



Certified End Page

BRIGHTON REHABILITATION AND WELLNESS CENTER

STATE LICENSE NUMBER: 020802

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: BRIGHTON REHABILITATION AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 246 FRIENDSHIP CIRCLE BEAVER, PA 15009		
STATE LICENSE NUMBER: 020802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 020802 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on February 3-4, 2025, it was determined that Brighton Rehabilitation and Wellness Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a six-story, Type II (222), fire resistive building, with a basement and a penthouse, which is fully sprinklered.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K 0131 SS=D	<p>NFPA 101 Multiple Occupancies</p> <p>Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following:</p> <ul style="list-style-type: none"> o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. <p>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0131	<p>131</p> <ol style="list-style-type: none"> 1. The Door between west wing and main building was corrected to securely latch in its frame. 2. An ongoing audit is conducted and reviewed by the Director of maintenance or Designee to assess doors across the campus to ensure they latch to their frame. 	<p>Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025</p>

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K 0131 SS=D	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain a two-hour fire resistance rating to separate buildings of different construction types, between the main building and the west wing, affecting one of twenty-six smoke compartments. Findings include: 1. Observation on February 3, 2025, revealed the door between the west wing and the main building failed to latch in its frame when tested. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 2:00 p.m., confirmed the deficiency with the doors in the two-hour rated occupancy separation wall.	K 0131		
K 0225 SS=E		K 0225		

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K 0225 SS=E	Continued from page 3 NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	225 Main 1 1. The 5 totes located in the 5 main stair well were moved to activities storage location. The greater than 1/8" gap in smoke doors in stairwell enclosure in the 4 main and 4 east cross over was corrected. 2. An ongoing audit is conducted and reviewed by the Director of maintenance or Designee to assess doors across the campus to ensure they have gaps less than 1/8".	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

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K 0225 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain exit stairways in two instances, on two of six floors. Findings Include: 1. Observation on February 3, 2025, revealed the following stairway deficiencies: a) 9:40 a.m., there was storage in the stairwell of 5 main; b) 10:05 a.m., there was a gap greater than 1/8" between smoke doors in the stairwell enclosure in the crossover between 4 Main and 4 East. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:30 p.m., confirmed the stairway and smokeproof enclosure deficiencies.	K 0225		

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K 0321 SS=D	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in two instances, affecting two of 26 smoke compartments. Findings include: 1. Observation on February 3, 2025, revealed the following hazardous area enclosure deficiencies: a) 10:34 the laundry room door had a gap larger than 3/4 inch at the bottom of the door; b) 10:40 a.m., the closer to the basement Mechanical Room was disconnected from the frame and hanging loosely; c) 11:10 a.m., the smoke doors to 3 West had a gap larger than 3/4 of an inch at the bottom of the doors; d) 11:15 a.m., the door labeled "#1 Heat Room", would not close and latch in it's frame. Interview with the Facility Administrator and	K 0321		

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K 0321 SS=D	Continued from page 7 Maintenance Director on February 4, 2025, at 2:00 p.m., confirmed the listed hazardous area enclosure deficiencies.	K 0321		
K 0324 SS=E	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 0324	324 main 1 1. A new vendor was contracted to ensure a regulatory schedule was maintained for semi-annual fire suppression system inspection for kitchen hoods. 2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued bi-annual inspections are completed.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

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K 0324 SS=E	Continued from page 8 This REQUIREMENT is not met as evidenced by:	K 0324		

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K 0324 SS=E	Continued from page 9 Based on documentation review, observation, and interview, it was determined the facility failed to maintain the kitchen hoods in two instances, affecting one of three smoke compartments. Findings include: 1. Review of documentation on February 3, 2025, revealed the following kitchen hood deficiencies: a) 8:35 a.m., the facility failed to provide documentation for the semi-annual fire suppression system inspection due in October 2024; b) 8:40 a.m., the facility failed to provide documentation for the semi-annual hood cleaning due in August 2024. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:30 p.m., confirmed the lack of documentation at the time of the survey.	K 0324		

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K 0345 SS=F	<p>NFPA 101 Fire Alarm System - Testing and Maintenance</p> <p>Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0345	<p>345 main 1</p> <p>1. A new vendor was contracted to ensure a regulatory inspection deficiencies were corrected. A new vendor was contracted to ensure a regulatory semi-annual visual inspection of the fire alarm system is completed. The smoke detector was uncovered at the time of the survey.</p> <p>2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued bi-annual inspections and corrections, are completed. Ongoing audits are conducted to ensure smoke detectors are uncovered.</p>	<p>Completion Date: 02/21/2025</p> <p>Status: APPROVED</p> <p>Date: 02/12/2025</p>

