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	04/14/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to investigate sexually inappropriate resident behaviors to ensure resident safety for one of five residents (Resident R3). Findings include: Review of facility Abuse Prohibition revised 11/14/25, indicated the Center will implement an abuse prohibition program through identification of possible incidents or allegations which need investigation and investigating of incidents and allegations. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs dated 3/5/26, included diagnoses of chronic kidney disease (gradual loss of kidney function), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and depression. Review of Section C: Cognitive Patterns indicated that Resident R3 had moderate cognitive impairment. Review of the plan of care dated 11/12/25, indicated Resident R3 has the Tendency to exhibit sexually inappropriate behavior. Review of a progress note dated 11/12/25, at 2:53 p.m. indicated, CNA (nurse aide) reports to this nurse that resident was talking in appropriately to her. resident said to CNA when are you going to let me hit that. he then tried hitting CNA in the butt with a shirt. Review of a psychiatry note dated 12/22/25, indicated, Primary care reports to CRNP (nurse practitioner) that resident has been having inappropriate sexual behaviors towards CNAs and RNs (registered nurses) including groping private areas, making crude comments. Review of a progress note dated 3/3/25, at 3:43 a.m. indicated, Notified by CNA [Nurse Aide Employee E7] that resident had requested assistance with scratching his back as it was itching. CNA went into room to offer assistance and the resident then attempted to stick his hand between her legs and when he couldn't do that he proceeded to grab her buttocks. CNA visibly upset. [Local police] notified and report made as this'd is not resident's first time sexually harassing a CNA. Review of a psychiatry note dated 3/3/26, indicated, Staff report ongoing concerning behaviors including repeated requests for doors to be closed when female staff are present in the room, including during a recent blood draw with a female phlebotomist. Review of a psychiatry note dated 4/10/26, indicated, Since last evaluation, 1:1 supervision has been reinstated per corporate request. Another reported incident earlier today in which the resident made an inappropriate verbal remark to a staff member (let me hit that) occurred. Overall, presentation remains consistent with neurocognitive disorder with behavioral disinhibition and impaired judgment, likely contributing to recent inappropriate verbal behavior. Hard to determine whether this is true cognitive impairment or secondary gain concerns. Despite remorse and partial awareness, risk for recurrence remains given cognitive limitations. Notes from primary care reviewed also consistent with that these issues could be related to chronic long standing alcohol related dementia or could also be a desire for secondary gain. On 4/14/26, review of facility-provided investigation documents failed to reveal steps taken to ensure that Resident R3 had not been inappropriate with peer residents in addition to staff members. During an interview on 4/14/26, at approximately 3:00 p.m. the Director of Nursing confirmed Resident R3 had known sexually inappropriate behaviors and that an investigation to ensure that Resident R3 had not been inappropriate with peer residents in addition to staff members had not been completed. During an (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 4/14/26, at approximately 6:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to investigate sexually inappropriate resident behaviors to ensure resident safety for one of five residents. 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.10 (c) Resident care policies.28 Pa. Code: 211.12 (d)(1)(2) Nursing services.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and documents, clinical records, and staff interview, it was determined that the facility failed to correctly identify residents during medication administration to make certain that residents are free of significant medication errors for one of four residents (Resident R1). This was identified as past noncompliance.Findings include: Review of the facility policy Identification of Patient dated 7/1/25, indicated, All patients will receive a patient identification bracelet upon admission. Refusal will be documented in the medical record. Review of facility policy Medication Errors dated 7/1/25, 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 very 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], with the diagnoses of end stage renal disease (ESRD, an inability of the kidneys to filter the blood) and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking). Review of Resident R1's physician order dated 3/17/26, indicated Resident R1 received outpatient dialysis on Monday, Wednesday, and Friday. Review of facility submitted information dated 3/18/26, indicated, On March 18, 2026, an individual was transported from dialysis to the facility by [Transportation Company] and the driver stated ?I'm here to drop off [Resident R1's first name] from dialysis. The receptionist directed the driver to [Resident R1's room], based on the expected return of newly admitted resident, [Resident R1], who had been sent out for dialysis earlier that morning at approximately 05:00 am. At approximately 11:45, upon arrival at the facility, staff entered the resident room and a photo of the individual was obtained as per our admission process. The Day shift nurse