

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2025
NAME OF PROVIDER OR SUPPLIER  Brighton Rehabilitation and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, facility documents, resident clinical records and staff interviews, it was determined that the facility failed to ensure a resident had the capacity to understand the terms of an admission notice agreement (important information for nursing facilities and their spouses) for two of five residents (Residents R2 and R3), and failed to ensure residents and resident representatives were given a choice regarding facilities in which to transfer a resident to for three of seven residents (Residents R6, R7, and R8). Findings include:</p> <p>Review of the facility admission notice packet indicated this information packet contains important information about your rights as a resident of a nursing facility, and information about Medical Assistance (MA), a program which can help pay for nursing facility care for people who cannot pay all of the cost of care by themselves. Federal law requires the nursing facility to give you this information. The four parts to this admission packet contain:</p> <p>Part one - Notice of rights of nursing residents (applies to everyone).</p> <p>Part two- Medical assistance payment for nursing care eligibility got nursing care eligibility requirements and procedures (everyone should read this part- Even if you don't need MA now).</p> <p>Part three- Protecting resources and income for the spouse living at home (applies if you have a spouse who is living in the community).</p> <p>Part four- Resource Assessment Form PA-1572 (to be used by a couple when one of them is in a nursing facility, other medical institution or assessed eligible for home and community-based services and the other lives in the community).</p> <p>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 aids in detecting cognitive impairment. The BIMS total score suggests the following distributions:</p> <p>13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment</p> <p>Review of the admission record indicated Resident R2 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/23/25, indicated the diagnoses of traumatic brain injury (a type of brain injury caused by a blow or penetration to the head that can impact quality of life and cognitive ability), mood disorder and arteriovenous malformation of cerebral vessels (a tangle of blood vessels in the brain that can cause bleeding, seizures or neurological symptoms) Resident R2's MDS assessment section C0500 BIMS score was a eleven, indicating moderately impaired.</p> <p>Review of Resident R2's admission notice packet indicated that the resident signed the document on 7/7/25.</p> <p>Review of Resident R2's Notice of Medicare non-coverage (NOMNC) dated 7/15/25, indicated on 7/15/25, NONMC issued with last covered day being 7/18/25. Resident R2 has moderate cognitive impairment and not sure he would understand the insurance explanation and appeal process. Called sister explained insurance benefits and appeal process offered the quality improvement organization (QIO) and it was declined.</p> <p>Review of the skilled nursing facility advance beneficiary notice of non-coverage (SNF ABN) indicated on 7/15/25 sister was called and issued NONMC and SNF-ABN with last covered day of 7/18/25. Offered QIO number and declined to remain here for long term care.</p> <p>During an interview completed on 9/18/25, at 3:00 p.m. the Business Office Director Employee E3 indicated that Resident R2 is having a hard time understanding the billing process, they have been trying to complete a Medicaid application.</p> <p>During an interview completed on 9/18/25, at 3:30 p.m. the Director of Nursing (DON) confirmed Resident R2 signed the admission assessment without the capacity to understand the terms of an admission notice agreement.</p> <p>Review of admission record indicated Resident R3 was admitted to the facility on [DATE].</p> <p>Review of MDS indicated diagnosis of genetic related intellectual disability (condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently) and schizoaffective disorder (mental health condition that is marked by a mix of symptoms such as hallucinations and mood disorder).</p> <p>Review of the facility admission paperwork dated 8/4/25, indicated Resident R3 signed admission paperwork.</p> <p>Review of the clinical record included guardianship paperwork (paperwork from the court system to determine competency - if person is able to make own decisions) showing Resident R3 had a guardian due to being unable to make own decisions.</p> <p>During an interview on 9/17/25, at approximately 4:15 p.m. the Nursing Home Administrator (NHA) and the DON were informed that the facility failed obtain signatures from the guardian of Resident R3 who was deemed not competent of making their own decisions.</p> <p>Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R6's MDS dated [DATE], indicated diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anemia (too little iron in the blood), and hyperlipidemia (high levels of fats in the blood). Question C0500 BIMS Summary Score indicated the resident scored a -, indicating Resident R6's BIMS was not assessed. Resident R6's previous MDS assessment dated [DATE], Question C0500 BIMS Summary Score indicated the resident scored a 6, severe impairment. Review of a Social Service dated 9/18/25, stated, Spoke with family and resident, agreeable to transfer to an alternate health care facility. Alternate facility will transport tomorrow. No other questions or concerns at this time. During a telephonic interview on 9/24/25, at 11:26 a.m. Resident R6's resident representative stated, They didn't give me much information about her [Resident R6] being transferred. It sounded like she had to move and that it was not an option. I was contacted by the Marketing Manager from the new facility, I've never heard from anyone from the prior facility.