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K 0345 SS=F	Continued from page 11 Based on document review, observation, and interview, it was determined the facility failed to maintain the fire alarm system in three instances, affecting the entire facility. Findings include: 1. Review of documentation on Febraury 3, 2025, revealed the following fire alarm deficiencies: a) 9:00 a.m., the facility failed to provide documentation that showed corrections of deficiencies found on the annual fire alarm system inspection; b) 9:04 a.m., the facility failed to provide documentation for the semi-annual visual inspection of the fire alarm system. Interview with the Facility Administrator and Maintenance Director on Febraury 4, 2025, at 1:30 p.m., confirmed the facility could not provide documentation for the above listed deficiencies. 2. Observation on Febraury 4, 2025, at 11:30 a.m.,	K 0345		

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K 0345 SS=F	Continued from page 12 revealed a covered smoke detector in the closet of the auditorium stage. Interview with the Facility Administrator and Maintenance Director on Febraury 4, 2025, at 1:30 p.m., confirmed the facility could not provide documentation for the above listed deficiency.	K 0345		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 13 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	353 main 1 1. A new vendor was contracted to ensure a regulatory semi-annual sprinkler inspection is completed. A new vendor was contracted to correct deficiencies identified in annual fire pump inspections. The sprinkler head in central supply was corrected to be flush with the ceiling tile. The ceiling tile in the west 2 electrical closet was corrected. ceiling tile across from resident room 409 was corrected. 2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued semi-annual inspections and corrections, are completed.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

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K 0353 SS=F	Continued from page 14 Based on observation, document review, and interview, it was determined the facility failed to maintain the automatic sprinkler system in five instances, affecting the entire facility. Findings include: 1. Document review on February 3, 2025, revealed the following automatic sprinkler system deficiencies: a) 9:30 a.m., facility failed to perform the semi-annual sprinkler system inspection that was due August of 2024; b) 9:31 a.m., the facility failed to correct deficiencies on the annual fire pump inspection. Interview with the Facility Administrator and Director of Maintenance on February 4, 2025, at 1:30 p.m., confirmed the facility lacked documentation for the above listed items. 2. Observation on February 3, 2025, revealed the following sprinkler system deficiencies:	K 0353		

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K 0353 SS=F	Continued from page 15 a) 9:50 a.m., there was a sprinkler head in central supply that was not flush with the ceiling tile, leaving a gap; b) 10:37 a.m., there was a missing ceiling tile across from resident room 409 Main. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:30 p.m., confirmed the above listed sprinkler deficiencies. 3. Observation on Febraury 4, 2025, at 10:45 a.m., revealed a missing ceiling tile in the 2 West electrical panel closet. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:30 p.m., confirmed the above listed sprinkler deficiency.	K 0353		

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K 0355 SS=F	<p>NFPA 101 Portable Fire Extinguishers</p> <p>Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0355	<p>355</p> <ol style="list-style-type: none"> 1. A new vendor was contracted to complete the annual fire extinguisher inspection. The inspections are always performed by certified vendors/persons as identified by all past documentation available to the surveyors. 2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued annual inspections of fire extinguishers, are completed. 	<p>Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0355 SS=F	Continued from page 17 Based on documentation review and interview, it was determined the facility failed to maintain portable fire extinguisher inspections in two instances, affecting the entire facility. In accordance with NFPA 10, 7.1.2.1. Findings include: 1. Review of documentation on February 3, 2025, at 8:30 a.m., revealed the following portable fire extinguisher inspection deficiencies: a) the facility failed to provide an annual portable fire extinguisher inspection report; b) the facility is unable to confirm if the person/persons who performed the annual portable fire extinguisher inspection are certified to inspect portable fire extinguishers. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:30 p.m., confirmed the listed portable fire extinguisher	K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0355 SS=F	Continued from page 18 inspection deficiencies.	K 0355		
K 0363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are	K 0363	363 main 1 1. the door to room 450 was corrected. the door to room 355 was corrected. the door to room 358 was corrected. the door to the housekeeping closet in the basement was corrected. 2. An ongoing audit is conducted and reviewed by the Director of maintenance or Designee to assess doors across the campus to ensure they latch to their frame.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0363 SS=E	Continued from page 19 permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363		

