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	08/08/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies, documents, observations, and staff interviews it was determined that the facility failed to provide a dignified dining experience on 8/5/25, during the breakfast meal service to one of five residents. (Resident R14) on the secure memory care unit. Findings include:A review of facility Resident Rights Under Federal Law policy dated 7/7/25, indicated To treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of there self-esteem and self-worth. 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 2023, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions:13 - 15: cognitively intact8 - 12: moderately impaired0 - 7: severe impairment Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (memory and cognitive ability loss), morbid obesity (excessive accumulation of body fat), psychotic disorder (a group of serious mental illnesses). Review of the MDS dated [DATE], indicated the diagnoses remain current. Resident R14 has a BIMS of 2 and Section GG: Self Care, GG0130 Eating setup or clean-up assistance helper sets up or cleans up; resident completes activity. helper assists only prior to following the activity. Resident R14 care plan dated 2/3/25, indicated Assist resident to cut foods into bite sized pieces prior to meal. During an observation on 8/5/25, at 9:15 am and 10:00 am, it was revealed that Resident R14 was lying in bed (appeared to be asleep), with the breakfast tray on the over the bed table positioned within the resident's reach. The dietary slip was checked for accuracy and confirmed to be correct with no appearance of any item having been consumed, tasted, or cut into pieces. During an interview on 8/5/25, at 10:00 Licensed Practical Nurse (LPN) Employee E1 confirmed the resident breakfast tray was delivered at 7:35 am and the food had not been consumed, tasted, or cut into pieces. During an interview on 8/15/25, at approximately 11:00 a.m. the Director of Nursing confirmed that the facility failed to provide a dignified dining experience on 8/5/25, during the breakfast meal service to one of five residents. (Resident R14) on the secure memory care unit.Pa Code: 201.29(k) Resident rightsPa Code: 207.2(a) Administrator's responsibility

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility records, resident, and staff interviews, it was determined that the facility failed to make certain call lights were accessible and answered timely for 19 of 21 residents as required (Resident R61, R163, R500, R501, R502, R503, R504, R506, R507, R508, R509, 510, R511, R512, R513, R514, R515, R516, and R517).Findings include:The facility policy Call Lights dated 7/7/25, indicated Patients will have a call light or alternative communication device at each patient's bed side, toilet, and bathing room to allow patients to call for assistance when unattended. Staff will respond to call lights and communication devices promptly. Review of Resident R61's clinical record indicated admission to the facility on 4/28/22. Review of Resident R61's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/11/25, indicated diagnoses of Alzheimer's disease (destruction of memory and thinking skills), foot drop (inability to lift the front part of the foot), and history of falls. Review of Section GG: Functional Abilities GG0130, indicated that Resident R61 is independent with toileting hygiene and GG0170 toilet transfers requires setup assistance. During an interview and observation on 8/5/25, at approximately 10:30 a.m., Resident R61 stated she rarely uses the call light and if she needs help, she has the light next to her bed and one in the bathroom. The call light cord in the bathroom was wrapped around the grab bars rendering it inoperable. Review of Resident R163's clinical record indicated admission to the facility on 6/3/24. Review of Resident R163's MDS dated [DATE], indicated diagnoses of traumatic brain injury (brain injury from a forceful bump to the head), polyneuropathy (nerve damage in the skin, muscles, and organs), and muscle weakness. Review of Section GG: Functional Abilities GG0130, indicated that Resident R163 is partial/moderate assistance with toileting hygiene (helper does less than half the effort) and GG0170 toilet transfers requires supervision or touch assistance. During an interview and observation on 8/5/25, at approximately 10:40 a.m., Resident R61 stated she uses the bathroom and would use the bathroom call light pull cord if she needs help. The call light cord in the bathroom was wrapped around the grab bars rendering it inoperable. During an interview on 8/5/25 at 10:45 a.m. Employee E2 Licensed Practical Nurse (LPN) confirmed the call light cords were wrapped around the grab bars rendering them inoperable for Residents R61 and R163. During a resident group interview on 8/5/25, at 1:30 p.m., seventeen of nineteen residents, in attendance stated that they consistently wait thirty minutes or longer for their call light to be responded to. (Resident R500, R501, R502, R503, R504, R506, R507, R508, R509, 510, R511, R512, R513, R514, R515, R516, and R517). The residents in attendance expressed frustration regarding the wait time. The residents stated they have reported this at their resident council meeting. Review of six months of resident council meeting minutes, 1/29/25, 2/26/25, 3/26/25, 4/28/25, 5/28/25, and 6/25/25 revealed resident complaints, under the nursing section, that the call lights were not being answered timely for six of the six months reviewed. During an interview on 8/6/25 at 11:00 a.m. the Director of Nursing (DON) confirmed the facility failed to make certain call lights were accessible and answered timely for 19 of 21 residents as required (Resident R61, R163, R500, R501, R502, R503, R504, R506, R507, R508, R509, 510, R511, R512, R513, R514, R515, R516, and R517). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28 Pa Code: 201.29 (l)(o) Resident rights.