STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395015	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Rehabilitation and Wellness Center	246 Friendship Circle Beaver, PA 15009

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for two of six residents (Residents R149 and R169) and the facility failed to provide the right to a dignified dining experience for two of two lunches observed. Findings include: Review of facility policy Resident Rights dated 10/1/24, indicated the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Review of the clinical record indicated Resident R149 was admitted to the facility on [DATE]. Review of Resident R149's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/2/25, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). During an observation on 2/11/25, at 10:45 a.m. Resident R149 was sitting in his wheelchair, self-propelling in the hallway with other residents wearing a sweatshirt, socks, and a brief (adult protective underwear). Resident R149 failed to have clothing on to cover up his lower body. During an interview on 2/11/25, at 10:49 a.m. Licensed Practical Nurse (LPN) Employee E18 stated, He does this all the time, I'll try to cover him up. During an interview on 2/11/25, at 10:51 a.m. LPN Employee E18 confirmed that Resident R149 should have been dressed appropriately and failed to maintain Resident R149's dignity by allowing him to self- propel around nursing unit in his brief. Review of the clinical record indicated Resident R169 was admitted to the facility on [DATE]. Review of Resident R169's MDS dated [DATE], indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and hip fracture. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided pressure ulcer list indicated Resident R169 developed a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to her right buttock on 1/9/25. During an observation of wound care on 2/13/25, from 11:04 a.m. through 11:42 a.m. Wound Care Registered Nurse Employee E3 wrote on the dressing after it was placed on Resident R169's right buttock. During an interview on 2/13/25, at 11:44 a.m. Wound Care Registered Nurse Employee E3 confirmed the facility failed to maintain Resident R169's dignity when writing on the dressings after placement on the resident. During a lunch time observation on 2 Main Dining Room on 2/10/25 all residents were observed with plastic utensils. 3 Main Dining Room on 2/10/25 all residents were observed to have plastic utensils. During a lunch time observation on 2 Main Dining Room on 2/11/25 all residents were observed with plastic utensils. 3 Main Dining Room on 2/11/25 all residents were observed to have plastic utensils. During the tray line observation on 2/12/25 at 11:30 a.m. all resident trays were observed with plastic utensils. During an interview on 2/12/25, at 11:45 a.m. Dietary Manager Employee E23 confirmed the facility failed to provide metal silverware to residents, therefore failing to provide a dignified dining experience. 28 Pa. Code: 201.29(j) Resident rights.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to fully investigate an incident to eliminate possible abuse or neglect for one of three residents (Resident R456). Findings include: Review of the facility policy Incident and Accident Reports reviewed 10/1/24, indicated the facility will document all unusual occurrences and events. It was indicated an elopement requires an incident report to be completed. Review of the facility Abuse: Protection From Abuse reviewed 10/1/24, indicated an Accident or Incident Report Form must be completed for all reported accidents or incidents. An employee witnessing an accident or incident involving a resident, employee must report such occurrence to his or her immediate supervisor, as soon as practical. An investigation is implemented and witness statements are obtained. Review of Resident R456's admission record indicated he was admitted on [DATE]. It was indicated the resident was admitted to the locked unit. Review of Resident R456's Minimum Data Set assessment (MDS -a periodic assessment of resident care needs) dated 2/1/25, included diagnoses of malignant neoplasm of brain (growth of cancerous cells in the brain), metabolic encephalopathy (change in how your brain works due to an underlying condition), and mood disorder due to physiological condition. Review of Section C0500-BIMS screening indicated a score of 10, which indicated Resident R456 was moderately impaired. Review of a progress note dated 2/3/25, at 8:35 p.m. entered by the Director of Nursing (DON) indicated the police were on site, a preliminary search of immediate area was done, and the resident was not located. Review of the facility's investigation for Resident R456's elopement on 2/10/25, at 12:30 p.m., failed to include any witness statements. During an interview on 2/10/25, at 12:54 p.m., the DON confirmed the facility failed fully investigate Resident R456's elopement to rule out neglect. The DON confirmed the facility failed to obtain witness statements. 