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K 0363 SS=E	Continued from page 20 Based on observation and interview, it was determined the facility failed to maintain corridor doors in four instances, affecting four of twenty-six smoke compartments. Findings include: 1. Observation on February 3, 2025, revealed the following corridor door deficiencies: a) 10:00 a.m., the door to room 450 on the fourth floor failed to latch when tested; b) 10:20 a.m., the door to room 355 on the third floor failed to latch when tested; c) 10:35 a.m., the door to room 358 on the third floor failed to latch when tested; d) 9:45 a.m., the door to the housekeeping closet in the basement failed to latch when tested. Interview with the Facility Administrator and Maintenance Director on February 3, 2025, at 2:00 p.m., confirmed the corridor door deficiency	K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0363 SS=E	Continued from page 21	K 0363		
K 0374 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	0374 1. The smoke barrier doors between the main building and east building on the fourth floor were corrected. 2. An ongoing audit is conducted and reviewed by the Director of maintenance or Designee to assess doors across the campus to ensure they latch to their frame.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

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K 0374 SS=D	Continued from page 22 Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors in one instance, affecting two of twenty six smoke compartments. Findings include: 1. Observation on February 3, 2025, revealed the smoke barrier doors between the Main building and the East building on the fourth floor failed to self-close and latch when tested. Interview with the Facility Administrator and Maintenance Director on February 3, 2025, at 2:00 p.m., confirmed the smoke barrier door deficiency	K 0374		
K 0908 SS=F		K 0908		

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K 0908 SS=F	Continued from page 23 NFPA 101 Gas and Vacuum Piped Systems - Inspection and Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0908	908 main 1 1. A new vendor was contacted to complete the annual medical gas system inspection. 2. An ongoing audit is conducted and reviewed by the Director of maintenance or Designee to ensure continued annual medical gas system inspections, are completed.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

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K 0908 SS=F	Continued from page 24 Based on document review and interview, it was determined the facility failed to maintain medical gas requirements in one instance, affecting the entire facility. Findings include: 1. Review of Documentation on February 4, 2025, at 8:45 a.m., revealed the facility lacked documentation verifying that an annual medical gas system inspection was performed. Interview with the Facility Administrator on February 4, 2025, at 8:45 a.m. confirmed the medical gas system inspection documentation was not available at the time of survey.	K 0908		
K 0920 SS=E		K 0920		

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K 0920 SS=E	Continued from page 25 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	920 1. the electrical panel in the mechanical room in the main laundry room was corrected. the elevator panel in the was elevator pit rom was corrected. the elevator panel in the elevator penthouse of the main building was corrected. 2. An ongoing audit is conducted and reviewed by the Director of maintenance or Designee to assess electrical and control panels to ensure they are covered.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

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K 0920 SS=E	<p>Continued from page 26</p> <p>Based on observation and interview, it was determined the facility failed to maintain electrical equipment in three instances, affecting three of 26 smoke compartments, per <i>NFPA 99 2012 Edition, Chapter 10.1.1</i></p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation on February 3, 2025, revealed the following electrical equipment deficiencies: <ul style="list-style-type: none"> a) 10:07 a.m., the electrical panel in the mechanical room of the main laundry was missing a cover; b) 10:30 a.m., the elevator control panel in the west elevator pit room was missing a cover; c) 11:05 a.m., the elevator control panel in the elevator penthouse was missing a cover. <p>Interview with the Facility Administrator and the Director of Maintenance on February 4, 2025, at 1:30 p.m., confirmed the listed electrical equipment deficiencies.</p>	K 0920		

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K 0920 SS=E	Continued from page 27	K 0920		
K 0923 SS=D	<p>NFPA 101 Gas Equipment - Cylinder and Container Storage</p> <p>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which</p>	K 0923	<p>923 main 1</p> <ol style="list-style-type: none"> 1. the oxygen cylinder in the oxygen storage room on 4 main was placed in a caddy at the time of the survey. 2. the director of maintenance of designee will audit oxygen storage rooms weekly for 4 weeks to ensure compliance. 	<p>Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025</p>

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K 0923 SS=D	Continued from page 28 they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

