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	01/14/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, staff interviews, and facility reported incident, it was determined that the facility failed to make certain that residents were protected from harmful chemicals that resulted in actual harm for a resident (Resident R1) when the resident ingested ethylene glycol (chemical found in antifreeze) resulting in hospitalization. This failure created an Immediate Jeopardy situation for one of 108 residents. Findings include: Review of the facility policy, Accidents/Incidents, indicated the facility will report, review, and investigate all accidents/incidents which occurred, or allegedly occurred involving a resident who is receiving services. The policy is to provide standards for review and investigation of accidents/incidents and to determine the root cause and contributing factors, identify measures to reduce further occurrences and adverse outcomes. Review of the Environmental Protection Agency (EPA - a federal agency, that sets and enforces rules and standards that protect the environment) publication, Label Review Manual: Chapter Seven, dated 03/2018, indicated the following:Table 3. Typical Statements for Acute Oral ToxicityCategory Signal Word Statement I (one) DANGER; POISON Fatal if swallowed.II (two) WARNING May be fatal if swallowed.III (three) CAUTION Harmful If swallowed.IV (four) CAUTION (optional) No statement is required, May use Category III statement. Review of the Safety Data Sheets (SDS - provides essential information about hazardous chemicals) for Peak 50/50 Prediluted Antifreeze (substance added to liquid to lower its freezing point; antifreezes commonly added to cooling systems of automobile engines) dated 1/1/20, indicated in Section 2: Hazards Identification that Peak 50/50 antifreeze is designated to have acute oral Toxicity Category of 4. Harmful if swallowed. Repeated Exposure is Category 2: May cause damage to organs (kidneys) through prolonged or repeated oral exposure. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggest the following distributions:13 - 15: cognitively intact8 - 12: moderately impaired0 - 7: severe impairment Review of the clinical record indicated Resident R1 was re-admitted to the facility on [DATE], with diagnoses that included toxic effects of glycols (suspected antifreeze oral consumption), Parkinson's Disease (chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), and depression. Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of the MDS Section C: Cognitive Patterns. Question C0500: BIMS Summary Score was 15. Review of a Medical Provider Note progress note dated 9/15/25, at 2:02 p.m. indicated the facility providers were aware of Resident R1's prior attempts of self-harm: Pt (patient) had recent hospitalization to [hospital] 201 (voluntary admission) for Seroquel (anti-psychotic medication) overdose and requested for the Seroquel to be increased. Request was declined. Review of (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

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 01/14/2026

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital Discharge Clinical Summary dated 10/25/25, indicated Resident R1 was admitted to the hospital on [DATE], with acute kidney injury (AKI, kidneys suddenly lose their ability to filter waste from the blood), and metabolic acidosis due to ethylene glycol (when ethylene glycol is ingested causing kidney damage). Further review of the hospital progress notes indicated the following: -On 10/27/25, at 11:57 a.m. a practitioner progress note indicated the emergency room evaluation was consistent with ethylene glycol toxicity. Resident R1 does have a history of cocaine use and Seroquel overdose.-On 10/28/25, at 11:39 a.m. an acute progress note indicated Resident R1 was hospitalized from [DATE] through 10/25/25, for suspected self-harm attempt with injection of ethylene glycol that requires ICU (intensive care unit) with intubation (placed on a ventilator to assist with breathing), and temporary dialysis. Resident R1 also had a recent psychiatric hospital admission.-On 10/30/25, at 12:00 a.m. an initial psychiatry progress note indicated Resident R1 has an extensive psychiatric history including inpatient hospitalization. History of possible self-harm attempts which the resident denies. Requests for Seroquel increase, not advisable due to history of overuse. Review of the care plan updated 10/30/25, indicated Resident R1 had potential risk for ideations of self-harm related to PTSD (post-traumatic stress disorder (stress after trauma), glycol toxicity, and hallucinations (a false perception of sensory experiences, they seem real but are not). Review of a facility submitted documents dated 12/21/25, indicated Resident R1 was noted to have altered mental status (change in a person's usual mental function) and was transferred to the local emergency room for evaluation. On 12/22/25, the facility received a telephone call from the hospital with concerns that Resident R1 had ingested antifreeze and requested staff to search her room for suspicious items. Staff found a gallon bottle of Peak 50/50 Prediluted Antifreeze in Resident R1's room. During an interview on 1/13/26, at 1:38 p.m. Registered Nurse (RN) Unit Manger Employee E1 stated a physician from the hospital called due to suspicious labs. RN Employee Unit Manager stated he was not aware of Resident R1's history of self-harm. Licensed Practical Nurse (LPN) Employee E2 searched Resident R1's room and found the jug of antifreeze in a yellow dollar general bag, the cap still contained the plastic seal around the lid so he thought the jug was not open, but he was