STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395651	A. BLDG: 00 B. WING:	01/02/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BIRCHWOOD REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **026402**	**395 EAST MIDDLE ROAD NANTICOKE, PA 18634**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Revisit and Abbreviated Complaint Survey completed on January 2, 2025, it was determined that Birchwood Healthcare and Rehabilitation Center corrected the federal deficiency cited during the survey of December 10, 2024, but remained out of compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0677 SS=D		F 0677		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0677 SS=D	Continued from page 1 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Step 1: Resident CR1 was discharged from the facility on 12/16/2024. Step 2: Current residents have been reviewed to ensure bathing preference is accurate and is documented as being provided per schedule. Step 3: The DON/Designee will educate certified nursing assistants to the facility process for providing and documenting resident bathing as scheduled. Step 4: The IDT will complete random audits weekly x 4 weeks then monthly x 2 months to ensure bathing is being completed per the resident preference and schedule. Trends will be reviewed by the QAPI committee for follow-up as needed.	Completion Date: **01/21/2025** Status: **APPROVED** Date: **01/10/2025**

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F 0677 SS=D	Continued from page 2 Based on clinical record reviews and staff interviews, it was determined the facility failed to ensure that a dependent resident was provided with the necessary services to maintain personal hygiene by failing to provide showers as scheduled for one of six residents sampled (Resident CR1). Findings include: A review of the clinical record revealed that Resident CR1 was admitted to the facility on November 25, 2024, and had diagnoses, which included dementia (the loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and a fracture of the right foot. The resident was discharged from the facility to home on December 16, 2024. A review of the resident's shower record revealed the resident was to be showered on Tuesdays and Fridays on the 3:00 PM to 11:00 PM shift.	F 0677		

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F 0677 SS=D	Continued from page 3 A review of the resident's shower schedule for the dates of November 26, 2024, through December 16, 2024, revealed the resident received a bed bath on November 26, November 29, December 3, December 6, December 10, and December 13, 2024. There was no documented evidence in the resident's clinical record or care plan of any resident refusals or reasons for providing a bed bath and not showering this resident as scheduled and as requested. Interview with the Nursing Home Administrator on January 2, 2025, at approximately 12:00 PM confirmed the facility failed to provide adequate services for personal hygiene to meet the residents' needs and preferences. 28 Pa Code 211.12 (d)(5) Nursing services.	F 0677		

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F 0692 SS=D		F 0692		

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F 0692 SS=D	Continued from page 5 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Step 1: Resident CR1 was discharged from the facility on 12/16/25. Step 2: Current residents newly admitted/readmitted to the facility, since 12/01/2024 have been reviewed to ensure weekly weights have been obtained as ordered. Any resident evaluated as having a weight change has been reviewed by the Registered dietician for applicable follow-up and notification to the physician and resident representative. Step 3: The Registered dietician and Clinical Administrative team have been re-educated by the RDCO-Clinical nurse to the facility process for monitoring of resident weights and applicable follow-up for those residents identified as having a weight change. Step 4: The Registered Dietician/Designee will complete random audits weekly x 4 weeks then monthly x 2 months to ensure residents weights are being obtained	Completion Date: **01/21/2025** Status: **APPROVED** Date: **01/10/2025**

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F 0692 SS=D	Continued from page 6	F 0692	as ordered and that applicable follow-up for weight changes is being completed. Audits will be reviewed by the QA Committee for further follow-up as needed.	

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F 0692 SS=D	Continued from page 7 Based on review of select facility policy and clinical records, and staff interview it was determined the facility failed to timely monitor the nutritional parameters of a resident with an identified significant weight loss for one of six residents sampled (Resident CR1). Findings include: Review of the facility Weight Assessment and Intervention Policy last reviewed March 4, 2024, indicated that residents are monitored for undesirable or unintended weight loss or weight gain. Residents are weighed upon admission and at intervals established by the interdisciplinary team. Weights are recorded in each unit's weight record chart and in the individual's medical record. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual	F 0692		

