Printed: 11/21/2025
Form Approved OMB
No. 0938-0391

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	08/27/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, facility documents, and staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of four residents reviewed (Resident R1). This was identified for past non-compliance for Resident R1.Finding include: Review of facility policy Abuse: Protection From Abuse dated 10/1/24, indicated the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. Involuntary seclusion/restraint is defined as separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. The facility is a restraint free facility. The facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff members from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. 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 intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/19/25, indicated diagnoses of high blood pressure, anoxic brain damage (occurs when the brain is deprived of oxygen, leading to damage or deal of brain cells), and repeated falls. Question C0500 BIMS Summary Score indicated the resident scored a 6, severe impairment. Review of facility submitted documentation dated 8/19/25, indicated the following: Resident R1 was sitting in her cardiac chair (a specialized medical device that offers multiple positioning options) at the nurses station. Therapy assistant and CNA (Certified Nurse Aide) were attempting to reposition resident in her chair, but were having difficulty moving her. CNA looking to see why she couldn't move and noted a sheet wrapped around her abdominal area and tied behind the chair. Sheet was immediately untied and removed completely. Investigation initiated immediately. Resident was assessed and did not show any signs of pain or discomfort. Head to toe assessment negative for redness, bruising, or injury. Physician, family, and police department notified. ADON (Assistant Director of Nursing) assessed other residents on the unit and no other concerns noted. Abuse prohibition education initiated, all staff are educated on abuse and neglect upon hire and yearly thereafter. Facility is conducting interviews to identify an AP (alleged perpetrator). Review of facility documentation witness statements indicated the following: Physical Therapist (PT) Employee E1 stated, Walking on to floor patient [Resident R1] was sliding down cardiac chair. I grabbed Nurse Aide (NA) Employee E2 to help me reposition. Multiple attempts patient was not moving, NA Employee E2 looked under chair, patient was tied down by bed sheet, knotted under chair. Myself and NA Employee E2 untied and repositioned patient while our therapy secretary (Therapy Assistant Employee E3) braced the wheelchair for us. Therapy Assistant Employee E3 stated, Walking floor for therapy appointments and stopped to help PT Employee E1 and NA Employee E2 by bracing back of cardiac chair belonging to Resident R1. After multiple unsuccessful attempts at repositioning, NA Employee E2 looked under chair to find patient tied down by bed sheet - knotted tightly under chair. Resident R1 was tied around her midsection (over ribcage) and was immobile. NA Employee E2 untied knot and NA Employee E2 and PT Employee E1 were able to reposition Resident R1. Resident R1 seemed unaware of her predicament but nonetheless was checked for further physical/emotional harm. NA Employee E2 stated, We went to go move Resident R1 up in the chair and it seemed as if she was stuck, so we checked around the chair. we ended up finding out that the flat sheet was tied around her belly and under the chair in a knot. During an interview on 8/27/25, at 11:05 a.m. the Director of Nursing (DON) confirmed that the facility failed to ensure Resident R1 was free from abuse. This was identified for past non-compliance for Resident R1. During this interview, the DON confirmed the facility was able to identify an AP and the employee had been terminated from the facility. The facility implemented a plan of correction that included the following:Resident R1 was assessed and no injury was identified, no signs or symptoms of pain or discomfort.Walking rounds were completed on all units 8/19/25, no additional restraints in use.Facility abuse policy was reviewed with no revisions made.DON implemented re-education in all departments on abuse prevention policy; staff to be educated prior to next shift On 8/20/25

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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The facility is a restraint free facility. The facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff members from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. 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 intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. 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Resident was assessed and did not show any signs of pain or discomfort. Head to toe assessment negative for redness, bruising, or injury. Physician, family, and police department notified. ADON (Assistant Director of Nursing) assessed other residents on the unit and no other concerns noted. Abuse prohibition education initiated, all staff are educated on abuse and neglect upon hire and yearly thereafter. Facility is conducting interviews to identify an AP (alleged perpetrator). Review of facility documentation witness statements indicated the following: Physical Therapist (PT) Employee E1 stated, Walking on to floor patient [Resident R1] was sliding down cardiac chair. I grabbed Nurse Aide (NA) Employee E2 to help me reposition. Multiple attempts patient was not moving, NA Employee E2 looked under chair, patient was tied down by bed sheet, knotted under chair. 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