD-Gradual loss of kidney function, which can result in renal failure). A review of Resident 7's physician's order dated May 20, 2026, revealed an order for Fluid Restriction: 1500ml daily every 8 hours 24 Hour Total: 1500ml Dietary: 840ml. Breakfast 360ml, Lunch 240ml, 240ml Nursing: 660ml. 7-3 270ml, 3-11 270ml, 11-7 120ml. A review of Resident 7's May and June 2026 Medication Administration Record revealed that the resident's total fluid intake each shift was not monitored/documented. Further MAR review revealed the resident receives Ensure Plus (237 ml) twice daily at 10:00 a.m. and 4:00 p.m., where total amount consumed were not monitored/documented. An observation conducted June 3, 2026, at 1:37 p.m., revealed a 16 ounce of white styrofoam cup filled with cold water on the resident's bedside table and an extra cup of coffee. An interview conducted with Resident 7 on June 3, 2026, at 1:37 p.m., revealed that they requested an extra cup of coffee. The resident reported that the staff provides and refills the cup of water. The residents reported that they were aware of the fluid restriction but did not know how many fluids to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	take every shift/meal. An interview was conducted with the Director of Nursing on June 5, 2026, at 10:24 a.m. The DON confirmed that the cup of water should not have been placed in the resident's room. The DON also confirmed that the resident's fluid intake was not appropriately monitored and followed. The facility failed to ensure Resident 1 and 7's fluid restriction orders were followed. A review of Resident 37's diagnosis list revealed the resident has a diagnosis of chronic diastolic congestive heart failure, (a sudden worsening of a longˆterm condition associated with fluid retention, and the heart is too stiff to fill properly, causing fluid buildup in the lungs or body and the need for controlled fluid intake). A review of Resident 37's physician order dated April 24, 2026, at 10:00 p.m., revealed an order for, Fluid restriction: 2000 ml three times a day 24 hours total: Dietary 1320 ml: Breakfast 360 ml, lunch 480ml, dinner 480 ml. Nursing 680 ml: 7-3 270 ml, 3-11 270 ml, 11-7 140 ml. A review of Resident 37's May 2026 and June 2026 Medication Administration Record (eMAR) revealed the resident's total fluid intake each shift was not monitored or documented. There was no documentation identifying the amount of fluid provided to Resident 37. An observation conducted on June 2, 2026, at 11:54 a.m., revealed one 8-ounce Styrofoam cup and two 16-ounce Styrofoam cups full of water, along with a 16-ounce Coca-Cola bottle on Resident 37's sliding table. An observation conducted on June 3, 2026, at 12:55 p.m., revealed one 8-ounce Styrofoam cup and two 16-ounce Styrofoam cups on Resident 37's sliding tray. An interview conducted with Resident 37 on June 3, 2026, at 12:55 p.m., revealed the resident was unable to state the amounts of fluids they were permitted to have per meal or per shift. An interview conducted with Licensed Nursing Employee E9 on June 03, 2026, at 1:00 p.m., confirmed Resident 37 on is on a fluid restriction and should not have the soda or multiple cups of water on the sliding tray. An interview conducted with the Director of Nursing (DON) on June 5, 2026, at 10:24 a.m., confirmed Resident 37 was on a fluid restriction and should not have had soda or multiple cups of water at the bedside. The DON confirmed that the cups of water should not have been placed in Resident 37's room and fluid intake was not appropriately monitored. The facility failed to ensure Resident 37's fluid restriction order was followed. A review of Resident 53 physician diagnosis list includes history of falling (meaning Resident has fallen before and is at higher risk of falling again). A review of Resident 53's physician order dated April 21, 2025, at 3:00 p.m. revealed an active order for Fall mat to the window side of the bed-check placement every shift. A review of Resident 53's care plan revealed Fall mat to the window side of the bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation conducted on June 02, 2026, at 10:10 a.m. revealed the fall mat on the left side of the bed and no mat on the right side (window) of the bed. An observation conducted on June 03, 2026, at 2:10 p.m. revealed the fall mat on the left side of the bed and no mat on the right side (window) of the bed. An observation conducted on June 04, 2026, at 1:27 p.m. revealed the fall mat on the left side of the bed and no mat on the right side (window) of the bed. An interview conducted with the Licensed Nursing Employee E10 confirmed the care plan and physician orders state there should be a fall mat placed on the right side of the resident's bed. RN confirmed floor mat was placed on the left side, not on the right side as indicated in Resident's care plan intervention and physician order. The facility failed to ensure Resident 53's fall mat order was followed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service 28 Pa Code 211.5(f) Clinical Records 28 PA Code 211.10(a) Resident care policies