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K 0923 SS=D	Continued from page 29 Based on observation and interview, it was determined the facility failed to properly store gas cylinders in one instance, affecting one of 26 smoke compartments. Findings include: 1. Observation on February 4, 2025, at 11:10 a.m., revealed an unsecured cylinder in the oxygen storage room on 4 Main. Interview with the Facility Administrator and the Director of Maintenance on February 4, 2025, at 1:30 p.m., confirmed the cylinder was not properly stored.	K 0923		



Certified End Page

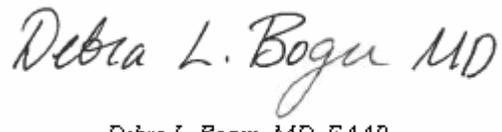
BRIGHTON REHABILITATION AND WELLNESS CENTER

STATE LICENSE NUMBER: 020802

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 020802 Component 02 Annex Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on February 3-4, 2025, it was determined that Brighton Rehabilitation and Wellness Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a three-story, Type II (000), unprotected noncombustible building, without a basement, which is fully sprinklered.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K 0131 SS=E	<p>NFPA 101 Multiple Occupancies</p> <p>Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following:</p> <ul style="list-style-type: none"> o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. <p>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0131	<p>131 main 2</p> <ol style="list-style-type: none"> 1. The Door between west wing and main building was corrected to securely latch in its frame. 2. An ongoing audit is conducted and reviewed by the Director of maintenance or Designee to assess doors across the campus to ensure they latch to their frame. 	<p>Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0131 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain a two-hour fire resistance rating to separate buildings of different construction types, between the main building and the west wing, affecting one of six smoke compartments. Findings include: 1. Observation on February 3, 2025, revealed the door between the West Wing and the Main building failed to latch in its frame when tested. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 2:00 p.m., confirmed the deficiency with the doors in the two-hour rated occupancy separation wall.	K 0131		
K 0225 SS=E		K 0225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 020802		STREET ADDRESS, CITY, STATE, ZIP CODE: 246 FRIENDSHIP CIRCLE BEAVER, PA 15009		
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K 0225 SS=E	Continued from page 3 NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	225 1. The greater than 1/8" gap in smoke doors in stairwell enclosure in the 4 main and 4 east cross over was corrected. 2. An ongoing audit is conducted and reviewed by the Director of maintenance or Designee to assess doors across the campus to ensure they have gaps less than 1/8".	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0225 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain exit stairways in one instance, on one of six floors. Findings Include: 1. Observation on February 3, 2025, at 10:05 a.m, revealed a gap greater than 1/8" between smoke doors in the stairwell enclosure in the crossover between 4 Main and 4 East. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:30 p.m., confirmed the stairway and smokeproof enclosure deficiencies.	K 0225		
K 0345 SS=F		K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0345 SS=F	Continued from page 5 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	345 main 2 1. A new vendor was contracted to ensure a regulatory inspection deficiencies were corrected. A new vendor was contracted to ensure a regulatory semi-annual visual inspection of the fire alarm system is completed. The smoke detector was uncovered at the time of the survey. 2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued bi-annual inspections and corrections, are completed. Ongoing audits are conducted to ensure smoke detectors are uncovered.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
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K 0345 SS=F	Continued from page 6 Based on document review and interview, it was determined the facility failed to maintain the fire alarm system in two instances, affecting the entire facility. Findings include: 1. Review of documentation on Febraury 3, 2025, revealed the following fire alarm deficiencies: a) 9:00 a.m., the facility failed to provide documentation that showed corrections of deficiencies found on the annual fire alarm system inspection; b) 9:04 a.m., the facility failed to provide documentation for the semi-annual visual inspection of the fire alarm system. Interview with the Facility Administrator and Maintenance Director on Febraury 4, 2025, at 1:30 p.m., confirmed the facility could not provide documentation for the above listed deficiencies.	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0353 SS=F	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0353	<p>355 main 2</p> <p>1. A new vendor was contracted to complete the annual fire extinguisher inspection. The inspections are always performed by certified vendors/persons as identified by all past documentation available to the surveyors.</p> <p>2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued annual inspections of fire extinguishers, are completed.</p>	<p>Completion Date: 02/21/2025</p> <p>Status: APPROVED</p> <p>Date: 02/12/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 020802		STREET ADDRESS, CITY, STATE, ZIP CODE: 246 FRIENDSHIP CIRCLE BEAVER, PA 15009		
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K 0353 SS=F	Continued from page 8 Based on observation, document review and interview, it was determined the facility failed to maintain the automatic sprinkler system in two instances, affecting the entire facility. Findings include: 1. Document review on February 3, 2025, at 9:30 a.m., revealed the following automatic sprinkler system deficiencies: a) 9:30 a.m., facility failed to perform the semi-annual sprinkler system inspection that was due August of 2024; b) 9:31 a.m., the facility failed to correct deficiencies on the annual fire pump inspection. Interview with the Facility Administrator and Director of Maintenance on February 4, 2025, at 1:30 p.m., confirmed the facility lacked documentation for the above listed items.	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
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K 0355 SS=F	<p>NFPA 101 Portable Fire Extinguishers</p> <p>Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0355	<p>355 main 2</p> <p>1. A new vendor was contracted to complete the annual fire extinguisher inspection. The inspections are always performed by certified vendors/persons as identified by all past documentation available to the surveyors.</p> <p>2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued annual inspections of fire extinguishers, are completed.</p>	<p>Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025</p>