28 Pa. Code: 201.149(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785 Based on review of facility policy, resident records, admissions documentation and staff interview it was determined that the facility failed to provide a comprehensive review of resident admission rights and maintain admission documentation for one out of out three sampled records (Resident R247). Findings include: The facility Resident rights policy dated last reviewed 10/1/24, indicated the facility will protect and promote the rights of each resident, and informing the resident about what rights and responsibilities he or she has. Review of Resident R247's admission record indicated she was admitted on [DATE]. Review of Resident R247's diagnoses that included dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), and hypertension (a condition impacting blood circulation through the heart related to poor pressure). Review of Resident R247's transfer and discharge notice dated 8/20/24, indicated that Resident R247 was being discharged due to non-payment. Review of Resident R247's clinical records, social service notes, and communications with family did not include an admissions packet or discussion upon admission that included patient portion liability, the daily rate cost structure, resident rights, representative/resident appeal rights, potential obligations to pay from resident resources, Medicare process, Medicaid process, and the consequences for failure to pay. During an interview on 2/11/25, at 11:40 a.m. Director of social services Employee E9 stated: there is no official POA (Power of Attorney) documents for Resident R247. During an interview on 2/12/25, at 10:05 a.m. Business Office manager Employee E31 stated the following: Resident R247 does not have an admission record. During an interview on 2/12/25, at 10:19 a.m. the Admission Director Employee E21 confirmed that the facility failed to provide a comprehensive review of resident admission rights and maintain admission documentation for Resident R247 as required. 28 Pa Code: 201.18 (b)(2) Management. 28 Pa Code: 201.24 (a) Admission policy. 28 Pa Code: 201.19 (i) Resident rights.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy and documents, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision which resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of two residents (Resident R456). This failure created an immediate jeopardy situation for one of two residents (Resident R456). Findings include: Review of the facility Resident Elopement policy last reviewed 10/1/24, indicated cognitively impaired residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the physical structure of the facility without the knowledge of facility staff. Upon admission, residents will be assessed for elopement risk. Cognitively impaired residents with the physical ability to leave the facility without assistance, and who have demonstrated or vocalized a desire to leave the facility will be placed on a unit with an electronic monitoring system or similarly secured unit. In the event that a facility does not have an operational electronic monitoring system, the resident will be evaluated for transfer to a more appropriate facility that offers electronic monitoring. The resident and legally responsible person shall be notified of the facility recommendation. Interim safety monitoring measures shall be implemented pending transfer. Elopement risk will be care planned with individualized approaches to reduce the potential for elopement and/or to redirect the resident in the event that an elopement attempt is made. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R456's admission record indicated he was admitted on [DATE]. It was indicated the resident was admitted to the locked unit. Review of Resident R456's Minimum Data Set assessment (MDS -a periodic assessment of resident care needs) dated 2/1/25, included diagnoses of malignant neoplasm of brain (growth of cancerous cells in the brain), metabolic encephalopathy (change in how your brain works due to an underlying condition), and mood disorder due to physiological condition. Review of Section C0500-BIMS screening indicated a score of 10, which indicated Resident R456 was moderately impaired. Review of Resident R456's admission Elopement Risk assessment dated [DATE], revealed the assessment was left blank and not completed, however it indicated the resident was not at risk for elopement. The facility failed to complete and accurately identify Resident R456 as an elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a progress note dated 1/27/25, at 10:25 a.m. stated the resident was irate, requested to be discharged and refused to sign the admission packet. The facility failed to complete an elopement risk assessment for Resident R456. Review of a progress note dated 1/27/25, at 11:58 a.m. entered by Social Worker, Employee E23 indicated the resident was in jail when he had a change in condition which led to hospitalization . It was indicated he was in jail for drug related charges. The resident had brain surgery. It was indicated the resident's discharge plan was to a facility that specialized in cognitive therapy. Review of a progress note dated 1/27/25, at 10:56 p.m. indicated Resident R456 stated it's wrong what you all are doing to me, I should be home. Resident began to ask when he was going to be discharged . The facility failed to complete an elopement risk assessment for Resident R456 after he displayed exit seeking behaviors. Review of Resident R456's psychiatric evaluation dated 1/28/25, indicated the resident was memory impaired and had difficulty with short term recall. His insight, judgement, and impulse control was poor. The resident was displaying severe agitation placing him at risk for harming himself and others. It was stated patients with brain injuries are periodically unable to restrain impulses that result in verbal or physical aggression. Review of Resident R456's smoking assessment dated [DATE], indicated the resident does not have cognitive loss. The facility failed to accurately assess Resident R456 for safe smoking. It was indicated the resident was safe to smoke with direct supervision. Review of Resident R456's physician order dated 2/2/25, indicated the resident may go on a leave of absence with a responsible party or escort. Review of information submitted to the Department of Health on 2/3/25, indicated Resident R456 was unable to be located. A search of the facility was conducted and police were notified. During an interview with his roommate it was indicated Resident R456 was talking about leaving to get his check. The facility was notified Resident R456 was back in Pittsburgh at a friend's house. Resident R456 returned to the facility on [DATE], and discharged against medical advice. Review of a progress note dated 2/3/25, at 8:35 p.m. entered by the Director of Nursing (DON) indicated the police were on site, a preliminary search of immediate area was done, and the resident was not located. Review of progress note dated 2/3/25, entered by Unit Manager, Licensed Practical Nurse, Employee E13 indicated a nurse notified her at 7:30 p.m. that Resident R456 was not able to be located. It was indicated the DON and police were notified. The facility contacted the resident's family member around 9:00 p.m. and the resident's family member informed staff Resident R456 was seen in Pittsburgh. During an interview on 2/10/25, at 9:52 a.m. Unit Manager LPN, Employee E27 stated elopement risk assessments are completed upon admission, and residents are reassessed if the resident displays exit seeking behaviors. It was indicated typically wander guards are applied, and if the resident refuses, then the doctor is notified, and it is documented in the clinical record. Staff are to monitor the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/10/25, at 11:04 a.m. LPN Employee E26 stated Resident R456 was pretty defiant, difficult to redirect, anxious and wanted to leave. It was indicated Resident R456 had an order for a leave of absence to go smoke. LPN, Employee E26 stated someone was always with him when he left the unit, or he could go to the outdoor pavilion located on 2 West. Review of the facility's investigation for Resident R456's elopement on 2/10/25, at 12:30 p.m., revealed Resident R456 signed himself out on 2/3/25, sometime between 1:41 p.m. and 1:47 p.m. The section for who the resident was escorted by was left blank. No witness statements were obtained. During an interview on 2/10/25, at 12:54 p.m., the DON indicated video surveillance revealed Resident R456 getting on a bus at 2:08 p.m. on 2/3/25. It was indicated the resident's roommate said Resident R456 stated he was going to smoke after lunch, and he never returned. The DON confirmed Resident R456 was not escorted to supervised smoking on 2/3/25. The DON stated he was allowed off the unit. The DON confirmed the facility failed to complete an elopement assessment upon admission and failed to reassess Resident R456 when he displayed exit-seeking behaviors. The DON confirmed the facility failed to accurately complete Resident R456's smoking assessment. During an interview on 2/10/25, at 1:50 p.m. Nurse Aide, Employee E30 stated on 2/3/25, she worked 7 a.m. until 11 p.m. It was indicated when Resident R456 was admitted he was very confused, very agitated, and aggressive. His whole demeanor was not wanting to be here. NA, Employee E30 stated the unit Resident R456 was on, is a completely locked down unit. NA, Employee E30 stated she has been working on that unit for five years and just in her opinion she doesn't think residents should be allowed off the unit unattended to smoke. It was indicated Resident R456's family member was the first to take him off the unit to smoke and NA, Employee E30 stated staff on the unit are not responsible to take residents to smoke. NA, Employee E30 stated it was questioned what staff should do when the resident's brother isn't available to take the resident to smoke. It was indicated he was let off the unit by the supervisor and he returned to the unit the first time, however the second time he did not. During an interview on 2/10/25, at 2:02 p.m. LPN, Employee E26 stated she worked 7 a.m. until 3 p.m. on 2/3/25. It was indicated the last time she seen Resident R456 was on 2/3/25, sometime after lunch and he wanted a cigarette. LPN, Employee E26 stated she did not see him get on the elevator and didn't know he left. It was indicated Resident R456 recently received an order for an LOA (leave of absence) and he signed a smoking contract with RN, Employee E27. During an interview on 2/10/25, at 2:22 p.m. Unit Manager, LPN Employee E13 indicated she worked 3 p.m. until 11 p.m. on 2/3/25. It was indicated she only became familiar with Resident R456 after he eloped. She indicated his short-term memory was not so good and it was her understanding staff were letting him off the unit to smoke. Unit Manager, LPN E13 stated she never seen Resident R456 on 2/3/25, and was notified by staff around 7 p.m. that he was not on the unit and missing. It was indicated dinner was served around 5 p. m. and staff failed to realize Resident R456 was missing then. Unit Manager, LPN, Employee E13 stated Resident R456 was not identified as an elopement risk, so no interventions were in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/10/25, at 2:32 PM, NA Employee E33 stated she worked 7 a.m. until 7 p.m. on 2/3/25, and was not assigned Resident R456. It was indicated the few interactions she had with Resident R456, he was aggressive and combative. It was indicated he verbally expressed that he did not want to be at the facility. She indicated she heard him talking about smoking, but she did not know residents on the locked unit had privileges to go smoke. It was indicated the last time she seen him was after lunch and he was getting irate about wanting to smoke a cigarette. NA, Employee E33 stated I would never let a resident off the locked unit unattended, first of all it's a locked down unit, I don't know much about him, but he's on the locked unit for a reason. On 2/11/25, at 10:13 a.m. the NHA and DON were notified that Immediate Jeopardy was called due to the elopement of Resident R456 on 2/3/25, and facility staff were provided an Immediate Jeopardy template, and a corrective action plan was requested. On 2/11/25, at 3:07 p.m. an immediate action plan was received and accepted which included the following interventions: 1. The facility made contact with R456 and family who returned to the facility and signed out of the facility Against Medical Advice. Facility will reassess all residents for elopement risk by 2/11/25. Assessments will be confirmed completed on 2/11/25. 2. All residents assessed to be at risk of elopement will have care plan and interventions implemented to reduce the risk of successful elopement by 2/11/25. Residents being housed on east side locked units who are not identified as needing a locked unit will have a physician order permitting them to leave unit unsupervised. 3. Administrator and Director of Nursing will review facility elopement policy and revise as necessary by 2/11/25. 4. All facility staff will be re-in serviced on elopement policy and identifying exit seeking behaviors upon arrival for next scheduled shift. Any staff not scheduled to work prior to 2/12/25, will be contacted by telephone by 2/12/25, to receive education. 5. Director of nursing will audit all new admissions for 30 days to ensure elopement risk assessment is complete and newly admitted residents who are at risk for elopement have care plan interventions in place to reduce the risk of successful elopement. 6. Policy revision, staff education and ongoing audits will be shared QAPI committee. Elopement policy was reviewed and revised on 2/11/25. During a phone interview on 2/12/25, at 9:54 a.m. RN, Employee E32 stated she was assigned Resident R456 on 2/3/35. It was indicated she was told the Unit Manager allowed Resident R456 to go off the unit to smoke, and was unsure when he left that day. She indicated she was unsure what interventions were in place for him and that he's new so it depended on whatever the Unit Manager allowed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During in-person interviews completed from 2/12/25, at 12:20 p.m. until 2/12/25, at 2:16 p.m. 58/58 staff confirmed they were educated. Staff were educated on how and when to complete an elopement assessment, and what to do for residents that are displaying exit seeking behaviors. Staff were educated on the updated elopement policy. During phone interviews completed on 2/13/25, at 10:19 a.m. 9 of 9 staff members confirmed they were educated on elopement risks. All staff must confirm they were educated prior to the start of their next shift and sign the education sheet in-person. 430 of 430 staff were educated. On 2/13/25 at 10:17 a.m., all residents' assessments for elopement risk were reviewed and found to be completed, and care plans were reviewed and updated if needed for 461 of 461 residents. Review of 8/130 Residents who resided on the locked unit had a physician order permitting them to leave the unit unsupervised. Staff education was verified with dated sign-in sheets and review of all current staff and agency staff utilized in the facility having signed and/or educated over the phone as indicated. On 2/13/25, the facility completed an audit of residents who were newly admitted as of 2/11/25. Daily audits will be completed by DON or designee for next 30 days to ensure an elopement risk assessment was completed. The facility's next QAPI meeting is scheduled for 2/27/25. Verification of the facility's Corrective Action Plan revealed all elements of plan were met. The Immediate Jeopardy was lifted on 2/13/25, at 11:13 a.m. During an interview on 2/14/25, at 2:45 p.m., the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to provide adequate supervision resulting in Resident R456's elopement. This failure created an immediate jeopardy situation for Resident R456 and potentially put him at risk of harm or injury. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18 (e)(1)(3) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.