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation review of facility's policy and clinical records, and interview with resident and staff, it was determined that the facility failed to follow a respiratory order and provide sanitary measures for handling, cleaning and storage of respiratory equipment for two out of eight residents reviewed (Resident 34, and 37).Findings include: Review of facility policy Administering Medications through a Small Volume (Handheld) Nebulizer (a medical device that coverts liquid medication into a fine mist for inhalation directly into the lungs for the treatment of breathing difficulty. It consists of a mask or mouthpiece, a medicine cup, tubing and a machine that converts the liquid medication into a mist, dated2001, revealed: Rinse and disinfect the nebulizer equipment according to facility protocol; or a. wash pieces in warm, soapy water; b. allow to air dry on a paper towel. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Observation of Resident 34's bedside table on June 4, 2026, at approximately 9:30 a.m. revealed a nebulizer mask attached to a medicine cup and tubing laying on top of various belongings on Resident 34's bedside table. The tubing was unlabeled and there was a small amount of clear liquid in the medication cup. Observation of Resident 34's bedside table on June 5, 2026, at approximately 1:05 p.m. revealed a nebulizer kit laying on top of various belongings on Resident 34's bedside table. There was no label on the tubing, indicating when it had last been changed, and there was asmall amount of clear liquid in the medication cup. The observation was witnessed by E9 on June 5, 2026, at approximately 1:10 p.m. A review of Resident 37's diagnosis list revealed that the resident was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia (meaning your lungs aren't getting enough oxygen, both longˆterm and suddenly, causing dangerously low oxygen levels in the blood), and chronic respiratory failure with hypercapnia (meaning your lungs aren't getting enough oxygen and they cannot get rid of carbon dioxide, both longˆterm and suddenly). A review of Resident 37's physician's order dated March 20, 2026, at 7:00 p.m., revealed and active order for 0xygen at 2L/min continuously via nasal canula every shift for COPD. Baseline o2 saturation is 90%. An observation conducted on June 2, 2026, at 11:00 a.m., revealed an oxygen concentrator set at 4–5 L/min, with the flowmeter ball fluctuating between 4 and 5 L/min. An observation conducted on June 2, 2026, at 1:00 p.m., revealed an oxygen concentrator set at 4–5 L/min, with the flowmeter ball fluctuating between 4 and 5 L/min. An observation conducted on June 3, 2026, at 12:45 p.m., revealed an oxygen concentrator set at 4–5 L/min, with the flowmeter ball fluctuating between 4 and 5 L/min. An interview with the Director of Nursing (DON) conducted on June 5, 2026, at 10:00 a.m., confirmed Resident 37's oxygen concentrator was not set according to the physician's order. The DON stated (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident should have been receiving 2L/min as ordered. The facility failed to ensure Resident 37's oxygen was administered in accordance with the physician's order. A review of Resident 37's physician's order dated June 20, 2026, revealed an order Resident to use [their] own AVAP (Average Volume-Assured Pressure Support a noninvasive ventilator with automatic mode that adjusts pressure to deliver a consistent targeted volume of air, q HS (every bedtime) setting in accordance with pre-set up. An observation conducted on June 2, 2026, at 1:00 p.m., June 3, 2026, at 9:00 a.m., and June 4, 2026, at 10:00 a.m., revealed a bedside machine that was labeled CPAP (Continuous Positive Airway Pressure- This delivers a steady stream of pressurized air through a tube and mask to keep your throat open as you sleep) The machine was set up at 6.0 cm H2o. An interview was conducted with Resident 37 on June 4, 2026, at 2:00 p.m. Resident 37, who was alert and oriented, confirmed that they have been using the CPAP machine since the machine that they brought from home broke a few weeks ago. The residents reported that the facility provided the current machine that they have been using. A review of the nursing progress notes dated April 16, 2026, at 10:23 p.m., revealed Called to [respiratory company name] therapist to set up a new BIPAP (A non-invasive ventilation device that delivers two distinct levels of air pressure to assist breathing) machine because the resident's own has malfunctioned. Awaiting call back. An interview with the Director of Nursing (DON) was conducted on June 5, 2026, at 10:00 a.m. The DON confirmed that the residents' order for an AVAP was not followed. The facility failed to ensure Resident 37's order for an AVAP at bedtime was followed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service 28 Pa Code 211.5(f) Clinical Records