able to twist the lid off without breaking the plastic seal around the lid. He stated he did not see a receipt in the bag. RN Unit Manager Employee E2 stated Resident R1's usual behavior was quiet, she stayed to herself, didn't use the call bell, and either kept her door shut or the privacy curtain closed. During an interview on 1/13/26, at 1:52 p.m., LPN Employee E2 stated on 12/22/25, the hospital called regarding abnormal labs and asked if someone could search Resident R1's room for antifreeze. The antifreeze gallon was found in Resident R1's closed cupboard in a yellow dollar store bag. A receipt was not included. LPN Employee E2 stated Resident R1 door-dashed a lot (of deliveries) in the evenings. LPN Employee E2 stated she did not have any suspicions nor noticed any abnormal behavior the week prior to the incident. The Nursing Home Administrator (NHA) and Director of Nursing were made aware that an Immediate Jeopardy situation existed for residents on 1/13/26, at 3:10 p.m. and a corrective action plan was requested. On 1/13/26, at 7:30 p.m. an acceptable Corrective Action Plan was received which included the following interventions:1. Initial audit will be completed to determine any resident with diagnosis of self-harm attempt or ideation and care plans will be updated with interventions.2. DON or designee will educate staff on policy of accidents policy OPS100 prior to the start of their next shift.3. The facility will establish a protocol related to door dash and deliveries, it will be shared at the AD HOC resident council, to families via regroup, and staff with be educated.4. DON or designee will complete a weekly audit for eight weeks to determine if any resident with self-harm attempts and/or ideation is placed on psych services, care plan initiated, and interventions added to the Kardex.5. Results (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of the audit will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly. During an interview on 1/14/26, at 9:15 a.m. RN Employee E4 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 9:20 a.m. Nurse Aid (NA) Employee E5, E6, and E7, Housekeeping Employee E8, and LPN Employee E9 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:22 a.m. RN Employee E19 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:23 a.m. LPN Employee E11 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:25 a.m. Housekeeper Employee E12 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:27 a.m. LPN Employee R13 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:27 a.m. LPN Employee E10 and E11 confirmed they received education on safety related to dementia residents and chemical storage, prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 9:30 a.m. LPN Employee E14 , and NA Employee E15 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:33 a.m. Physical Therapy Assistance (PTA) Employee E17 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:35 a.m. Laundry Employee E18 confirmed they received education on safety related third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:43 a.m. Front Desk Employee E19 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 10:00 a.m. RN Unit Manager Employee E1 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:00 a.m. RN Employee E20 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:00 a.m. NA Employee E21 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 11:01 a.m. Therapy Director Employee E22, NA Employees E23 and E24 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:04 a.m. NA Employee E25 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 11:08 a.m. Assistant Director of Therapy Employee E26, and NA Employees E27 and E28, confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:12 a.m. Physical Therapy (PT) Employee E29 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:15 a.m. Speech Therapy (ST) Employee E34 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 11:21 a.m. Maintenance Director Employee E30, and Maintenance worker Employee E31 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:30 a.m. Physical Therapy Assistant (PTA) Employee E32 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:33 a.m. Central Supply Coordinator Employee E33 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 11:35 a.m. Certified Occupational Therapy Assistant (COTA) Employee E35 and PTA Employee E36 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:37 a.m. Scheduler/Payroll Employee E37 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. The Immediate Jeopardy was removed on 1/14/26, at 2:38 p.m. after it was verified that the corrective action plan was implemented. 28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 201.18 (a)(b)(1)(3)(e)(1) Management.28 Pa. Code 211.5(f)(h) Clinical (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	records.28 Pa. Code 211.11(c)(d) Resident care plan.28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, observation and staff interview it was determined that the facility failed to ensure that the residents received appropriate treatment and services to correct assessed problems associated to an event of self-harm for one of two residents reviewed (Resident R1) resulting in actual harm, transfer to the hospital (Resident R1); and the investigation also determined that the facility had no system in place to ensure that other residents in the facility with similar needs were receiving the appropriate mental health services, resulting in an Immediate Jeopardy situation for one of 108 residents (Resident R1). Findings include: Review of facility policy Behaviors: Management of Systems indicated that based on the comprehensive assessment, staff must ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Review of the clinical record indicated Resident R1 was re-admitted to the facility on [DATE], with diagnoses that included toxic effects of glycols (suspected antifreeze oral consumption), Parkinson's Disease (chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), and depression. Review of Resident R1's care plan updated 10/30/25, indicated Resident R1 had potential risk for ideations of self-harm related to PTSD (post-traumatic stress disorder (stress after trauma), glycol toxicity, and hallucinations (a false perception of sensory experiences, they seem real but are not). Review of Resident R1's physician orders from 10/25/25, through 12/3/25, revealed orders for psychiatry/psychology consultation and pharmacy orders for medications to treat insomnia, anxiety, depression, and overdose reversal medications. Review of the progress notes indicated the following:On 9/15/25, at 2:02 p.m. a Medical Practitioner Note stated Pt (patient) had recent hospitalization to [hospital] 201 (voluntary admission) for Seroquel (anti-psychotic medication) overdose and requested for the Seroquel to be increased. On 9/25/25, at 6:41 p.m. a general progress note indicated Resident R1 was to be discharged at 5:00 p.m. on 9/25/25, but when they went into Resident R1's room, her belongings were gone. When they called Resident R1 she was already at home. Review of hospital Discharge Clinical Summary dated 10/25/25, indicated Resident R1 was admitted to the hospital on [DATE], with acute kidney injury (AKI) (kidneys suddenly lose their ability to filter waste from the blood), and metabolic acidosis due to ethylene glycol (when ethylene glycol is ingested causing kidney damage). Further review of the progress notes indicated the following:-On 10/27/25, at 11:57 a.m. a Practitioner progress note indicated the emergency room evaluation was consistent with ethylene glycol toxicity. Resident R1 does have a history of cocaine use and Seroquel overdose. -On 10/28/25, at 11:39 a.m. an acute progress note indicated Resident R1 was hospitalized from [DATE] through 10/25/25, for suspected self-harm attempt with ingestion of ethylene glycol that required ICU (intensive care unit) with intubation (placed on a ventilator to assist with breathing), and temporary dialysis (a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately), Resident R1 also had a recent psychiatric hospital admission. -On 10/30/25, at 12:00 a.m. an initial psychiatry progress note indicated Resident R1 has an extensive psychiatric history including inpatient hospitalization. History of possible self-harm attempts which the resident denies. Requests for Seroquel increase, not advisable due to history of overuse. Review of behavior charting for October 2025, revealed three of six shifts without documented behavior monitoring (50% missed documentation). Review of behavior charting for November 2025, revealed 24 of 90 (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	shifts without documented behavior monitoring (approximately 27% missed documentation). Review of behavior charting for December 2025, revealed 26 of 61 shifts without documented behavior monitoring (approximately 43% missed documentation). Further review of Resident R1's medical records failed to include consistent lack of any behavioral health interventions to address residents previous histories of suicidal attempts/ideations. Review of a facility submitted documents dated 12/21/25, indicated Resident R1 was noted to have altered mental status (change in a person's usual mental function) and was transferred to the local emergency room for evaluation. On 12/22/25, the facility received a telephone call from the hospital concerning Resident R1 possibly ingesting antifreeze and requested staff to search her room for suspicious items. Staff found a gallon of Peak 50/50 Prediluted Antifreeze in Resident R1's room. During an interview on 1/13/25, at 3:35 p.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) stated they were unaware of Resident R1's history of self-harm, and the facility did not have a procedure to ensure residents with prior self-harm attempts were referred to mental health services. An immediate jeopardy situation was identified to the NHA on 1/13/26, at 3:46 p.m. the facility failed to ensure appropriate treatment and services to attain the highest practicable mental health and psychosocial well-being were provided for Resident R1, resulting in hospitalization from ingesting antifreeze, and had no system in place to ensure that other residents in the facility with similar needs were receiving the appropriate mental health services. The immediate corrective action plan included the following interventions: 1. Initial audit will be completed on current and new admissions to determine any resident with a DX (diagnosis) of suicide attempt or suicidal ideation have care plans that will be updated with interventions 1/13/26.2. NHA or designee will educate admission director and clinical liaison to attempt to identify potential needs related to suicide attempts or suicide ideations prior to admission. Prior to the start of their next shift, DON or designee will educate staff related to any new admission coming in with a history of past attempts for self-harm on the plan of care needs.3. DON or designee will complete a weekly audit on new admissions for eight weeks to determine if any resident with history of suicide attempt or suicidal ideation is placed on psych services, care plan initiated and interventions added to Kardex4. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.During an interview on 1/14/26, at 9:15 a.m. RN Employee E4 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 9:20 a.m. Nurse Aid (NA) Employee E5, E6, and E7, Housekeeping Employee E8, and LPN Employee E9 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview During an interview on 1/14/26, at 9:22 a.m. RN Employee E19 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:23 a.m. LPN Employee E11 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:25 a.m. Housekeeper Employee E12 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	verbalized the education back during the interview. During an interview on 1/14/26, at 9:27 a.m. LPN Employee R13 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:27 a.m. LPN Employee E10 and E11 confirmed they received education on safety related to dementia residents and chemical storage, prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 9:30 a.m. LPN Employee E14 , and NA Employee E15 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:33 a.m. Physical Therapy Assistance (PTA) Employee E17 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:35 a.m. Laundry Employee E18 confirmed they received education on safety related third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 9:43 a.m. Front Desk Employee E19 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 10:00 a.m. RN Unit Manager Employee E1 confirmed they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:00 a.m. RN Employee E20 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:00 a.m. NA Employee E21 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 11:01 a.m. Therapy Director Employee E22, NA Employees E23 and E24 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:04 a.m. NA Employee E25 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 11:08 a.m. Assistant Director of Therapy Employee E26, and NA Employees E27 and E28, confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:12 a.m. Physical Therapy (PT) Employee E29 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management (continued on next page)

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 01/14/2026
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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:15 a.m. Speech Therapy (ST) Employee E34 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 11:21 a.m. Maintenance Director Employee E30, and Maintenance worker Employee E31 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:30 a.m. Physical Therapy Assistant (PTA) Employee E32 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:33 a.m. Central Supply Coordinator Employee E33 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During a group interview on 1/14/26, at 11:35 a.m. Certified Occupational Therapy Assistant (COTA) Employee E35 and PTA Employee E36 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. During an interview on 1/14/26, at 11:37 a.m. Scheduler/Payroll Employee E37 confirmed that they received education on safety related to third party delivery services (door dash, uber eats, amazon etc.), incidents and accidents, and management and symptoms of behaviors prior to beginning work, and verbalized the education back during the interview. The Immediate Jeopardy was removed on 1/14/26, at 2:38 p.m. after it was verified that the corrective action plan was implemented. 28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.18(a) Management28 Pa. Code 201.18 (b)(1)(3)(e)(1) Management28 Pa. Code 211.5(f) Clinical records28 Pa. Code 211.5(h) Clinical records28 Pa. Code 211.11(c) Resident care plan28 Pa. Code 211.11(d) Resident care plan28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.16(a) Social services

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	01/14/2026

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to protect residents from self-harm attempt. This failure resulted in a resident with an history of self-harm to have harmful chemicals in their possession, leading the resident being admitted to the hospital after ingesting ethylene glycol (chemical found in antifreeze) created an Immediate Jeopardy situation for one of two residents (Resident R1).Findings include:Review of the facility-provided Nursing Home Administrator (NHA) job description indicated the position was to create an environment where staff members are highly engaged and are focused on providing the highest level of clinical care and compassion to patients, residents, and families. The Administrator administers, directs, and coordinates all activities of the facility to assure that the highest degree of quality of care is consistently provided to residents.Review of the facility-provided Director of Nursing (DON) job description indicated, The Director of Nursing leads the facility clinical team to fulfill the organization's mission, vision, and values. This position has overall accountability for providing leadership, direction, and administration of day-to-day operations associated with direct patient care activities, nursing practice, and clinical education and development, including continuous improvement of nursing services and staff to meet residents and their families' needs and expectations.Based on findings identified in this report, the facility failed to prevent and failed to protect residents from attempts at self-harm. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed.During an interview on 1/14/26, at approximately 2:30 p.m. the NHA and DON confirmed that they failed to effectively manage the facility to protect residents from self-harm. This failure resulted in a resident being hospitalized after ingesting ethylene glycol (chemical found in antifreeze; antifreeze - added to liquid to prevent it from freezing).28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.