</p> <p>Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE].</p> <p>Review of Resident R7's MDS dated [DATE], indicated diagnoses of hyperlipidemia, hypothyroidism (when the thyroid gland does not produce enough thyroid hormone), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness).</p> <p>Review of Resident R7's medical record revealed a progress note dated 9/17/25, stated, Resident agreed voluntarily to go to an alternate health care facility. Family is aware of discharge. Alternate facility's vehicle will transfer resident to their facility.</p> <p>During a telephonic interview on 9/24/25, at 10:26 a.m. Resident R7's resident representative stated, We never had any say in where she goes. I'm not sure how they picked the facility. I never heard from the facility. Only the new facility contacted me.</p> <p>Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE].</p> <p>Review of Resident R8's MDS dated [DATE], indicated diagnoses of malnutrition (lack of sufficient nutrients in the body), schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), and low blood pressure. Resident R8's previous MDS assessment dated [DATE], Question C0500 BIMS Summary Score indicated the resident scored a 0, severe impairment.</p> <p>Review of Resident R8's medical record revealed a progress note dated 9/17/25, stated, Resident agreed voluntarily to go to an alternate health care facility. Family is aware of discharge. Alternate facility's vehicle will transfer resident to their facility.</p> <p>During a telephonic interview on 9/24/25, at 9:37 a.m. Resident R8's resident representative stated, I didn't know this was happening. The facility did not explain the process, and I was not told that she was moving. I did not pick the facility. The new facility was the one that told me she was there. She [Resident R8] is not capable of understanding.</p> <p>During an interview on 9/25/25, at 12:21 p.m. the NHA, and DON were informed that the facility failed to ensure residents and resident representatives were given a choice regarding facilities in which to transfer a resident to for three of seven residents (Residents R6, R7, and R8).</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code: 201.14(a)(c) Responsibility of licensee.28 Pa. Code: 201.18(e)(1) Management.28 Pa. Code: 201.29 (a)(c.3)(1)(2) Resident rights.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observations, review of clinical records, and staff interview it was determined that the facility failed to provide reasonable accommodation of needs for two of 25 residents reviewed (Resident R2 and R3). Findings include: During an observation of resident rooms on the first floor on 10/29/25 Resident R2 and R3 bathroom had caution tape around the commode. During an interview on 10/29/25, at 11:00 a.m., Licensed Practical Nurse (LPN) Employee E3 stated that Resident R2 and R3's restroom has been inoperable for a few months. Employee E3 stated Resident R2 and R3 have to use the restroom on the other nursing unit Grove 2. During an interview on 10/29/25 at 1:00 p.m. Maintenance Employee E4 stated Resident R2 and R3 have not been able to use their commode for a month, and he hasn't looked at it in the past week. During an interview on 10/29/25, at 1:30 p.m., the Director of Nursing confirmed that the facility failed to offer Resident's R2 and R3 a room move and to provide reasonable accommodation of needs for two of 25 residents reviewed (Resident R2 and R3). 28 Pa. Code 201.29 (a) Resident Rights.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure the resident representatives were appropriately notified of a decision to transfer residents from the facility for seven of nine residents reviewed (Residents R4, R5, R6, R7, R8, R9, and R10). Findings include:</p> <p>Review of facility policy Transfer and discharge date d 10/1/24, indicated the facility must notify the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for the transfer, and record the reasons in the clinical record.</p> <p>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:</p> <p>13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment</p> <p>Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE].</p> <p>Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/17/25, indicated diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms), anxiety, and insomnia. Question C0500 BIMS Summary Score indicated the resident scored a 13, cognitively intact. Review of a progress note dated 9/17/25, stated, Patient has agreed voluntarily to go to an alternate health care facility. Family is aware of DC (discharge). Alternate facility's vehicle will transfer patient to their facility today.</p> <p>During a telephonic interview on 9/24/25, at 10:05 a.m., Resident R4's resident representative stated, She [Resident R4] called me and told me that day she was going, and other people were going too. No one from the facility ever told me. The new facility called me. She [Resident R4] never expressed to me that she wanted to leave; she said nurses were leaving and they were transferring people out. A lot of nurses got let go.</p> <p>Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE].</p> <p>Review of Resident R5's MDS dated [DATE], indicated diagnoses of bipolar disorder (a mental condition marked by alternating periods of elation and depression), high blood pressure, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Question C0500 BIMS Summary Score indicated the resident scored a 11, moderately impaired.</p> <p>Review of a Social Service note dated 9/18/25, stated, Spoke with family and resident, agreeable to transfer to an alternate health care facility. Alternate facility will transport tomorrow. No other questions or concerns at this time. During a telephonic interview on 9/24/25, at 10:12 a.m. Resident R5's resident representative stated, I found out she [Resident R5] was transferred a few days ago. I was notified by someone I think from the new facility.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE].</p> <p>Review of Resident R6's MDS dated [DATE], indicated diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anemia (too little iron in the blood), and hyperlipidemia (high levels of fats in the blood). Question C0500 BIMS Summary Score indicated the resident scored a -, indicating Resident R6's BIMS was not assessed. Resident R6's previous MDS assessment dated [DATE], Question C0500 BIMS Summary Score indicated the resident scored a 6, severe impairment. Review of a Social Service dated 9/18/25, stated, Spoke with family and resident, agreeable to transfer to an alternate health care facility. Alternate facility will transport tomorrow. No other questions or concerns at this time. During a telephonic interview on 9/24/25, at 11:26 a.m. Resident R6's resident representative stated, They didn't give me much information about her [Resident R6] being transferred. It sounded like she had to move and that it was not an option. I was contacted by the Marketing Manager from the new facility, I've never heard from anyone from the prior facility.</p> <p>Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE].</p> <p>Review of Resident R7's MDS dated [DATE], indicated diagnoses of hyperlipidemia, hypothyroidism (when the thyroid gland does not produce enough thyroid hormone), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness).</p> <p>Review of Resident R7's medical record revealed a progress note dated 9/17/25, stated, Resident agreed voluntarily to go to an alternate health care facility. Family is aware of discharge. Alternate facility's vehicle will transfer resident to their facility.</p> <p>During a telephonic interview on 9/24/25, at 10:26 a.m. Resident R7's resident representative stated, We never had any say in where she goes. I'm not sure how they picked the facility. I never heard from the facility. Only the new facility contacted me.</p> <p>Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE].</p> <p>Review of Resident R8's MDS dated [DATE], indicated diagnoses of malnutrition (lack of sufficient nutrients in the body), schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), and low blood pressure. Resident R8's previous MDS assessment dated [DATE], Question C0500 BIMS Summary Score indicated the resident scored a 0, severe impairment.</p> <p>Review of Resident R8's medical record revealed a progress note dated 9/17/25, stated, Resident agreed voluntarily to go to an alternate health care facility. Family is aware of discharge. Alternate facility's vehicle will transfer resident to their facility.</p> <p>During a telephonic interview on 9/24/25, at 9:37 a.m. Resident R8's resident representative stated, I didn't know this was happening. The facility did not explain the process, and I was not told that she was moving. I did not pick the facility. The new facility was the one that told me she was there. She [Resident R8] is not capable of understanding.</p> <p>Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R9's MDS dated [DATE], indicated diagnoses of peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), dementia, and memory deficit. Question C0500 BIMS Summary Score indicated the resident scored a 14, cognitively impairment. Resident R9's previous MDS assessment dated [DATE], indicated the resident scored a 12, moderately impaired.</p> <p>Review of Resident R9's medical record revealed a progress note dated 9/17/25, stated, Resident agreed voluntarily to go to an alternate health care facility. Family is aware of discharge. Alternate facility's vehicle will transfer resident to their facility.</p> <p>During a telephonic interview on 9/24/25, at 9:48 a.m. Resident R9's resident representative stated, I didn't know he left until the new facility called me. He [Resident R9] never expressed any interest to me in leaving the facility.</p> <p>Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE].</p> <p>Review of Resident R10's MDS dated [DATE], indicated diagnoses of hypothyroidism, COPD, and chronic kidney disease.</p> <p>Review of Resident R10's medical record revealed a progress note dated 9/17/25, stated, Resident agreed voluntarily to go to an alternate health care facility. Family is aware of discharge. Alternate facility's vehicle will transfer resident to their facility.</p> <p>During a telephonic interview on 9/24/25, at 12:20 p.m. Resident R10's resident representative stated, I didn't have a clue that she was being transferred. How am I supposed to know where she is if they don't tell me. They dropped the ball on that big time.</p> <p>During an interview on 9/25/25, at 10:47 a.m. information was disseminated to the Director of Nursing that the facility failed to ensure the resident representatives were appropriately notified of a decision to transfer residents from the facility for seven of nine residents reviewed (Residents R4, R5, R6, R7, R8, R9, and R10).