evaluated the resident name [Resident R1's first name], verified the photograph in PCC, and the individual verbally confirmed his name as [Resident R1's first name]. Based on this identification, the nurse administered scheduled medications, including Flomax (medication to treat an enlarged prostate), Sinemet (medication to treat Parkinson's disease), Vitamin D and a multivitamin. Subsequently, the facility received a call from another facility [Facility Two, approximately seven miles away] indicating that one of their residents, also named [Resident R1's first name], had been transported to the wrong facility. An investigation was initiated immediately, and it was determined that the transportation company had transported and dropped off the wrong resident [Resident R1's first name] to our facility. It was determined that the individual was not [Resident R1] that was admitted to our facility on 3/18/2026. A call was placed to [Facility Two], and transportation was notified and arrived to pick the resident [Non-facility resident] up and transport him back to the facility. [Non-facility resident] appeared comfortable, no adverse reactions noted prior to transfer. Resident documents from dialysis were reviewed and the resident had no known allergies. A call was placed to [Facility Two] and the nurse was informed that the resident (Resident R1) was doing fine. Review of an employee statement written by Registered Nurse (RN) Employee E5 dated 3/18/26, indicated, This event occurred on 3/18/26 at 1145. I went into [Resident R1's room number] for an admission skin assessment and noticed his profile was not completed. I took his picture. When I asked Mr. [Resident R1] if that was his name and to repeat his name to me, and he mumbled and hand gestured, acknowledging the fact that this was him. He didn't answer any of my questions directly but didn't deny being [Resident R1]. Review of an employee statement written by Licensed Practical Nurse (LPN) Employee E1 dated 3/18/26, indicated, On 3-18-26 at 11:45 a.m. pt (patient) [Resident R1] returned from dialysis to his room. This pt left for dialysis at 5am before my shift and he returned from dialysis around 11:45 a.m. At 11:54 a.m. I went into the room to administer his medication. Asked his name he nodded and answered yeah. And the pt does not have name band, but has picture in profile. I gave medication as ordered and pt tolerated medication well. Pt call bell within reach and left room. Review of an undated employee statement written by (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrative Employee E2 (indicated, On [DATE] on or around 12:15 PM, as I was passing on the hallway, the receptionist waved to me and said They said the new admission is said to be confused and he is probably not our [Resident R1's first name], I guess transportation brought him to the wrong facility. I immediately notified [Nursing Home Administrator]. He immediately left his office and went to the room to follow up. I also went to the admission office and notified the Admissions Director to follow up on the new admission based on the information the receptionist shared. Review of an employee statement written by Receptionist Employee E4 dated 3/18/26, indicated that at 11:45 a.m. [Transportation Company] arrived at the center. Driver sated I am returning [Resident R1's first name] from dialysis, what room is he? I repeated, ?You have [Resident R1's first name] from dialysis. The driver said yes. I told him [Resident R1's room number]. At approximately 12pm, I answered the phone. I was [Transportation Company]. They asked me to check if [Resident R1] was in his room. I asked [Employee E3] to check [Resident R1's room number] to see if the resident was in there she said yes. I then received another phone call from [Facility Two] stating we have the wrong resident. I notified the NHA and Employee E2. I received another call regarding it being the wrong resident and I then notified the NHA. Review of an employee statement written by Administrative Employee E3 dated 3/19/26, indicated, On March 18 2026 around 12:30 pm I was walking to [Resident R1's room] to complete a 72-hour financial meeting with [Resident R1] when [receptionist [NAME] E4] was on the phone and asked me to check an see if he was in his room. I said yes that is where I am heading now. I knocked on the door and said Mr. [Resident R1's last name] as I looked at the gentleman sitting in a chair next to the bed by the door. I had never seen what [Resident R1] looked like he was admitted Tuesday and I was not at work, then was out to an appointment in the morning when I received the paperwork He looked up at me and said Huh, I said hello [Resident R1's first name] I am here to go over some paperwork with you. He said when am I going back to [Facility Two]. I stated he would have to speak with the doctor of physical therapist, I then asked if I could speak to him about his insurance coverage or if there is someone in his family I should call. He said huh? So I leaned in and spoke a little louder and repeated the question. He replied the meal was excellent but I want to go home now. I said ok Mr. [Resident R1's last name] I will be back. I walked back to the office and as I passed [receptionist Employee E4] I said he's there I am not sure he knows who or where he is. I went and explained the conversation with [[NAME]] and she recommended having [[NAME]] call the family. Review of an employee statement written by RN Employee E6 dated 3/18/26, indicated, At approximately 1215 p.m. NHA notified us of the wrong resident being transported to the facility. I accompanied the NHA to the room. I asked the resident to acknowledge his name, he mumbles, I checked both arms for an ID band, no band present. I looked in the bag on the back of the WC (wheelchair), I saw leg rest in the bag when we applied the leg rest. I also found a dialysis communication binder in the back of the WC with the resident's name on the outside and a face sheet with the resident's photo. We brought the resident out to the lobby and remained with him until transport arrived at the center to take the resident back to his facility. At approximately 1pm a driver walked into the building and the resident [External Resident R2] said, ?