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:	01/30/2025

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 completed on January 30, 2025, it was determined that Birchwood Rehabilitation & Healthcare Center corrected the federal deficiencies cited during the survey of January 2, 2022, under the requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care however remained out of compliance with the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.	F 0000		

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.

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:	01/30/2025

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
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. Incentives put in place for staff to pick up shifts, not call out and assist with recruiting efforts. 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.	Completion Date: **02/06/2025** Status: **APPROVED** Date: **02/10/2025**

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

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:	01/30/2025

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
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 9 shifts out of 21 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. January 23, 2025 - 9.1 nurse aides on the evening shift, versus the required 10.27 for a census of 113. January 24, 2025 -10.73 nurse aides on	P 5520		

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:	01/30/2025

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
P 5520	Continued from page 2 the day shift, versus the required 11.40 for a census of 114. January 24, 2025 -9.77 nurse aides on the evening shift, versus the required 10.36 for a census of 114. January 25, 2025 -10.90 nurse aides on the day shift, versus the required 11.5 for a census of 115. January 26, 2025 -10.20 nurse aides on the day shift, versus the required 11.40 for a census of 114. January 26, 2025 -8.73 nurse aides on the evening shift, versus the required 10.36 for a census of 114. January 26, 2025 -6.07 nurse aides on the night shift, versus the required 7.6 for a census of 114. January 27, 2025 -7 nurse aides on the day shift, versus the required 7.53 for a census of 113. January 29, 2025 -9.80 nurse aides on the	P 5520		

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:	01/30/2025

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
P 5520	Continued from page 3 evening shift, versus the required 10.55 for a census of 116. 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 30, 2025, at approximately 11:00 AM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		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:	01/30/2025

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
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. Incentives put in place for staff to pick up shifts, not call out and assist with recruiting efforts. 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.	Completion Date: **02/06/2025** Status: **APPROVED** Date: **02/10/2025**

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:	01/30/2025

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
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 three shifts out of 21 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. January 25, 2025 - 2.72 LPNs on the night shift, versus the required 2.88 for a census of 115. January 26, 2025 - 3.59 LPNs on the day	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:	01/30/2025

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
P 5530	Continued from page 6 shift, versus the required 4.56 for a census of 114. January 27, 2025 - 4.19 LPNs on the day shift, versus the required 4.52 for a census of 113. 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 30, 2024, at approximately 11:00 AM, 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:
	395651	A. BLDG: 00 B. WING:	01/30/2025

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
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. Incentives put in place for staff to pick up shifts, not call out and assist with recruiting efforts. 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.	Completion Date: **02/06/2025** Status: **APPROVED** Date: **02/10/2025**

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:	01/30/2025

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
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: January 25, 2025 - 3.02 direct care nursing hours per resident. January 26, 2025 - 2.60 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 30, 2025, at approximately 11:00 AM,	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: _____	01/30/2025

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
P 5640	Continued from page 9 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: 01/30/2025

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