STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395596	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeville Rehabilitation & Care Center	3590 Washington Pike Bridgeville, PA 15017

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on a review of facility policy, resident interview, observations, and staff interview it was determined the facility failed to assess the clinical appropriateness of medication self-administration for three of 11 residents (Resident R2, R3, and R4). Findings include: Review of facility policy Medication Administration reviewed August 2024, indicated residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care center ' s Interdisciplinary Team (IDT), and in accordance with procedures for self-administration of medications and state regulations. The resident is always observed after administration to ensure the dose was completely ingested. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, congestive heart failure (CHF - progressive heart disease that affects pumping action of the heart muscles), and depression. During an interview and observation on 2/24/25, at 9:39 a.m. Resident R2 was sitting in bed with her over-the-bed table over her lap, holding a medicine cup of pills. Resident R2 stated that she felt she needed pudding to help take the medications. Review of the Medication Administration Record (MAR) indicated Resident R2 was scheduled, and administered, the following medications at 9:00 a.m. on 2/24/25: Cyanocobalamin (synthetic compound of vitamin B-12) 1000 micrograms (mcg), one tablet Diltiazem ER (treat high blood pressure, heart pains, and arrhythmia ' s; ER -extended release) 180 milligrams (mg), one tablet Doxycycline (antibiotic) 100 mg, one tablet Eliquis (anticoagulant used to treat and prevent blood clots) 2.5 mg, one tablet Florastor (probiotic to help prevent the growth of harmful bacteria in the stomach and intestines), one tablet (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Furosemide (diuretic used to treat fluid retention) 40mg, one tablet Guaifenesin (expectorant, helps clear mucus from your chest) 600 mg, two tablets Isosorbide ER (dilates blood vessels making it easier for blood to flow through them) 30 mg, one tablet Multivitamin (supplement) one tablet Pantoprazole (reduces stomach acid) 40 mg, one tablet Sotalol (treat and prevent abnormal heart arrhythmia ' s) 80 mg, one tablet Spironolactone (diuretic) 25mg, one tablet Review of Resident R2's clinical record failed to reveal a physicians order for self-administration, a self-administration assessment, or care planning for self-administration of medications. During an interview on 2/24/25, at 9:40 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed she should have observed Resident R2 taking her medications. Review of the clinical record indicated Resident R3 was readmitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and depression. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 2/14/25, indicated the diagnoses are current. During an observation on 2/24/25, at 10:00 a.m. Resident R2 was sitting in her bed with a medicine cup of pills on the over-the-bed table. Review of the MAR indicated Resident R3 was scheduled, and administered, the following medications at 9:00 a.m. on 2/24/25: Coreg (treats high blood pressure and heart failure) 12.5 mg, one tablet Duloxetine (used to treat depression) 60 mg, one capsule Furosemide 20 mg, one tablet Minoxidil (used to treat high blood pressure) 2.5 mg, one tablet Sucralfate (used to treat stomach ulcers) 1 gram, one tablet Saxagliptin (used to treat diabetes) 5 mg, one tablet Review of Resident R3's clinical record failed to reveal a physicians order for self-administration, a self-administration assessment, or care planning for self-administration of medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25, at 10:02 a.m. Registered Nurse (RN) Employee E2 confirmed she did not observe Resident R3 swallow her medications. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE], with diagnoses that included CHF, high blood pressure, and anxiety. Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of the physician order dated 2/6/25, indicated Fluticasone nasal suspension two sprays in both nostrils in the morning for allergies. The physician order was discontinued on 2/23/25. Further review of a physician order dated 1/27/25, indicate Refresh tears eye drops instill two drops in both eyes four times a day for dryness. The physician order was discontinued on 2/23/25. Review of a progress note dated 2/21/25, at 3:26 p.m. indicated Resident R4 was sent to the local emergency room for unrelieved chest pain and admitted to the hospital. She was not at the facility on 2/24/25. During an observation on 2/24/25, at 10:03 a.m. one opened bottle of Fluticasone nasal suspension, and one opened bottle Refresh artificial tears were located on Resident R4 ' s over-the-bed table. Resident R4 was not in the room at that time. Review of the care plan dated 8/18/21, indicated administer medications as ordered and assess for effectiveness and side effects. Review of Resident R4's clinical record failed to reveal a physicians order for self-administration, a self-administration assessment, or care planning for self-administration of medications. During an interview on 2/24/25, at 10:10 a.m. the Nursing Home Administrator confirmed the medications should be locked in the medication cart. During an interview on 2/24/25, at 10:15 a.m. the Director of Nursing confirmed that the facility failed to assess the clinical appropriateness of medication self-administration for Resident ' s R2, R3, and R4. 28 Pa. Code: 211.9(d) Pharmacy services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on review of facility policy, clinical record review, resident and staff interviews, it was determined that the facility failed to make certain that showers and baths were provided for one of three residents (Resident R1). Findings include: Review of facility policy Activities of Daily Living (ADLs) reviewed 10/24/24, indicated based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's ADL abilities are maintained or improved and do not diminish unless due to unavoidable circumstances of the resident's clinical condition. ADLs include bathing, dressing, grooming, toileting, transferring, eating, walking, speech, and language. Review of facility policy Resident Rights Under Federal Law reviewed August 2024, indicated residents have the fundamental right to considerate care that safeguards their personal dignity along with respecting cultural, social, and spiritual values. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. The resident has a right to choose activities, schedules, health care and providers of health care services consistent with his/her interests, assessments, and plan of care. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included diabetes, anoxic brain damage (occurs when the brain is deprived of oxygen leading to damage of brain cells), and high blood pressure. Review of the Minimum Data Set (MDS - comprehensive, standardized assessment of each resident's functional capabilities and health needs) dated 1/22/25, revealed the diagnoses remain current. Review of Section GG: Self-Care, Question E. Shower/Bathe self, indicated Resident R1 requires the assistance of two or more helpers to complete the activity. A review of the clinical record indicated Resident R1 received a shower on the following dates: September 2024 - no documented showers October 2024 - 10/2/24, and 10/4/24 November 2024 - 11/11/24, and 11/20/24 December 2024 - 12/1/24, 12/7/24, and 12/14/24 January 2025 - 1/1/25, and 1/24/25 - documented as showered independently February 2025 - 2/10/25, 2/12/25, 2/19/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25, at 1:45 p.m. Resident R1 stated he prefers showers over bed baths. Resident R1 stated he was unsure when his last shower was. During an interview on 2/24/25, at 2:00 p.m. the Director of Nursing confirmed the facility failed to consistently provide showers and/or baths for Resident R1. 28 Pa. Code: 211.12(1) Nursing services. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (2)(5) Nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that residents are free of significant medication errors for one of 11 residents (Resident R5). This was identified as past non-compliance. Findings include: Review of facility policy Medication Administration reviewed August 2024, indicated prior to administration, review and confirm medication orders for each individual resident. Medications are administered in accordance with written orders of the prescriber. Review of facility policy Medication Errors reviewed August 2024, indicated the facility shall ensure medications will be administered according to prescriber ' s orders. To prevent medication errors and ensure safe medication administration, nurses should verify the right medication, dose, route, and time of administration. Review of a clinical record indicated Resident R5 was admitted to the facility on [DATE], with diagnoses that included pain in right shoulder, high blood pressure, and constipation. Review of a physician order dated 2/6/25, indicated Kenalog-40 (treats inflammation) injection solution 40 mg/ml (milligrams/milliliter) one milliliter intra-articularly (into the joint) one time only for right shoulder pain. Review of a physician order dated 2/6/25, indicated Lidocaine injection solution 1% (local anesthesia) two milliliters intra-articularly one time only for right shoulder pain to be injected with the Kenalog by Certified Registered Nurse Practitioner (CRNP) Employee E5. Review of a Medication Administration Record (MAR) indicated Resident R5 received the Kenalog and lidocaine injections on 2/7/25, at 5:29 a.m. by Licensed Practical Nurse (LPN) Employee E6. Review of a progress note dated 2/7/25, at 8:00 a.m. indicated Resident R5 was sent to the local emergency room for evaluation once medication error was found. Review of the hospital records dated 2/7/25, at 12:57 p.m. indicate Resident R5 was returned to the facility without concerns. Resident R5 was unavailable for interview due to discharge from the facility. Review of the care plan dated 1/22/25, indicated to administer medications as ordered and assess for effectiveness and side effects and report abnormalities to physician. During an interview on 2/24/25, at 1:00 p.m. the Director of Nursing stated multiple unsuccessful attempts were made to obtain a statement from LPN Employee E6. LPN Employee E6 was unavailable for interview. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided documentation of the in-service training that was provided to the nursing staff, including Registered Nurses and Licensed Practical Nurses, at the facility on 2/10/25, which addressed safe and accurate medication practices. Education on medication practices which included verifying resident name, medication name, form, dose, route, and time. During an interview on 2/24/25, at 1:50 p.m. the Director of Nursing confirmed the nurse failed to follow physician ' s order for medication administration for Residents R5 resulting in a significant medication error. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43725 Based on review of facility policy, observations and staff interviews, it was determined that the facility failed to properly secure medication and treatment carts for two of five carts observed (600 hall medication cart, and 100/200 hall treatment cart). Findings include: Review of facility policy Storage of Medications reviewed August 2024, indicated medications and biologicals are stored properly. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. During an observation on 2/24/25, at 10:22 a.m. 600 hall medication cart was located in the 600 hall unlocked and unattended. During an interview on 2/24/25, at 10:22 a.m. Registered Nurse (RN) Employee E3 confirmed the medication cart should have been secured when unattended. During an observation on 2/24/25, at 10:30 a.m. 100/200 hall treatment cart was located by the nurses station unlocked and unattended. During an interview on 2/24/25, at 10:30 a.m. Licensed Practical Nurse, Employee E4 confirmed the treatment cart should have been secured when unattended. During an interview on 2/24/25, at 10:35 a.m. the Director of Nursing confirmed the medication and treatment carts should be secured when unattended. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.