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 201.29 (a)(c.3)(1)(2) Resident rights.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider, and failed to document a reason for transfer to an alternate health care provider for seven of seven residents sampled with facility-initiated transfers (Residents R4, R5, R6, R7, R8, R9, and R10). Findings include:</p> <p>Review of facility policy Transfer and discharge date d 10/1/24, indicated the facility must notify the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for the transfer, and record the reasons in the clinical record.</p> <p>Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE].</p> <p>Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/17/25, indicated diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms), anxiety, and insomnia.</p> <p>Review of the clinical record indicated Resident R4 was transferred to an alternate health care provider on 9/17/25.</p> <p>Review of Resident R4's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of Resident R4's clinical record failed to include documentation regarding the reason for the resident's transfer to an alternate health care facility on 9/17/25.</p> <p>Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE].</p> <p>Review of Resident R5's MDS dated [DATE], indicated diagnoses of bipolar disorder (a mental condition marked by alternating periods of elation and depression), high blood pressure, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of the clinical record indicated Resident R5 was transferred to an alternate health care provider on 9/19/25.</p> <p>Review of Resident R5's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R5's clinical record failed to include documentation regarding the reason for the resident's transfer to an alternate health care facility on 9/19/25.</p> <p>Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE].</p> <p>Review of Resident R6's MDS dated [DATE], indicated diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anemia (too little iron in the blood), and hyperlipidemia (high levels of fats in the blood).</p> <p>Review of the clinical record indicated Resident R6 was transferred to an alternate health care provider on 9/19/25.</p> <p>Review of Resident R6's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of Resident R6's clinical record failed to include documentation regarding the reason for the resident's transfer to an alternate health care facility on 9/19/25. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE].</p> <p>Review of Resident R7's MDS dated [DATE], indicated diagnoses of hyperlipidemia, hypothyroidism (when the thyroid gland does not produce enough thyroid hormone), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness).</p> <p>Review of Resident R7's medical record indicated resident was transferred to an alternate facility on 9/17/25.</p> <p>Review of Resident R7's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the resident's transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of Resident R7's clinical record failed to include documentation regarding the reason for the resident's transfer to an alternate health care facility on 9/17/25.</p> <p>Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE].</p> <p>Review of Resident R8's MDS dated [DATE], indicated diagnoses of malnutrition (lack of sufficient nutrients in the body), schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), and low blood pressure.</p> <p>Review of Resident R8's medical record indicated resident was transferred to an alternate facility on 9/17/25.</p> <p>(continued on next page)</p>		

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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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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R8's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the resident's transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of Resident R8's clinical record failed to include documentation regarding the reason for the resident's transfer to an alternate health care facility on 9/17/25.</p> <p>Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE].</p> <p>Review of Resident R9's MDS dated [DATE], indicated diagnoses of peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), dementia, and memory deficit</p> <p>Review of Resident R9's medical record indicated resident was transferred to an alternate facility on 9/17/25.</p> <p>Review of Resident R9's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the resident's transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of Resident R9's clinical record failed to include documentation regarding the reason for the resident's transfer to an alternate health care facility on 9/17/25.</p> <p>Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE].</p> <p>Review of Resident R10's MDS dated [DATE], indicated diagnoses of hypothyroidism, COPD, and chronic kidney disease</p> <p>Review of Resident R10's medical record indicated resident was transferred to an alternate facility on 9/17/25.</p> <p>Review of Resident R10's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the resident's transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of Resident R10's clinical record failed to include documentation regarding the reason for the resident's transfer to an alternate health care facility on 9/17/25.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/25/25, at 11:25 a.