

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 12/03/2025
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 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>Based on review of facility policy and staff interviews, it was determined that the facility failed to provide adequate supervision to ensure a safe environment with unrestricted access to the outdoor courtyard area for thirteen of one 168 residents. Findings include: Review of the facility policy Resident Rights dated 7/7/25, indicated this includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. During an observation with the Director of Nursing (DON) on 10/7/25 at approximately 9:20 a.m. the facility [NAME] Garden exit door was propped open. This door is located down a corridor next to the family room, out of the view of the nursing units. A resident was observed in the courtyard unattended, an additional resident was attempting to egress out to the courtyard, and visitors processed out the during this observation period. The door has two signs one reads Keep Door Closed the second reads Not an Exit . The DON confirmed the door should not be propped open at the time of the observation. During an interview on 10/7/25, at approximately 2:30 p.m., the Nursing Home Administrator (NHA), DON, and Assistant Director of Nursing (ADON) they confirmed the courtyard is the new smoking location as of 10/6/25, the door is not part of the wander guard or alarm system, any mobile resident could egress through this location with the door propped open as the door locks when properly closed. During an observation on 10/8/25, at approximately 9:30 a.m. The exit door to the courtyard was observed as closed. During an interview on 10/8/25, at approximately 10:00 a.m. the NHA and the DON confirmed that the facility failed to provide adequate supervision to ensure a safe environment with unrestricted access to the outdoor courtyard area for mobile residents, by propping open a secure door. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.</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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents are free of significant medication errors for one of eighteen residents (Resident R1). Findings include: Review of facility policy Medication Errors dated 7/7/25, indicated Significant Medication Error means one which causes the patient discomfort or jeopardizes their health and safety. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: Right medication, dose, route, and time of administration; Right patient and right documentation. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/2/25, included diagnoses of diabetes mellitus (high blood sugar), end stage renal disease (kidney failure requiring dialysis), and high blood pressure. Review of the physician orders September 2025, indicated to give Resident R1 insulin Lantus (glargine - long-acting insulin) 4 units inject subcutaneously two times a day, timed at 9:00 a.m. and 9:00 p.m. Review of the Medication Administration Record (MAR) for September 2025 indicated Resident R1 was given Lantus insulin as per provider order. Review of the physician orders September 2025, indicated to give Resident R1 insulin Lispro (fast-acting insulin) 4 units inject subcutaneously every four hours daily, timed at 7:30 a.m., 11:30 a.m., 4:30 p.m. and 9:30 p.m. and additional units, according to a blood glucose reading following the sliding scale: 200-299 = 1 unit 300-399 = 2 units 400-499 = 3 units 400-499 = 4 units 500-599 = 5 units Call provider if blood sugar is greater than 500. Review of the Medication Administration Record (MAR) for September 2025 indicated Resident R1 was given Lispro insulin as per provider order. During a phone interview with LPN Employee E1 on 10/7/25 at approximately 2:20 p.m., Employee E1 stated on she was preparing insulin for the insulin for Resident R2, 30 units of NovoLog and prior to administration was interrupted by a resident. Employee E1 returned to the room and confirmed that she inadvertently administered Resident R2 insulin to Resident R1. Review of the approximate event timeline of 9/22/25 reveals: 5:50 p.m., the incorrect resident was administered insulin. 5:52 p.m., the supervisor was notified. 6:00 p.m., the resident notified her family. 6:15 p.m., the provider notified, and orders received to monitor blood sugars. Blood sugar was 354.6:30 p.m., the supervisor notified residents family. 7:45 p.m., the family requested resident be sent to the emergency department. 8:10 p.m., the resident was transported to the emergency department where she received D10w (an intravenous solution) at 250cc/hr. Resident R1 returned from the emergency department 9/23/25 approximately 10:00 a.m. During an interview on 10/8/25, at approximately 10:30 a.m., the Director of Nursing confirmed the facility failed to make certain that residents are free of significant medication errors for one of eighteen residents. 28 Pa. Code 207.2(a) Administrator's responsibility. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>		