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to monitor the resident's behaviors, medication side effects, and document indications for a resident receiving a psychotropic medication for one of the five residents reviewed (Resident 13). Findings: A review of the facility's policy titled Psychotropic Medication Use, undated, revealed that psychotropic medication management is an interdisciplinary process that involves determining adequate indication for use, and adequate monitoring for efficacy and adverse consequences. The same policy revealed that residents receiving psychotropic medications are monitored, and the response to treatment is documented. In addition, residents are monitored for adverse consequences associated with psychotropic medications, including anticholinergic effects, cardiovascular effects, metabolic effects, neurologic effects, and psychosocial effects. A review of Resident 13's diagnosis list includes bipolar disorder (A Disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and anxiety disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A review of Resident 13's physician's order dated November 5, 2025, revealed an order for Olanzapine (An anti-psychotic medication) oral tablet 20 mg one tablet at bedtime for Bipolar. A review of Resident 13's physician's order revealed an order for Lorazepam 1 mg, one tablet every 12 hours as needed for anxiety. The order was renewed every 14 days. A review of Resident 13's May 2026 Medication Administration records revealed that from May 1 until May 31, 2026, the resident was administered as-needed Lorazepam 41 times without an appropriate indication. In addition, residents' behaviors and psychotropic side effects monitoring were not documented. An interview conducted with the Director of Nursing (DON) on June 5, 2026, at 9:28 a.m., confirmed that Resident 13 was administered as-needed Lorazepam without appropriate indications. The DON further confirmed that behavior and side effects monitoring for the use of anti-psychotic medication was not done. The facility failed to ensure Resident 13 had an appropriate indication before administering an as-needed anti-anxiety medication, and their behaviors and medication side effects were monitored. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service 28 Pa Code 211.5(f) Clinical Records 28 PA Code 211.10(a) Resident care policies

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to incorporate PASSAR level 2 recommendations into the resident's care plan for one out of eight residents reviewed (Resident 9).Findings include:Review of Resident 9's annual Minimum Data Set (MDS - a mandatory assessment of a resident's care needs and medical condition) dated December 5, 2025 revealed that Resident 9 was completely dependent on facility staff for the completion of activities of daily living and required substantial assistance for mobility. Resident 9 had diagnoses that included anxiety disorder, bipolar disorder (a severe mood disorder) and schizophrenia (severe mental disorder affecting how a person thinks, feels, and behaves). Resident 9 received antipsychotic (for the treatment of bipolar disorder and schizophrenia) medication, anti-platelet (for the prevention of blood clots) medication, hypoglycemic (for the treatment of increased blood sugar) medication and anti-seizure medication. The facility failed to indicate on the MDS that the resident qualified for a Level II Preadmission Screening and Resident Review (PASARR - a mandatory screen of all residents entering long term care for severe mental illness or disability that determines if a resident qualifies for a higher level of care while in the facility due to that severe mental illness or disability) determination.Review of Resident 9's PASARR dated June 25, 2019, revealed that Resident 9 requires a further Level II (indicating that a resident may require certain care and services provided by the nursing home, and/or specialized services provided by the State) evaluation Review of Resident 9's facility care plan revealed that Resident 9 meets the criteria PASARR II level of determination secondary of serious mental illness. Review of Resident 9's care plan interventions revealed Consult MCO (managed care organization - a contracted service provider).Review of Resident 9's facility care plan specified the name of the MCO and the name of a contact but did not specify the specialized services the resident was to receive or the frequency with which they were to be provided.Review of the Person-Centered Service Plan provided by the MCO dated June 17, 202, revealed that Resident 9 was to receive specialized services thorough the MCO weekly for 90 days between January 13, 2025, and June 16, 2026, a total number of two times. Interview with Employee E4 on June 4, 2026 at approximately 11:00 a.m. with the Director of Nursing in attendance revealed that the resident was to receive specialized services but could not indicate what those specialized services entailed. Further interview revealed that the facility failed to maintain any documentation of these services in the resident's record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, the facility failed to ensure that the attending physician documented their rationale for not addressing a medication irregularity documented by the pharmacist during their monthly review of medications for three of 16 residents reviewed (Residents 3, 9, and 18). Findings include: Review of Resident 3's monthly Pharmacist Medication Regime Reviews (MRR) revealed a regime review dated June 1. 2026, noting a recommendation for the resident's Voltaren gel (a topical anti-inflammatory drug used for relief of joint pain) order, indicating on for 12 hours and off 12 hours. A recommendation was made to please remove these instructions since the gel can be applied up to four times daily. The physician signed and disagreed with the recommendation on June 1. 