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider, and failed to document a reason for transfer to an alternate health care provider for seven of seven residents sampled with facility-initiated transfers (Residents R4, R5, R6, R7, R8, R9, and R10).</p> <p>28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, clinical record review, and interviews with staff, it was determined that the facility failed to ensure that residents are free of significant medication errors for one of five residents reviewed (Resident R1). Findings include: Review of facility policy Medication Administration dated 10/1/25, indicated medications are administered, as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so to comply with Federal Laws governing Medication Administration and in order to ensure the safe, accurate and timely administration of medications. The employee who administers medications to residents shall record and sign on the individual medication record of each resident the medication, dosage and time it was given. This shall be done as soon as possible after the medications have been given. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/10/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety. Review of a progress note dated 9/6/25, stated, Nurse on unit reported that she inadvertently administered AM (morning) meds to resident upon residents request when the resident had already requested and received them from the nurse on the previous shift. Resident states I don't remember receiving them, but I'm fine. Resident assessed and appeared to be with mild shortness of breath and hypotensive (low blood pressure). Call placed to physician and n.o. (new order) received to send to ER (emergency room). Unable to reach daughter and voice mail left for return call. ER called for nurse-to-nurse report. Emergency Medical Services called for transport to the ER. Review of facility investigation documents indicated the following medications were administered to Resident R1 twice on 9/6/25:- Aspirin (given to reduce the bloods' ability to clot) 81 milligrams (mg)- Centrum Silver (a multivitamin)- Isosorbide Mononitrate Extended Release (a medication given to widen blood vessels, allowing for more blood and oxygen to reach the heart, reducing strain; can lower blood pressure) 60 mg, give two tablets - Lisinopril-Hydrochlorothiazide (a combination medication given to lower blood pressure) 20 mg/12.5mg, give two tablets. Review of a telephonic witness statement dated 9/8/25, Licensed Practical Nurse (LPN) Employee E2 stated, Resident R1 was up going to the bathroom and wanted her meds, so I gave them to her. I couldn't click them off [document medications as administered in the electronic medical record] so I told the nurse there that she got meds and I left. Apparently, she didn't remember she got them. Review of a telephonic witness statement dated 9/8/25, LPN Employee E2 stated, I was working on 4 Main, and the second nurse was running late. LPN Employee E1 gave me report on my people and then left the census sheet on the cart for the other nurse. Resident R1 came up to me and asked if she could have her meds before smoke time, so I got on the electronic medical record and gave her what she was due for. After I gave them to her, I then realized the nurse had wrote on the census sheet that Resident R1 was done. I immediately called the supervisors and checked on Resident R1. I called the physician and they said to send her out to the ER. She seemed fine and didn't remember getting meds already. During an interview on 10/29/25, at 1:31 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents are free of significant medication errors for one of five residents reviewed (Resident R1). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>Based on review of facility financial documents, and interviews with vendor and staff, it was determined that the facility failed to pay bills in a timely manner. Findings include: Review of the Nursing Home Administrator's job description indicated the primary purpose of the nursing home administrator is to manage the facility in accordance with current applicable federal, state, and local standards, guidelines, and regulations that govern long-term care facilities. To ensure the highest degree of quality care is provided to residents at all times. Be responsible for all financial transactions. Review of facility document Amendment to Payment and Forbearance Agreement dated 8/29/25, indicated that the facility was placed on weekly payment plans to Staffing Agency Vendor. During an interview on 9/24/25, at 11:54 a.m. Staffing Agency Vendor Representative stated prior to the above agreement, the facility owed \$3,829,128.60 for services provided. The Staffing Agency provided the facility with a suspension on 9/16/25 at 5:06 p.m. due to non-payment of services. Payment was received from the facility on 9/17/25, at 11:52 a.m. when suspension was lifted. During an interview on 9/25/25, at 9:15 a.m. Water Vendor Representative stated that the facility owes \$274,465.77. A payment was made on 9/2/25, of \$60,883.20, and an additional payment was due on 9/22/25, of \$29,272.00, which had not been paid at the time of the interview. Water Vendor Representative stated that they have filed for Court Action to receive payments for both the Water Vendor and Sewage Vendor combined to ensure that they receive payments as the facility Owes almost a half a million dollars for Water and Sewage, and we need to make sure we get paid. During an interview on 9/25/25, at 9:34 a.m. the Sewage Vendor representative confirmed that the facility owes \$217,024.70 for sewage and I have to email every month to remind them, and then I have to wait. During an interview on 9/25/25, at 12:27 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to remain current in paying Staffing Agency Vendor and both Water and Sewage Vendors, and is hoping to have an approved payment plan for Water and Sewage Vendors soon. 28 Pa Code: 201.14 (a) Responsibility of management 28 Pa Code: 201.18 (b)(1) Management.