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K 0355 SS=F	<p>Continued from page 10</p> <p>Based on documentation review and interview, it was determined the facility failed to maintain portable fire extinguisher inspections in two instances, affecting the entire facility. In accordance with NFPA 10, 7.1.2.1.</p> <p>Findings include:</p> <p>1. Review of documentation on February 3, 2025, at 8:30 a.m., revealed the following portable fire extinguisher inspection deficiencies:</p> <p>a) the facility failed to provide an annual portable fire extinguisher inspection report;</p> <p>b) the facility is unable to confirm if the person/persons who performed the annual portable fire extinguisher inspection are certified to inspect portable fire extinguishers.</p> <p>Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:30 p.m., confirmed the listed portable fire extinguisher</p>	K 0355		

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K 0355 SS=F	Continued from page 11 inspection deficiencies.	K 0355		
K 0908 SS=F	NFPA 101 Gas and Vacuum Piped Systems - Inspection and Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0908	908 main 2 1. A new vendor was contacted to complete the annual medical gas system inspection. 2. An ongoing audit is conducted and reviewed by the Director of maintenance or Designee to ensure continued annual medical gas system inspections, are completed.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0908 SS=F	Continued from page 12 Based on document review and interview, it was determined the facility failed to maintain medical gas requirements in one instance, affecting the entire facility. Findings include: 1. Review of Documentation on February 4, 2025, at 8:45 a.m., revealed the facility lacked documentation verifying that an annual medical gas system inspection was performed. Interview with the Facility Administrator on February 4, 2025, at 8:45 a.m. confirmed the medical gas system inspection documentation was not available at the time of survey.	K 0908		
K 0919 SS=D	NFPA 101 Electrical Equipment - Other Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 10 (NFPA 99)	K 0919	919 main 2 1. the refrigerator in the nursing office was moved to be plugged into the wall. 2. The Director of Maintenance or designee will audit for 2 weeks to ensure maintained compliance.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
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K 0919 SS=D	Continued from page 13 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain electrical wiring systems and equipment in one instance, affecting one of six smoke compartments. Findings include: 1. Observation on February 4, 2025, at 9:35 a.m., revealed a refrigerator was plugged into a power strip/surge protector in Room 805, Nursing Office. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the misuse of electrical wiring.	K 0919		



Certified End Page

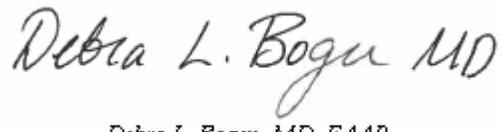
BRIGHTON REHABILITATION AND WELLNESS CENTER

STATE LICENSE NUMBER: 020802

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0000	INITIAL COMMENT Facility ID# 020802 Component 03 LTSR Building Based on a Medicare/Medicaid Recertification Survey completed on February 3-4, 2025, it was determined that Brighton Rehabilitation and Wellness Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type II (000), unprotected noncombustible building, without a basement, that is fully sprinklered.	K 0000		
K 0345 SS=F		K 0345		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K 0345 SS=F	Continued from page 1 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	345 LTSR 1. A new vendor was contracted to ensure a regulatory inspection deficiencies were corrected. A new vendor was contracted to ensure a regulatory semi-annual visual inspection of the fire alarm system is completed. 2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued bi-annual inspections and corrections, are completed.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