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F 0692 SS=D	Continued from page 8 weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month- 5% weight loss is significant; greater than 5% is severe; 3 months- 7.5% weight loss is significant, greater than 7.5% is severe; 6 months- 10% weight loss is significant, greater than 10% is severe. If the weight change is desirable, this is documented. A review of Resident CR1's clinical record revealed admission to the facility on November 25, 2024, with diagnoses to include dementia (the loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and fracture of the right foot. A review of the resident's weights noted the following: November 25, 2024- 165 pounds November 26, 2024- 165 pounds December 2, 2024- 152.2 pounds December 3, 3024- 152.2 pounds indicating a 12.8 pound weight loss or 7.8 % loss of body weight	F 0692		

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F 0692 SS=D	Continued from page 9 within eight days. Review of a dietary note dated December 12, 2024 (nine days after the weight loss occurred), noted the resident was at the facility for short-term rehabilitation. The note indicate the resident had a significant weight loss for one month which was unplanned and unfavorable. However, the note questioned the validity of the resident's initial weight. The note further indicated weight loss may be related to adjustment to facility and recent hospitalization. Physician, interdisciplinary team, and resident representative aware of weight change. The note recommended to continue weekly weights to monitor trend and add fortified foods to optimize PO (by mouth) intakes. Further review of the clinical record revealed no documented evidence that a weekly weight was obtained following the weight obtained on December 3, 2024. The resident was discharged from the facility to home on December 16, 2024.	F 0692		

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F 0692 SS=D	Continued from page 10 Interview with the Registered Dietitian on January 2, 2025, at approximately 11:30 AM confirmed the resident's weight loss was not timely addressed, a weekly weight was not obtained following the weight loss on December 3, 2024, and failed to provide documented evidence the resident's physician and resident representative were timely notified of the significant weight loss. 28 Pa Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services	F 0692		

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1. Facility cannot retroactively correct nurse aide staffing ratio. 2. Director of Nursing/Designee will conduct an initial audit of the next two weeks' schedule determine if nurse aide ratio is in compliance. 3. Director of Nursing or Designee will re-educate the scheduler on the proper nurse aide staffing ratios. The facility will hold labor meetings Monday-Friday to verify ratios are made. 4. Director of Nursing/Designee will conduct random audits of nurse aide staffing weekly for four weeks, then monthly for two months thereafter to verify proper nurse aide ratios. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary. 5. Date of compliance is January 21, 2025	Completion Date: **01/21/2025** Status: **APPROVED** Date: **01/10/2025**

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P 5520	Continued from page 1 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for 14 shifts out of 57 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum nurse aide staff of 1:10 on the day shift, 1:11 on the evening shift, and 1:15 on the night shift based on the facility's census. December 14, 2024 - 8.80 nurse aides on the day shift, versus the required 10.5 for a census of 105. December 14, 2024 -6.00 nurse aides on the night shift, versus the required 7.00 for a census of 105. December 15, 2024 -10.00 nurse aides on the day shift, versus the required 10.5 for a census of 105. December 18, 2024 -6.60 nurse aides on the night shift, versus the required 7.27 for a census of 109. December 19, 2024 -6.97 nurse aides on the night	P 5520		

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P 5520	Continued from page 2 shift, versus the required 7.40 for a census of 111. December 20, 2024 -9.70 nurse aides on the evening shift, versus the required 10.09 for a census of 111. December 20, 2024 -7.07 nurse aides on the night shift, versus the required 7.40 for a census of 111. December 23, 2024 -5.13 nurse aides on the night shift, versus the required 7.27 for a census of 109. December 24, 2024 -8.17 nurse aides on the day shift, versus the required 10.7 for a census of 107. December 24, 2024 -7.10 nurse aides on the evening shift, versus the required 9.73 for a census of 107. December 24, 2024 -5.57 nurse aides on the night shift, versus the required 7.13 for a census of 107. December 28, 2024 -7.93 nurse aides on the evening shift, versus the required 9.55 for a census of 105. December 28, 2024 -5.47 nurse aides on the night shift, versus the required 7.00 for a census of 105. December 31, 2024 -8.63 nurse aides on the evening shift, versus the required 9.64 for a census of 106.	P 5520		

