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	12/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeville Rehabilitation & Care Center	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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, incident investigations, and staff interviews, it was determined that the facility failed to ensure that residents are free from misappropriation of property for one of four residents (Resident R1).Findings include: Review of the facility policy Abuse Prohibition dated 10/27/25, defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the patient's consent. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, 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 intact8-12: moderately impaired0-7: severe impairment Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 11/13/25, included diagnoses of left knee replacement, obstructive sleep apnea (repeated interruptions in breathing during sleep, and morbid obesity (overweight with a body mass index (BMI) of 40 or higher (normal BMI for a female is 18.5 to 24.9) Review of Section C revealed Resident R1's BIMS score to be 13. Review of a physician's order dated 11/6/25, indicated Resident R1 is to receive Oxycodone HCL 5 mg (milligrams) tablet (a narcotic pain medication), to give 5 mg by mouth every 6 hours as needed for pain mild to moderate AND give 10 mg by mouth every 6 hours as needed for severe pain. Review of a physician's order dated 11/6/25, indicated Resident R1 is to receive Tylenol Extra Strength Oral Tablet 500 mg (milligrams) tablet (a pain medication), to give 1,000 mg by mouth every 8 hours as needed for mild pain. Review of Resident R1's Medication Administration Record (MAR) for November 2025, indicated sixteen administrations of oxycodone:11/09/25: 5 mg at 6:03 a.m.11/10/25: 5 mg at 1:30 a.m.; 5 mg at 11:15 a.m.; 5 mg at 4:00 p.m. 11/11/25: 10 mg at 5:57 a.m.11/12/25: 5 mg at 3:24 p.m.11/13/25: 10 mg at 8:00 p.m.11/14/25: 10 mg at 6:28 p.m. 11/15/25: 10 mg at 3:02 a.m.11/16/25: 10 mg at 4:13 a.m.; 10 mg at 8:35 p.m. 11/17/25: 10 mg at 8:00 p.m.11/18/25: 10 mg at 3:32 p.m.; 10 mg at 9:30 p.m.11/20/25: 5 mg at 3:21 a.m.; 10 mg at 4:00 p.m. Review of Resident R1's Medication Administration Record (MAR) for November 2025, indicated sixteen administrations of Tylenol Extra Strength:11/10/25: 1000 mg at 12:18 a.m.11/11/25: 1000 mg at 2:00 a.m.11/13/25: 1000 mg at 2:00 a. m. The MAR indicated RN Employee E4 administered oxycodone once and never administered Tylenol Extra Strength between 11/6/25, through 11/21/25. The MAR indicated RN Employee E5 never administer oxycodone or Tylenol Extra Strength between 11/6/25, through 11/21/25. Review of facility submitted documentation on 11/10/25, indicated that on 11/7/25, Employee E4 Registered Nurse (RN) worked the 11:00 p.m. to 7:00 a.m. shift and signed in a narcotic card containing 26 Oxycodone HCL 5 mg for Resident R1, from the facilities pharmacy provider, at approximately 0130 (1:30 a.m.). At 7:00 a.m. on 11/8/25 Employees RN E4 and RN E5 counted and the count was accurate. 11/8/25 RN Employee E5 worked from 7:00 a.m. to 11:00 p.m., at 11:00 p.m. on 11/8/25 Employees RN E5 and RN E4 counted 27 of 27 cards in the narcotic drawer and signed the count was correct. On 11/9/25 at approximately 4:45 a.m. Resident R1 requested the Oxycodone HCL 5 mg. Employee RN E4 was unable to locate the Oxycodone in the narcotic drawer, both the narcotic card and narcotic sheet was unaccounted for. Review of a statement written by RN Employee E5 dated 11/9/25, indicated I counted with RN Employee E4 at 11:00 p.m. count correct. I never gave Resident R1 a pain pill other than Tylenol as she did not request for anything stronger. RN Employee E5 at approximately 1:00 p.m. on 11/8/25 noted the binder fell off the med cart and RN Employee E5 had to put all the papers back in the narcotic book. Review of a statement written by RN Employee E4 dated 11/9/25, indicated, on 11/9/25 approximately 2306 (11:06 p.m.) Counted narcs (narcotics), TCU cart with RN Employee E5. 27 of 27 narcotic cards. Approximately 4:45 a.m. Resident R1 requested a pain pill oxycodone, and none were signed out on the computer. I looked for the controlled substance tracking sheet and card, there were none. I flipped to the shift change inventory count signoff sheet from the prior day and it was missing. Review of a statement written by Licensed Practical Nurse (LPN) Employee E6 dated 11/9/25. RN Employee E4 asked her opinion with Resident R1 wanting a pain pill however she doesn't have a medication card or paper for the requested narcotic. The resident states she has been getting pain medication, but it hadn't been documented in the computer as given. LPN Employee E6 and RN Employee E4 reviewed the controlled substance tracking book and RN Employee E4 stated the original tracking sheet had been removed and a new one placed (as the new document didn't have RN Employee E4's