2026, but did not provide a rational as to why he/she disagreed with the recommendation. Review of Resident 3's physician orders revealed the changes were not made. Review of Resident 9's physician order summary revealed an order dated March 28, 2025, for Protonix Tablet Delayed Release 40MG (milligrams). Give 1 tablet by mouth in the morning for GERD (gastro-esophageal reflux disease where stomach acid flows back up the tube connecting the mouth to the stomach). Review of Resident 9's Medication Reconciliation Review dated June 1, 2026 revealed the following: Currently receiving Protonix (pantoprazole) since 3/2023. Long term use of PPIs has been associated with increased risk of pneumonia, c. Difficult, hypomagnesemia fractures, and both B12 and iron deficiencies. Please consider a reduction to 20mg daily. The physician checked disagree on the Medication Reconciliation Review form and provided no rationale for the disagreement. Review of Resident 18's monthly Pharmacist Medication Regime Reviews revealed a regime review dated January 4, 2026, indicating the resident has been receiving Loratadine routinely since December 2024. A recommendation was made to please evaluate current need and consider PRN (as needed) use if appropriate. The physician signed and disagreed with the recommendation on January 6. 2026, but did not provide a rationale as to why he/she disagreed with the recommendation. Review of Resident 18's physician orders revealed the changes were not made. Review of Resident 18's monthly Pharmacist Medication Regime Reviews revealed a recommendation dated June 1, 2026, indicating the resident has been receiving Loratadine routinely since December 2024. Please evaluate current need and consider PRN use if appropriate. The physician signed and disagreed with the recommendation on June 1. 2026, but did not provide a rationale as to why he/she disagreed with the recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 18's physician orders revealed the changes were not made. 28 Pa. Code 211.10(c) Resident care policies Pa Code 211.12 (c) Nursing Services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interview, observation, and record review, the facility failed to deliver rehab services for one out of eight residents reviewed (Resident 34).Findings include:Review of facility policy Therapy Services Policy (undated) revealed Services will be designed to assist residents in attaining and maintaining their highest practicable level of physical.well-being.Review of Resident 34's annual Minimum Data Set (MDS - a mandatory assessment of a resident's care needs and medical condition) dated March 20, 2026, revealed that Resident 34 was cognitively intact, dependent on facility staff for the completion of activities of daily living and mobility. Resident 34's diagnoses included traumatic brain injury (TBI - a disruption of normal brain function caused by an external force ranging from mild concussions to severe, life-threatening injuries), multiple sclerosis (a disease that causes breakdown of the protective covering of the nerves), muscle wasting and atrophy (thinning of muscle mass due to diseasesor lack of use), and muscle weakness (generalized). Resident 34 was not receiving therapy services at the time of the annual assessment.Interview with Resident 34 on June 2, 2026, at approximately 9:30 a.m. revealed that they had been evaluated for therapy a couple of weeks ago and they came to my room a couple of times, but they stopped, and I don't know why. Review of Physical Therapy Evaluation & Plan of Treatment dated May 13, 2026, revealed that Resident 34 was certified for physical therapy for 12 times within the 30-day period between May 13, 2026, and Jun 11, 2026. The evaluation revealed Pt (patient) is a 35 y.o. (year old) female, history of TBI s/p (status post - after) MVA (motor vehicle accident). Pt was referred to PT (physical therapy) per pt's request. The evaluation revealed: patient demonstrates good rehab potential. Review of Physical Therapy Treatment Encounter Notes revealed that Resident 34 received therapy services on May 13, 2026, May 14, 2026, May 21, 2026, and May 23, 2026. Review of the Summary of Daily Skilled Services dated May 23, 2026, revealed actively participates with skilled interventions and Complexities/Barriers Impacting Session: None Present. Interview with E6 on June 5, 2026, at approximately 12:30 p.m. revealed that the resident was receiving therapy, but had been discharged on June 3, 2026. No discharge summary had been entered into Resident 34's chart. Interview with the E7 on June 5, 2026, at approximately 1:30 p.m., with the Director of Nursing and Nursing Home Administrator present, confirmed that Resident 34 had been discharged from therapy on June 3, 2026, but could not provide the discharge summary. E7 confirmed that Resident 34 could continue therapy services by asking for them. The facility failed to provide evidence documenting why Resident 34 was discharged from therapy after only 4 sessions or why Resident 34 went 11 days without therapy services without notification of discharge. E7 confirmed that Resident 34 could resume therapy services by asking for them. 28 Pa. Code: 211.12 (d)(1)(3) Nursing services28 Pa. Code: 211.12(d)(1)(5) Nursing services