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K 0345 SS=F	Continued from page 2 Based on document review and interview, it was determined the facility failed to maintain the fire alarm system in two instances, affecting the entire facility. Findings include: 1. Review of documentation on Febraury 3, 2025, revealed the following fire alarm deficiencies: a) 9:00 a.m., the facility failed to provide documentation that showed corrections of deficiencies found on the annual fire alarm system inspection; b) 9:04 a.m., the facility failed to provide documentation for the semi-annual visual inspection of the fire alarm system. Interview with the Facility Administrator and Maintenance Director on Febraury 4, 2025, at 1:30 p.m., confirmed the facility could not provide documentation for the above listed deficiencies.	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0353 SS=F	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0353	<p>353</p> <p>1. A new vendor was contracted to ensure a regulatory semi-annual sprinkler inspection is completed. A new vendor was contracted to correct deficiencies identified in annual fire pump inspections. The ceiling tile was corrected.</p> <p>2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued semi-annual inspections and corrections, are completed.</p>	<p>Completion Date: 02/21/2025</p> <p>Status: APPROVED</p> <p>Date: 02/12/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: 020802		STREET ADDRESS, CITY, STATE, ZIP CODE: 246 FRIENDSHIP CIRCLE BEAVER, PA 15009		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0353 SS=F	<p>Continued from page 4</p> <p>Based on observation, document review, and interview, it was determined the facility failed to maintain the automatic sprinkler system in three instances, affecting the entire facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Document review on February 3, 2025, at 9:30 a.m., revealed the following automatic sprinkler system deficiencies. <ol style="list-style-type: none"> a) 9:30 a.m., facility failed to perform the semi-annual sprinkler system inspection that was due August of 2024; b) 9:31 a.m., the facility failed to correct deficiencies on the annual fire pump inspection. <p>Interview with the Facility Administrator and Director of Maintenance on February 4, 2025, at 1:30 p.m., confirmed the facility lacked documentation for the above listed items.</p> <ol style="list-style-type: none"> 2. Observation on February 4, 2025, at 9:45 a.m., revealed there was a missing ceiling tile in the janitor 	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: BRIGHTON REHABILITATION AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 246 FRIENDSHIP CIRCLE BEAVER, PA 15009		
STATE LICENSE NUMBER: 020802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0353 SS=F	Continued from page 5 closet located in LTSR. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:30 p.m., confirmed the above listed sprinkler deficiency.	K 0353		
K 0355 SS=F	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	355 1. A new vendor was contracted to complete the annual fire extinguisher inspection. The inspections are always performed by certified vendors/persons as identified by all past documentation available to the surveyors. 2. The Director of Maintenance or designee will monitor alongside the vendor to ensure continued annual inspections of fire extinguishers, are completed.	Completion Date: 02/21/2025 Status: APPROVED Date: 02/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: BRIGHTON REHABILITATION AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 246 FRIENDSHIP CIRCLE BEAVER, PA 15009		
STATE LICENSE NUMBER: 020802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0355 SS=F	Continued from page 6 Based on documentation review and interview, it was determined the facility failed to maintain portable fire extinguisher inspections in two instances, affecting the entire facility. In accordance with NFPA 10, 7.1.2.1. Findings include: 1. Review of documentation on February 3, 2025, at 8:30 a.m., revealed the following portable fire extinguisher inspection deficiencies: a) the facility failed to provide an annual portable fire extinguisher inspection report; b) the facility is unable to confirm if the person/persons who performed the annual portable fire extinguisher inspection are certified to inspect portable fire extinguishers. Interview with the Facility Administrator and Maintenance Director on February 4, 2025, at 1:30 p.m., confirmed the listed portable fire extinguisher inspection deficiencies.	K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: BRIGHTON REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 246 FRIENDSHIP CIRCLE BEAVER, PA 15009		
STATE LICENSE NUMBER: 020802					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
K 0355 SS=F	Continued from page 7	K 0355			



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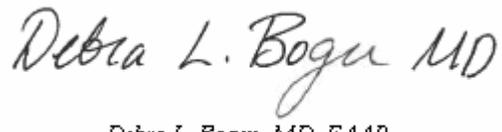
BRIGHTON REHABILITATION AND WELLNESS CENTER

STATE LICENSE NUMBER: 020802

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

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