</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>Based on review of facility documentation, and staff interview it was determined that the facility failed to employ a qualified social worker for approximately 388 residents for nine days (8/30/25, 8/31/25, 9/1/25, 9/2/25, 9/3/25, 9/4/25, 9/5/25, 9/6/25, and 9/7/25). Findings include: Review of the facility documentation (timecard) indicated that a new social worker (Employee E5) started at the facility on 8/6/25. Review of facility documentation indicated that the previous social worker's (Employee E6) last day was 8/29/25. Review of the new social worker personnel file resume indicated a Bachelor of Arts - but failed to include what the Bachelor of Arts was in or a degree in the personnel file. During an interview on 9/16/25, with Human Resource Employee E4 indicated that they spoke with Social Worker Employee E5 and they indicated their Bachelor of Arts is in social sciences which is similar to social work. Surveyor requested documentation showing what Bachelor of Arts was in. Review of facility documentation Social Worker Employee E5 university transcripts indicated a Bachelor of Arts in history with a minor in anthropology. Review of facility documents indicated Social Worker Employee E6 returned to work on 9/8/25. During an interview on 9/17/25, at approximately 4:25 p.m. the Nursing Home Administrator and the Director of Nursing were informed that the facility failed to employ a qualified social worker for approximately 388 residents for nine days (8/30/25, 8/31/25, 9/1/25, 9/2/25, 9/3/25, 9/4/25, 9/5/25, 9/6/25, and 9/7/25). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.16 (a) Social services</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on a review of facility documentation, cited deficiencies from previous surveys, review of plan of correction documentation, vendor interviews, and staff interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to correct previously cited deficiencies. This has to potential to effect 358 of 358 residents. Findings include: Review of the facility policy, Quality Assurance/ Performance Improvement (QAPI) dated 10/1/24, indicated that the facility will conduct quality assurance/improvement and assessment committee meeting at least quarterly to identify areas of service that are non-complaint, or with potential for improvement. The facility will ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. The plan is reviewed regularly to ensure that policy, procedure and adherence to standards and regulations is attained and maintained. The facility will develop and implement plans for improvement to address deficiencies identified by the performance improvement program and will document remedial action. The facility's deficiencies and plan of correction for the State Survey and Certification (Department of Health) for the survey ending 8/7/25, revealed the facility developed a plan of correction that included quality assurance systems to ensure the facility-maintained compliance with cited nursing home regulations. Review of the plan of correction for the survey ending 8/7/25 revealed the following: -Outstanding invoices from vendors necessary for resident care were paid to terms or developed a payment plan. -An initial audit conducted by the NHA (Nursing Home Administrator), confirmed vendors identified by surveyor were brought to terms or a payment plan was developed. -The accounts payable office representative and management team were re-in serviced by the NHA to ensure essential service vendors who are identifying delays in payment should be communicated directly to the NHA. -The NHA will audit ongoing to ensure vendors necessary for resident care are paid to terms or have a payment plan in place to ensure services continue. Audit findings will be shared with QAPI. The results of the current survey with investigations conducted 9/24/25, and 9/25/25, identified a repeated deficiency related to non-payment of Sewage Vendors, and Water Vendors. During the survey process the following was revealed: During an interview on 9/25/25, at 9:15 a.m. Water Vendor Representative stated that the facility owes \$274,465.77. A payment was made on 9/2/25, of \$60,883.20, and an additional payment was due on 9/22/25, of \$29, 272.00, which had not been paid at the time of the interview. Water Vendor Representative stated that they have filed for Court Action to receive payments for both the Water Vendor and Sewage Vendor combined to ensure that they receive payments as the facility Owes almost a half a million dollars for Water and Sewage, and we need to make sure we get paid. During an interview on 9/25/25, at 9:34 a.m. the Sewage Vendor representative confirmed that the facility owes \$217,024.70 for sewage and I have to email every month to remind them, and then I have to wait. During an interview on 9/25/25, at 12:27 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to remain current in paying Water and Sewage Vendors, and is hoping to have an approved payment plan for Water and Sewage Vendors soon, and that and facility's QAPI program failed to correct previously cited deficiencies. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management</p>		