[Driver's name], that's my ride.' I confirmed with the driver that his name was [Driver's name]. The driver confirmed and I asked if he usually transports this resident to/from dialysis. He said yes multiple days a week but not every time. At approximately 1:30 p.m. Resident (External Resident R2) left the facility with [Transportation Driver] to be transported back to his facility. Resident face sheet was checked resident had no known allergies, resident showed no signs or symptoms of adverse reaction from medication that was administered. NHA placed call to [Facility Two] to notify them that the resident left the facility to return to them and what medications were administered at our facility. On 3/18/26, the facility initiated a plan of correction that included:Resident identification immediately verified.Initial audit of all residents conducted to verify ID bands are present and match phot and identification listed in the electronic medical record.Staff reeducation on Identification of Patient policy.Staff reeducation on ensuring resident is identified using two patient identifiers via ID (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ban, photo ID in the electronic medical record, or resident verbally supplies full first and last name, date of birth (if capable) while being evaluated or prior to undergoing procedures/treatments.State survey agency notified.Quality Assurance and Performance Improvement (QAPI) ad hoc meeting completed. New admissions, residents returning from appointments will have their identification verified by the receptionist using ID band, verbal confirmation of full name, paperwork prior to sending to room. New admissions will have a photo taken upon arrival and uploaded to the electronic medical record for identification purposes.Director of Nursing to conduct audits weekly for four weeks, then monthly for two months, of ten residents to verify ID bands in place, and that it matches current ID/photo in the electronic medical record. Results of the audits to be presented at the QAPI meetings for review and recommendations. On 4/14/26, the initial audit, staff education, and ad hoc QAPI meeting were verified to be completed by 3/20/26. During an interview on 4/14/26, at approximately 6:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to correctly identify residents during medication administration to make certain that residents are free of significant medication errors for one of four residents. This was identified as past noncompliance. 28 Pa Code: 201.18 (b)(1)(3) Management 28 Pa Code: 211.10 (c) Resident care policies.28 Pa. Code 211.12 (d)(1)(2)(5) Nursing Services.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on a review of facility policy, resident interviews, and meal observations, it was determined that the facility failed to provide resident selected menu items for five of nine residents (Resident R4, R5, R6, R7, and R8).Findings include: Review of the facility policy Dining and Food Preferences dated 3/15/26, indicated that individual dining, food, and beverage preferences are identified for all residents and that the individual tray assembly ticket will identify food items appropriate for the resident based on diet order, allergies, intolerances, and preferences. During an observation of the evening meal on 4/14/26, the following was observed: Resident R4's meal ticket indicated she was to receive a chef salad with five Italian dressings. The salad and dressing were not present on the meal tray delivered in the surveyor's presence. Resident R5 meal ticket indicated chocolate pudding. Resident R5 stated that she has advised the kitchen staff multiple times that she does not want chocolate pudding every day. Additionally, Resident R5 stated that she requests to receive a banana each morning, but only receives them two to three days per week. Resident R6's meal ticket indicated she was to receive ground molasses barbeque chicken and marinated cauliflower. Resident R6 received dry ground chicken without barbeque sauce and did not receive cauliflower. Resident R7's meal ticket indicated he was to a double entree. Observation of the meal tray prior to any being consumed confirmed Resident R7 did not receive a double entree. During an interview on 4/14/26, at approximately 6:00 p.m. Resident R8 stated that often the food received is not what she requested. The family member for Resident R8 stated that they never know what to expect for meals because the menu doesn't have dates and the meals don't follow the menu to figure out what week it is. During an observation on 4/14/26, at approximately 6:05 p.m. the menu posted in the resident hallway was noted to have Week One, Week Two, and Week Three, but with no dates or signage to indicate what was the current week. During an interview on 4/14/26, at 6:45 p.m., the Nursing Home Administrator confirmed that the facility failed to provide resident selected menu items for five of nine residents. 28 Pa. Code 201.18(b)(3) Management.28 Pa Code: 211.6(a) Dietary service.