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P 5520	Continued from page 3 On the above dates mentioned, no additional excess higher-level staff were available to compensate this deficiency. An interview with the Nursing Home Administrator on January 2, 2025, at approximately 12:00 PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 4 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	1. Facility cannot retroactively correct LPN staffing ratio. 2. Director of Nursing/Designee will conduct an initial audit of the next two weeks schedule to determine if LPN ratio is in compliance. 3. Director of Nursing/Designee will re-educate the scheduler on the proper LPN staffing ratios. The facility will hold labor meetings Monday-Friday to verify ratios are made. 4. Director of Nursing/Designee will conduct random audits of LPN staffing weekly for four weeks, then monthly for two months thereafter to verify proper LPN ratios. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary. 5. Date of compliance will be January 21, 2025	Completion Date: **01/21/2025** Status: **APPROVED** Date: **01/10/2025**

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P 5530	Continued from page 5 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse staff to resident ratio was provided on each shift for nine shifts out of 57 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:25 on the day shift; 1:30 on the evening shift; and 1:40 on the night shift. December 14, 2024 - 4.03 LPNs on the day shift, versus the required 4.20 for a census of 105. December 15, 2024 - 3.94 LPNs on the day shift, versus the required 4.20 for a census of 105. December 20, 2024 - 1.97 LPNs on the night shift, versus the required 2.78 for a census of 111. December 21, 2024 - 3.94 LPNs on the day shift, versus the required 4.44 for a census of 111. December 24, 2024 - 3.06 LPNs on the evening	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395651	A. BLDG: 00 B. WING:	01/02/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5530	Continued from page 6 shift, versus the required 3.57 for a census of 107. December 25, 2024 - 3.91 LPNs on the day shift, versus the required 4.28 for a census of 107. December 25, 2024 - 2.44 LPNs on the night shift, versus the required 2.68 for a census of 107. December 27, 2024 - 1.91 LPNs on the night shift, versus the required 2.70 for a census of 108. December 28, 2024 - 1.91 LPNs on the night shift, versus the required 2.63 for a census of 105. On the above dates mentioned, no additional excess higher-level staff were available to compensate this deficiency. An interview with the Nursing Home Administrator on January 2, 2024, at approximately 12:00 PM, confirmed the facility had not met the required LPN to resident ratios on the above dates.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 7 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1. Facility cannot retroactively correct the overall PPD. 2. Director of Nursing/Designee will conduct an initial audit of the next two weeks schedule to determine if the overall PPD is in compliance. 3. Director of Nursing/Designee will re-educate the scheduler on the proper staffing PPD. The facility will hold labor meetings Monday-Friday to verify PPD is are met. 4. Director of Nursing/Designee will conduct random audits of overall PPD then monthly for two months thereafter to verify proper PPD. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary. 5. Date of compliance will be January 21, 2025	Completion Date: **01/21/2025** Status: **APPROVED** Date: **01/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395651	A. BLDG: 00 B. WING:	01/02/2025

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P 5640	Continued from page 8 Based on a review of nurse staffing, state regulation, and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily. Findings include: A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.20 hours of general nursing care to each resident: December 14, 2024 - 2.86 direct care nursing hours per resident. December 15, 2024 - 3.04 direct care nursing hours per resident. December 19, 2024 - 3.19 direct care nursing hours per resident. December 20, 2024 - 3.09 direct care nursing hours per resident. December 23, 2024 - 3.11 direct care nursing hours per resident. December 24, 2024 - 2.88 direct care nursing	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395651	A. BLDG: 00 B. WING:	01/02/2025

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P 5640	Continued from page 9 hours per resident. December 25, 2024 - 3.12 direct care nursing hours per resident. December 27, 2024 - 3.16 direct care nursing hours per resident. December 28, 2024 - 2.82 direct care nursing hours per resident. December 31, 2024 - 3.09 direct care nursing hours per resident. The facility's general nursing hours were below minimum required levels on the dates noted above. An interview with the Nursing Home Administrator on January 2, 2025, at approximately 12:00 PM, confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily.	P 5640		

Certified End Page

BIRCHWOOD REHABILITATION & HEALTHCARE CENTER

STATE LICENSE NUMBER: 026402

SURVEY EXIT DATE: 01/02/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY