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	06/11/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, resident and staff interview it was determined that the facility failed to protect resident property with the theft and loss of two residents personal items (Resident R1 and Resident R2) and failed to replace Resident R1 and R2 property. Findings include: Review of facility policy Resident Personal Belongings/Inventory, Storage and Retrieval - upon DC or change in location notification dated 10/1/24, indicated: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident ' s medical symptoms. Residents' property includes all residents' possessions, regardless of their apparent value to others since they may hold intrinsic value to the resident. Residents are permitted to keep personal clothing and possessions for their use while in the facility, as long as it does not infringe upon the rights of other residents (See F557). Examples of resident property include jewelry, clothing, furniture, money, and electronic devices, the resident's personal information such as name and identifying information, credit cards, bank accounts, driver's licenses, and social security cards. Any personal clothing or possessions retained by the facility for the residents during his/her stay is defined and inventoried upon admission and a copy of the inventory provided to the resident.7. The facility shall make reasonable efforts to safeguard personal property and promptly investigate complaints of such loss." Resident R1 was admitted to the facility on [DATE]. Resident R1 MDS (minimum data set - a periodic assessment of resident's needs) dated 5/7/25, indicated diagnosis of bipolar disorder (causes extreme mood swings), DMII (high levels of sugar in the blood), and muscle weakness (when your muscles can't work with the expected amount of force). Resident R2 was admitted to the facility on [DATE]. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R2 MDS dated [DATE], indicated diagnosis of idiopathic progressive neuropathy (illness where sensory and motor nerves of the peripheral nervous system are affected), Polyosteoarthritis (having arthritis that affects five or more joints), and anemia(not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's issues). Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, 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 R1 BIMS score = 15. Review of Resident R2 BIMS score = 15. During a review of facility documentation submitted to the state survey agency on 5/14/25, indicated On 5/14/25, at approximately 11 am Resident R1 reported to the Director of Nursing that her belongings and those of her roommate (Resident R2) were discarded without their permission. During an interview on 6/10/25, at 2:45 p.m. Resident R1 and Resident R2 indicated the following: Residents R1 and R2 were told that they had to move to another room (all residents form this unit were moved to other units in the facility). Resident R1 and R2 items were packed and labeled with their names on bins and bags. Employee E1 Unit Manager LPN informed residents they could leave their additional items in their former room due to new room being smaller. Resident R1 and R2 were not asked to make an inventory sheet or provided an inventory sheet during the move from their old room to their new room. Resident R2 was in room and Employee E2 came to room and asked Resident R2 if they still wanted an item (per residents the item was in a box prior and had not been opened or put together). Resident R2 asked Employee E2 where they got the item from and Employee E2 stated by the docks there were empty bins with their names on them. Resident R1 And R2 went to dock area where they discovered that their bins were empty - and later discovered that their old room where they left their items was emptied. Resident R1 and R2 were asked if an inventory list was provided to them for the move - to itemize their personal belongings and both Resident R1 and R2 indicated that they did not receive an inventory list for the move nor were instructed to do so. During review of facility documentation investigation the following witness statements indicated: Employee E2: I noticed a box on the loading dock with a wagon to be put together. So I assembled this wagon and took it to room [ROOM NUMBER] On nursing unit when I entered the room I asked Resident R2 why they got rid of their stuff because there were four empty blue totes with their names on it, on the loading dock, they said what? We Did Not Get Rid Of Our Stuff. By the time I made it back to the loading dock. Both Residents were out by the docks and other employees noticed their items inside the trash compactors. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee E3: On 5/13/25, I got a text from Employee E8 Supervisor, saying to throw away some items. I got it around 12:27 p.m. Throw away to dumpster per NHA. I went down after my lunch break which was around 1 p.m. Employee E4, was already in the process of gathering up the items to take to the dumpster. We had a brief conversation about what we thought was garbage. Employee E4: I was told by supervisor that NHA said to clean out the nursing unit (west), supervisor had asked me to do it because they didn't feel comfortable doing it. Supervisor also said that NHA said if there was anything we wanted we could take it if we wanted to. So I took a blue speaker and a mini camera, I never would have taken the if I didn't have permission. Employee E5: Around 2:00 p.m. on 5/13/25, I saw Employee E4, on the dock throwing things in the dumpster. Employee E4 said that everything in Resident Room on 1 west needed thrown away and we could take what we wanted. I went to 1 west and took a dresser, it was empty. I know what Residents it belonged to but Employee E4 said NHA said we could take it. Employee E6: I was performing mid-day rounds with NHA. NHA on west 1, we visited room [ROOM NUMBER] where as we observed a room with belongings stored, NHA indicated to me to clear out room and place contents in the facility dumpster. I inquired if all parties were notified and directed by NHA to dump it all. I then texted Employee E2 indicating per NHA please dumpster all these contents. Around 12:30 p.m. During an interview on 6/11/25, at 10:12 a.m, Employee E7 Director of Social Service indicated: that they became aware of the missing items and assisted Resident R1 and R2 with the grievance forms. Employee E7 was instructed to get a list of items that Resident R1 and R2 were stolen/missing. Employee E7 also indicated that they were told to find links to items and they sent those links to employees above them. Employee E7 did/does not have the ability to purchase any items for Resident R1 and R2. Employee E7 did send a list of 30 items for Resident R1 but to the best of their knowledge they have not been purchased. Employee E7 was asked if there was any process that takes place when units are temporarily shut down/residents are moved, per Employee E7 was not aware of a process where inventory is completed of items, all departments are notified of resident transfers, if any items were left in room, etc. During an interview on 6/11/25, at 11:04 a.m, Director of maintenance/laundry/housekeeping and interim dietary Employee E8 indicated the following: Employee E8 was doing rounds throughout the facility when he was texted by the NHA, saying that they wanted to do rounds with Employee E8. NHA and Employee E8 were on rounds on nursing unit 1 west when they came to room [ROOM NUMBER]. Employee E8 indicated NHA directed him to have room [ROOM NUMBER] cleared out , Employee E8 asked if all parties were notified (nursing, residents, etc.) and was told they were and to clear the room out take items to dumpster. Employee E8 was asked if there was any process that takes place when units are temporarily shut down/residents are moved, per Employee E8 was not aware of a process where inventory is completed of items, all departments are notified of resident transfers, if any items were left in room, etc. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25, at 11:58 a.m., LPN Unit Manager Employee E1 indicated the following: Employee E1 stated that she told Resident R1 and R2 that the unit was being shut down and residents would have to relocate to different units. Per Employee E1 they informed Resident R1 and R2 that they could store their items in their old room, the items were labeled with their names and either bagged or in blue storage containers. Employee E1 was asked if there was any process that takes place when units are temporarily shut down/residents are moved, per Employee E1 was not aware of a process where inventory is completed of items, all departments are notified of resident transfers, if any items were left in room, etc. The following items were submitted to the facility from Resident R1 and R2 on their grievance forms: Resident R1 : 2 large suitcases on wheels, at least 10/15 hoodies, 2 [NAME] brand 1 tan/1 purple (size 2x), 3 black hoodies Adidas/Reebok/champion (size 2x), 1 vs pink hoodie black (2x), 1 black hoodie (with hustle on front) (2x), 2 hoodies 1 pink 1 black (2x), 1 [NAME] (2x), 1 dark blue Adidas track suit, 1 pink champion sweat suit (2x), 1 white/black [NAME] Gucci track suit, 4 pair [NAME] vagara capri (2x), several t-shirt Gucci, [NAME], Burberry, vs pink, Adidas, etc., several pairs of leggings, 3 pairs of stretch jeans (2x), 1 pink sweat suit, several night shirts, several sports bra, 2 [NAME] secrets shine bras, 30 pairs of underwear, 40 pairs of socks assorted colors, 1 pink Adidas track suit with black stripes, 2 cameras (for video surveillance), 1 pair of tan Ugg boots, 2 pairs of slippers [NAME] and [NAME], 1 Snuggie blue with stars, 1 heated vest, 1 snow suit, 1 framed [NAME] picture, 2 blue tooth speakers, 2 babydolls (new), 1 jewelry box, and 1 pair of diamond earrings. Resident R2: several sweaters (pink 4x), 2 pairs of stretch jeans, 5 to 7 leggings various colors, 1 pink winter puff jacket fur around hood (4x), 1 pink hoodie Nike (man's 4x), 1 grey and black hoodie Adidas hoodie (men's 4x), 1 pair of black uggs boots outdoor boots, 1 pair of pink furry boots with ties 10 1/2, 1 [NAME] secrets throw blanket, white queens size dark pink plush blanket, box assorted makeup (mac, Revlon, elf), Adidas hoodie grey with black Adidas on the front (men's 5x), assorted stuffed animals [NAME] build a bear, etc., large 3 wick candle pink with crystal holder bath and body works, [NAME] collector's edition(Christmas 1975), glass tray for perfumes, set of electric candles grey 5 sizes with remote, [NAME] coffee mug, 1 pink [NAME] cup tall ex large size, Yellowstone mug, 7 drawer black dresser, large black and white frame [NAME] picture framed. As of 6/11/25, no items had been replaced for Resident R1 and Resident R2. During an interview on 6/11/25, at 2:48 p.m. Nursing Home Administrator confirmed that the facility has not replaced Resident R1 and R2 items. During an interview on 6/11/25, at 2:48 p.m. Nursing Home Administrator was informed that the facility failed to protect resident property with the theft and loss of two residents personal items (Resident R1 and Resident R2) and failed to replace Resident R1 and R2 property. 28 Pa. Code 201.18 (b)(2) Management 28 Pa. Code 201.29 (c) Resident rights