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement policies and procedures to investigate misappropriation of resident property for one of four residents (Resident R1).Findings include: Review of the facility policy Abuse Prohibition dated 10/27/25, defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the patient's consent. Review of the facility policy Controlled Substances dated 10/27/25, indicated controlled medications are substances that have and accepted medical use (medications which fall under U.S. Drug Enforcement Agency (DEA) Schedules II-V), have a potential for abuse. These medications are subject to special handling, storage, disposal, and record keeping at the nursing care center, in accordance with federal and state laws and regulations. Controlled medications are obtained from the locked cabinet, or safe, or medication cart. At each shift change, a physical inventory of controlled medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record. Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2023, 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 intact8-12: moderately impaired0-7: severe impairment Review of a physician's order dated 11/6/25, indicated Resident R1 is to receive Oxycodone HCL 5 mg (milligrams) tablet (a narcotic pain medication), to give 5 mg by mouth every 6 hours as needed for pain mild to moderate AND give 10 mg by mouth every 6 hours as needed for severe pain. Review of a physician's order dated 11/6/25, indicated Resident R1 is to receive Tylenol Extra Strength Oral Tablet 500 mg (milligrams) tablet (a pain medication), to give 1,000 mg by mouth every 8 hours as needed for mild pain. Review of Resident R1's Medication Administration Record (MAR) for November 2025, indicated sixteen administrations of oxycodone: 11/09/25: 5 mg at 6:03 a.m.11/10/25: 5 mg at 1:30 a.m.; 5 mg at 11:15 a.m.; 5 mg at 4:00 p.m. 11/11/25: 10 mg at 5:57 a.m.11/12/25: 5 mg at 3:24 p.m.11/13/25: 10 mg at 8:00 p.m.11/14/25: 10 mg at 6:28 p.m. 11/15/25: 10 mg at 3:02 a.m.11/16/25: 10 mg at 4:13 a.m.; 10 mg at 8:35 p.m. 11/17/25: 10 mg at 8:00 p.m.11/18/25: 10 mg at 3:32 p.m.; 10 mg at 9:30 p.m.11/20/25: 5 mg at 3:21 a.m.; 10 mg at 4:00 p.m. Review of Resident R1's Medication Administration Record (MAR) for November 2025, indicated sixteen administrations of Tylenol Extra Strength: 11/10/25: 1000 mg at 12:18 a.m.11/11/25: 1000 mg at 2:00 a.m. 11/13/25: 1000 mg at 2:00 a.m. The MAR indicated RN Employee E4 administered oxycodone once and never administered Tylenol Extra Strength between 11/6/25, through 11/21/25. The MAR indicated RN Employee E5 never administer oxycodone or Tylenol Extra Strength between 11/6/25, through 11/21/25. Review of facility submitted documentation on 11/10/25, indicated that on 11/7/25, Employee E4 Registered Nurse (RN) worked the 11:00 p.m. to 7:00 a.m. shift and signed in a narcotic card containing Oxycodone HCL 5 mg for Resident R1, from the facilities pharmacy provider, at approximately 0130 (1:30 a.m.). At 7:00 a.m. on 11/8/25 Employees RN E4 and RN E5 counted and the count was accurate. 11/8/25 RN Employee E5 worked from 7:00 a.m. to 11:00 p.m., at 11:00 p.m. on 11/8/25 Employees RN E5 and RN E4 counted 27 of 27 cards in the narcotic drawer and signed the count was correct. On 11/9/25 at approximately 4:45 a.m. Resident R1 requested the Oxycodone HCL 5 mg. Employee RN E4 was unable to locate the Oxycodone in the narcotic drawer, both the narcotic card and narcotic sheet was unaccounted for. 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RN Employee E4 asked her opinion with Resident R1 wanting a pain pill however she doesn't have a medication card or paper for the requested narcotic. The resident states she has been getting pain medication, but it hadn't been documented in the computer as given. LPN Employee E6 and RN Employee E4 reviewed the controlled substance tracking book and RN Employee E4 stated the

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly secure stored medications and/or biologicals in two of three medication rooms (TCU and Harmony Unit Medication Rooms).Findings include: Review of facility policy Medication Storage dated 10/27/25, indicated that medications and biologicals that the medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. During rounds on 12/22/25, at 10:45 a.m. the Director of Nursing (DON) and surveyor checked the Harmony Unit Medication Room and the TCU Medication Room. The doors were unlocked with medications that were designated to be returned, sitting on the counter. These doors require a key to be locked. Education was completed in November by the facility in response to this event, policy for controlled substances administration, ordering, storage, handling and disposal, confirmed with staff interviews. During an interview on 12/22/25, at approximately 9:50 a.m. Licensed Practical Nurse Employee E1 confirmed he had a key to the Harmony Unit Medication Room and that the door should be locked. During an interview on 12/22/25, at approximately 9:55 a.m. Licensed Practical Nurse Employee E2 confirmed she had a key to the Harmony Unit Medication Room and that the door should be locked and proceeded to lock the unlocked door. During an interview on 12/22/25, at approximately 10:00 a.m. Licensed Practical Nurse Employee E3 confirmed she had a key to the TCU Unit Medication Room and that the door should be locked and proceeded to lock the unlocked door. During an interview on 12/22/25, at approximately 2:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to properly secure medications and/or biologicals in one of two medication rooms. 28 Pa. Code: 211. 9(a)(1)(j.1)(k) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.