

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2025
NAME OF PROVIDER OR SUPPLIER Bridgeville Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3590 Washington Pike Bridgeville, PA 15017	

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 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on review of facility policy, observations and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment within the facility for one of five units. Findings include: Review of the facility policy Center Operations Policies and Procedures: Accommodation of Needs last reviewed on 5/1/25, indicated the resident/patient has the right to a safe, clean, comfortable, and home like environment including, but not limited to, receiving treatment and supports for daily living safely. This includes ensuring that the patient can receive care and services safely and that the physical layout of the Center maximizes patient independence and does not pose a safety risk. During an interview with Housekeeping Employee E1 on 7/15/25, at approximately 10:17 a.m., Employee E1 provided and explained the seven step cleaning procedure. Step three outlined bathroom cleaning as daily, equipment utilized, products, areas (toilets, sinks, pipes etc), and directions. During an observation rounds with the Director of Nursing (DON) on 7/15/25, at 11:28 a.m., the following was revealed: Resident rooms 507, 601, 602, 606, and 609 bathrooms were visibly soiled with debris and/or stains on the floor. The toilets had stains of an unknown origin both internally and externally. During an interview on 7/15/25, at 11:45 a.m., the Director of Nursing confirmed that the facility failed to maintain the facility in a homelike environment on one of five nursing units. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 201.29(k) Resident rights.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide appropriate assistance to prevent falls and injury for one of three residents reviewed (Resident R1). Findings include: Review of the facility policy Center Operations Policies and Procedures: Abuse Prohibition last reviewed on 5/1/25, includes the definition of Abuse and Neglect: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Neglect is defined as the failure, indifference, or disregard of the Center, its employees, or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the American Congress of Rehabilitation Medicine - Caregiver Guide and Instructions for Safe Bed Mobility published 4/28/17, indicated the patient should always roll toward you not away from you. Bed mobility refers to activities such as scooting in bed, rolling, side-lying to sitting, and sitting down. Review of the clinical record indicated Resident R1 was initially admitted to the facility on [DATE], with diagnoses which included non-Alzheimer's dementia (memory loss), seizure disorder (sudden bursts of electrical activity in the brain) and pressure ulcers (open wounds on skin). Review of the Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 5/20/25, indicated the diagnoses remained current, Section GG 0170 Mobility identified Resident R1 as dependent (which requires one staff to do all the effort or two staff) for bed mobility. Review of Resident R1 plan of care created on 5/9/25, indicated Resident R1 requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, bed mobility, transfers, locomotion, and toileting related to limited mobility. Resident R1 is at risk for falls due to impaired mobility. Review of the facility documentation revealed the resident sustained a fall from the bed as the nurse was providing care. Review of an incident documentation of the 6/22/25 event indicated that Resident R1 was being provided wound care by RN Employee E11. RN Employee E11 turned away from Resident R1 to get supplies and Resident R1 rolled out of bed onto the floor. Review of the statement that was attached to the investigation dated 6/22/25, from RN Employee E11 stated This Registered Nurse (RN) was doing wound care on resident, Nursing Assistant (NA) was in the room at the start but left and never returned in the middle of care. Nurse continued wound care. As I turned to grab the bandages off the dresser resident rolled off the opposite side of the bed. Resident landed on the right side of bed on floor. Review of the statement that was attached to the investigation dated 6/22/25, from Nursing Assistant Employee E12 stated I was the aide for Resident R1. I just got done washing and changing her prior to the nurse going in to do her dressing for her wounds. I got her together then left out of the room because the nurse said she didn't need my help. I was in another room helping another resident when I heard the nurse screaming, she needed help in the room. I went into the room and seen Resident R1 on the floor. Review of the facility investigation documents dated 6/24/25, The Director of Nursing (DON) and Human Resources (HR) Employee E13 interviewed RN Employee E11 and documented the interview. The documented included, We agreed we would go in together so Employee E12 could finish resident care. Employee E12 went in first I came in with treatment cart a few minutes later, on first or second would Employee E12 just left without saying anything and never came back. During fall Resident R1 was positioned on left side but not completely, on her back but tilted on her side and not flat. I was on right side of bed where all supplies were. I turned my head to grab the last dry dressing on the bedside table and when I turned around she was falling and I couldn't stop her. Employee E12 never returned during event. Review of the facility communication with Employee E11 and E12 employment agency on 6/24/25. The DON indicated both Employee E11 and E12 were to be placed on the facility's do not return list with the reason; for neglect when their negligence both resulted in a resident falling from the bed. During an interview on 7/15/24, at approximately 12:09 p.m. with Licensed Practical Nurse (LPN) Employee E3, it indicated that resident care is reviewed at the start of the shift. Report is received between shifts for any changes to the residents' care. LPN Employee E3 indicated additional staff are available to assist when requested. LPN Employee E3 indicated standard practice is to roll a resident toward staff when providing care, to keep the residents safe. During an interview on 7/15/24, at approximately 2:30 p.m. with NA Employee E4, it indicated that resident care is reviewed at the start of the shift NA Employee E4 indicated additional staff are available to assist</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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