

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 11/21/2025
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)
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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<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 review of facility provided policies and documentation, clinical records, and resident and staff interviews, it was determined that the facility failed to protect residents from staff-initiated abuse. This failure resulted in a staff member physically abusing a resident and multiple staff neglecting care of one of four residents reviewed (Resident R9). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective [DATE], 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: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment The facility's policy Abuse Prohibition dated [DATE], indicated it is the facility's policy that it prohibits abuse, neglect, mistreatment, etc., for all residents. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - federally mandated assessment of a resident's abilities and care needs) dated [DATE], included diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination) and multiple sclerosis (a disease that affects central nervous system). Review of Section C: Cognitive Patterns revealed a BIMS score of 15. Review of a nurse practitioner note dated [DATE], at 2:30 p.m. indicated, pt (patient) seen per nursing request. Pt had complaint of abuse by a NA (nurse aide) today. Pt states that there was no physical abuse, it was verbal. Pt reports that NA gave her a hard time and accused her of having an attitude. Review of facility submitted information dated [DATE], indicated that on [DATE], [Resident R9] had her son call this writer to voice a concern that the CNA [Nurse Aide (NA) Employee E1], assigned to this resident for the 7-3 shift on [DATE] was verbally abusive to the resident and left his mother naked in the bed and would not get her dressed. The son also stated that the CNA called the resident a profanity. Review of an interview completed with Resident R3 on [DATE], indicated, [Resident R9] stated that she was assigned to an agency CNA whose name she could not remember. The CNA was waiting for the nurse to come in to do a dressing and said 'he doesn't want to come and do it because you're so much work and he doesn't care if he comes in or not.' The CNA then sort of dressed me, she took off all my clothes at once and I got cold. I asked her to just do top or bottom first and she said 'no, we will do the bottom first.' She told me I was such a bitch. I asked her to get me dressed and into my other chair, since my electric chair isn't working right now and she told me 'no, I'm not taking care of you.' She walked out, came in and handed me a nursing gown, and left. Review of an employee statement written by NA Employee E1 dated [DATE], indicated Around 11:15 I went to do [Resident R9]. Everything was ok after I got done washing her about to get her dressed when she received a phone call from her power chair company. They told her that have to get something approved and so on. [Resident R9] then hung the phone up on them. I asked what she would like to wear and she started cussing calling me bitches to and that I need to get her dressed right now. I tried to give her something to cover up with and she throw it at me and was still cussing. I left out the room and went and let the nurse know what was going on. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated [DATE], indicated that the facility investigation substantiated the abuse investigation. During an interview on [DATE], at 6:53 p.m. Resident R9 stated that NA Employee E1 left her unclothed after Resident R9 had asked her for a cover. Resident R9 stated that she did not lay naked, and NA Employee E1 told her she had to wait. She kept yelling at me, telling me, you are the one with the attitude. You are the one being a bitch because you are mad the nurse wasn't here yet. You are the one that's miserable. You can't tell me what, I'll tell you what to do. Resident R9 stated she responded by saying, Maybe we will just not talk, to which Resident R0 stated NA Employee E1 responded, No, I'll talk and you listen. Resident R9 stated she has never been treated like that before while residing at the facility. Resident R9 stated, I was so upset, I have not cried that hard since my husband died. During an interview on [DATE], at approximately 7:15 p.m. the Nursing Home Administrator confirmed that the facility failed to protect residents from staff-initiated abuse. This failure resulted in a staff member physically abusing a resident and multiple staff neglecting care of one of four residents. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.20(a)(b) Staff development. 28 Pa. Code 201.29(a)(c)(d) Resident rights.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on review of resident and staff interviews, Resident Council minutes review, and grievance review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of eight of eleven residents (Residents R1, R2, R3, R4, R5, R6, R7, and R8). Findings include: During an interview on 11/5/25, at 5:00 p.m. when asked if he felt the facility maintained enough staff to care for resident needs, Resident R1 stated, No. Resident R1 stated that call light response usually takes a long time. Resident R1 further stated that he receives late medications and is not assisted in and out of bed timely. During an interview on 11/5/25, at 5:03 p.m. when asked if she felt the facility maintained enough staff to care for resident needs, Resident R2 stated, There could be more. During an interview on 11/5/25, at 5:09 p.m. when asked if he felt the facility maintained enough staff to care for resident needs, Resident R3 stated, At times not. During an observation on 11/5/25, at 6:18 p.m., Resident R4 and Resident R5's room smelled overpoweringly of urine. Review of Resident R4's toileting record indicated Resident R4 was incontinent of urine, and incontinence care was documented on 11/5/25, at 2:25 p.m. and not documented as completed again until 11/6/25, at 12:32 a.m. During an interview on 11/5/25, at 2:56 p.m., Resident R6, when asked if she felt the facility maintained sufficient staff to care for resident needs, stated, At times I be sitting in piss for two to three hours. People don't want to help. I had to call my family at 2:00 a.m. to have them call (the nurses). When I call the nurse's station, they hang up on me. Resident R6 stated that he waited from 3:00 a.m. until 11:00 a.m. before receiving assistance. Resident R6 stated he has been told, You aren't the only one here and stated, You are lucky to see them one time a shift. Observation at this time revealed large amounts of a brown substance under Resident R6's fingernails and for Resident R6 to be malodorous. During an interview on 11/5/25, at 6:35 p.m., Resident R7, when asked if she felt the facility maintained sufficient staff to care for resident needs, stated, No, all I hear is complaints that they only have three aides, and I have to wait. One time the night shift aide found out she had the whole floor and told me I will have to wait. Resident R7 stated she has waited up to three hours for assistance after activating her call light. Resident R7 stated that she was told on Monday (11/3/25) that she could not have a shower due to insufficient staffing, and that she would get it on Tuesday, But I didn't end up getting a shower at all. I'm completely dependent on aides. I've laid as much as 12 hours in my own body fluids. Sunday is the worst. Review of Resident R7's shower record revealed that on her scheduled shower day of Monday, 11/3/25, or Tuesday 11/4/25, she did not receive a shower. No shower refusals were documented. Review of Resident Council meeting minutes for 8/22/25, included concerns about staff not assisting to change soiled sheets. Review of Resident Council meeting minutes for 9/24/25, included concerns about from two residents about not getting showers when scheduled. Review of a grievance filed on behalf of Resident R8, dated 8/20/25, revealed concerns that Resident R8 was still in bed at 11:30 a.m. and had not been provided bathing assistance. During an interview on 11/5/25, at approximately 7:15 p.m. the Nursing Home Administrator and confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of eight of eleven residents. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code: 201.20(a) Staff development. 28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.</p>		