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy, resident council documents, resident council group interview, resident interview, and staff interview it was determined that the facility failed to respond to concerns from resident council and failed to respond to concerns in a timely manner for six out of six months (1/29/25, 2/26/25, 3/26/25, 4/28/25, 5/28/25, and 6/25/25).Findings include:The facilities Resident Council policy dated 11/15/24 with review date of 7/7/25, indicated The designated staff person acts as a liaison between the Council and Center/Community leadership in providing information on concerns, request, and recommendations to the Administrator/Executive Director and the appropriate department manager for attention and response. Responses and rationale will be documented, reviewed by the Administrator/Executive Director, and maintained with the Council Minutes. Review of Resident council minutes dated 1/29/25, 2/26/25, 3/26/25, 4/28/25, 5/28/25, and 6/25/25 identified resident concerns with staff response to call lights. The documentation did not indicate follow-up actions or communication from the nursing home administration to acknowledge or address call light response with the resident council. During a resident group interview on 8/5/25, at 1:30 p.m. 17 of 19 residents voiced concerns with the facility administration not resolving their concerns over call light response. Multiple residents stated, nothing gets addressed and nothing changes. During an interview on 8/7/25, at 11:00 a.m. the Nursing Home Administrator confirmed that the facility failed to respond to concerns from resident council and failed to respond to concerns in a timely manner for six out of six months (1/29/25, 2/26/25, 3/26/25, 4/28/25, 5/28/25, and 6/25/25). 28 Pa. Code 201.18(b)(1) Management

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Number of residents sampled: Number of residents cited: Based on a review of the resident council minutes, resident council meeting information, resident interviews, observation and staff interview, it was determined that the facility failed to serve food that was palatable and attractive.Findings include:Review of four months of resident council meeting minutes identified residents stating that the food was tasteless and often mush and unattractive on the plate. Buns were mushy because they were placed on plate with liquids.During the Resident Group Meeting held during the survey process on 8/5/25, the consensus of the residents identified that the food was unchanged, that the facility dietary department has not ever addressed the food issues. Food is, at times, not what you asked for.During resident interviews on 8/5/25, two residents that wished to remain anonymous stated that the only complaint they had in the facility was the food taste and how it looked when they received it.During an observation of tray line service on 8/6/25 from 11:42 a.m., through 12:40 p.m., the following was observed: Towards the end of tray line, Dietary Aide E7 told the Corporate Dietary Manager Employee E3 that she needed more dinner rolls as she would be out before tray line ended. The Dietary Manager brought her pieces of bread to replace dinner rolls. Six residents did not receive dinner rolls. When Pureed foods were plated, they were all placed in a big glob which was mac n' cheese, stewed tomatoes, and which ever meat they chose with all three items mixed together.Residents who had received buns with their meals for burgers, sloppy joes or hot dogs had stewed tomatoes juices soaking the buns as the staff did not place tomatoes in a bowl. When the last cart left the kitchen, it was identified to be 25 minutes later than posted meal delivery times. Posted to end at 12:05 p.m., not on the unit until 12:35 p.m.During an interview on 8/6/25, at 12:45 p.m., the Health Care Services Corporate Dietary Manager Employee E3 confirmed that the facility failed to serve food that was palatable and attractive. 28 Pa. Code 211.6(b) Dietary Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, and staff interview, it was determined that the facility failed maintain sanitary conditions to prevent the potential for cross-contamination or foodborne illness in the main kitchen (Main Kitchen).Findings include:During an observation of the kitchen on 8/5/25, from 9:15 a.m., through 9:50 a.m., the following was observed:The dish machine wash cycle was reaching temperature of only 142 degrees Fahrenheit (required to be 150-165 degrees). The rinse cycle reached 160 degrees (required to reach 180-194 degrees).The walk-in cooler fans had a white fuzzy substance on them. This fan blows air directly over food items. During an interview on 8/5/25, at 9:26 a.m., Health Care Services (HCS) corporate Dietary Manager Employee E3 confirmed that the facility failed to maintain sanitary conditions to prevent the potential for cross-contamination or foodborne illness in the main kitchen (Main Kitchen). During a second observation on 8/6/25, from 11:42 a.m., through 12:40 p.m., of the kitchen and tray line service the following was observed: Dietary [NAME] Employee E4 was touching outside of bag pulling out buns then touching food items with no change of gloves/ hand washing. She also left tray line for a pan of mashed potatoes and returned placed the potatoes and continued to serve with no hand washing/glove change. Two male Dietary Aides Employee E5 and E6 entered the kitchen with no beard guards over their facial hair had to walk through to the other side of the kitchen to obtain them.Dietary Aide Employee E5 began washing dishes and pans. He was observed placing soiled items into dish machine, running them through and then pulling them from the clean side with no hand washing/ glove change. During an interview on 8/6/25, at 12:40 p.m., HCS Corporate Dietary Manager Employee E3 confirmed that the facility failed maintain sanitary conditions to prevent the potential for cross-contamination or foodborne illness in the main kitchen (Main Kitchen). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code: 211.6(c) Dietary services.