STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395015	A. BUILDING _____ B. WING _____	04/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIGHTON REHABILITATION AND WELLNESS CENTER	246 FRIENDSHIP CIRCLE BEAVER, PA 15009

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to make certain social distancing was maintained by staff, properly store clean linens and soiled laundry, provide proper supplies to perform hand washing, properly store biohazardous waste, ensure sinks are accessible to perform handwashing, properly wear gloves and perform hand hygiene and create a clean and sanitary environment which created the potential for the cross-contamination and the spread of diseases and infections for seven of 11 nursing units (Grove 1, 2, 3 and 2 West and 2, 3 and 4 East Nursing Units). Findings include: Review of the facility policy Hand Hygiene dated 8/27/19, indicated that the purpose of hand hygiene is to decrease the risk of transmission of infection. Handwashing is performed when hands are visibly dirty or contaminated with proteinaceous material, are visible soiled with blood or other body fluids, before performing an invasive procedure, and after providing care to a resident. Review of the facility policy Cleaning, Disinfection and Sterilization dated 8/27/19, indicated that the purpose is to provide supplies and equipment that are adequately cleaned, disinfected or sterilized. Supplies and equipment will be cleaned immediately after use. Thermometers are cleaned with hospital disinfectant. Review of the facility policy Glove Use dated 8/27/19, indicated that gloves are disposable single-use and to perform hand hygiene after removing gloves. Gloves should be used when touching excretions, secretions, blood, body fluids, mucous membranes, handling potentially contaminated items, when hands will possible come in contact with blood, body fluids, or other potentially infectious material. Review of the facility policy Housekeeping Services dated 8/27/19, indicated that purpose is to promote a safe and sanitary environment and that regular scheduled environmental rounds should be done to monitor housekeeping, regulated medical waste and compliance to policy. During an observation on 4/17/20, at 2:55 p.m. of the building via the main entrance, numerous staff entered the building failing to maintain social distancing of at least 6 feet or more. During an interview on 4/17/20, at 3:15 p.m. the Nursing Home Administrator (NHA) confirmed the facility failed to practice proper social distancing which caused the potential of cross contamination and the spread of diseases and infections. During an observation on 4/17/20, from 4:18 p.m. through 4:32 p.m. of the Grove 1 Nursing Unit revealed the following: -Two clean linen carts in the hallway uncovered open to air. -double linen hamper with an open, blue bag tied to the side which contained residents soiled personal laundry in the hallway. -soiled utility room soap dispenser had a sign stating Broken push on handle and was stuck and did not dispense soap. During an interview on 4/17/20, at 4:34 p.m. the Assistant Director of Nursing (ADON) Employee E25 confirmed that the facility failed to properly store clean linens and soiled laundry and provide soap for hand washing which created the potential for cross-contamination and the spread of diseases and infections. During an observation on 4/17/20, from 4:35 p.m. through 4:43 p.m. of the Grove 2 Nursing Unit revealed the following: -soiled utility room over the hand washing sink was a large rubber floor matt blocking the sink. -no soap or paper towel dispensers. -sink in personal laundry- soap dispenser was empty. During an interview on 4/17/20, at 4:44 p.m. the ADON Employee E25 confirmed that the facility failed to provide proper supplies to perform hand washing which created the potential for cross-contamination and the spread of diseases and infections. During an observation on 4/17/20, from 4:45 p.m. through 4:55 p.m. of the Grove 3 Nursing Unit revealed the following: -hallway outside room [ROOM NUMBER] was a Broda Chair (reclining chair for resident comfort) which contained dried crusty substances on the seat and arms of the chair. -soiled utility room soap dispenser was empty. -numerous biohazardous bags on the floor open, spilling onto the floor. -window in soiled utility room was open and had no screen. During an interview on 4/17/20, at 4:58 p.m. the ADON Employee E25 confirmed that the facility failed to clean resident chair, provide proper supplies to perform handwashing and store biohazardous waste in a manner which created the potential for cross-contamination and the spread of diseases and infections. During an observation on 4/17/20, from 4:59 p.m. 5:04 p.m. of the 2 West Nursing Unit revealed the following: -Two clean linen carts in the hallway uncovered and open to air. -double linen hamper with an open, blue bag tied to the side which contained residents soiled personal laundry in the hallway. -soiled utility room handwashing and hopper (sink to flush and rinse bedpans) sinks was blocked by two trash cans and hampers. During an interview on 4/17/20, 5:04 p.m. ADON Employee E25 confirmed that the facility failed to properly store clean linen and soiled laundry, make certain that sinks are accessible to perform handwashing and properly dispose of waste in a manner to prevent cross-contamination and the spread of diseases and infections. During an observation on 4/17/20, from 5:05 p.m. through 5:35 p.m. of the 4 East Nursing Unit revealed the following: -Three clean linen carts in the hallway uncovered open to air. -shower room- on the shower curtain and floor was a brown substance. -soiled utility room (east side) sink was blocked by seven hampers and two trash cans. -sink had no soap in dispenser. -soiled utility room (west side) sink was blocked by boxes and two trash cans. -Solarium (dining room) two large soiled linen carts. During this same observation on 4/17/20, from 5:05 p.m. through 5:35 p.m., Nursing Assistant (NA) Employee E26 with gloved hands opened the soiled utility room door, removed gloves touched hair, removed gloves from pocket reapplied gloves without washing hands, removed towel from linen cart and cleaned brown substance off the floor in the shower room. During an interview on 4/17/20, at 5:35 p.m. Licensed Practical Nurse (LPN) Unit Manager E27 confirmed that the facility failed to properly store clean linens and soiled laundry, make certain that sinks are accessible to perform handwashing, create a clean environment, properly wear gloves and perform hand hygiene which created the potential for the cross-contamination, the spread of diseases and infections. During an observation on 4/17/20, from 5:37 p.m. through 6:00 p.m. of the 3 East Nurses Unit the following was observed: -two large soiled linen carts stored in the hallway. -on a table next to the soiled carts were five clear bags of clean lines open to air, falling out of the bags. -double linen hamper with an open, blue bag tied to the side which contained residents soiled personal laundry in the hallway. -toilet room (east side) three toilets had a brown substance on top, sides and the seat and three privacy curtains contained a brown substance on the surface. -in hallway outside room [ROOM NUMBER] was a pile of linens which was identified as dirty. -soiled utility room contained two trash cans and an open trash bag on the floor blocking the sink, the sink had a trash can lid on top of the sink and a shoe in the sink. -toilet room (west side) two of the three toilets had a brown substance on the floors and privacy curtains contained a brown substance on the surface. During an interview on 4/17/20, at 6:00 p.m. LPN Unit Manager E27 confirmed that the facility failed to properly store clean linens and soiled laundry, make certain that sinks are accessible to perform handwashing and create a clean environment which created the potential for cross-contamination and the spread of diseases and infections. During an observation on 4/17/20, from 6:05 p.m. through 6:10 p.m. of the 2 East Nurses Unit the following was observed: -two large soiled linen carts stored in the hallway. -double linen hamper with an open, blue bag tied to the side which contained residents soiled personal laundry in the hallway. -toilet room (east side) brown substance on brief on the floor, floor and privacy curtains had a brown substance on the surface. -soiled utility room contained a washcloth on the floor in a ball, with a brown substance, sink was blocked by two opened trash bags on the floor. During an interview on 4/17/20, at 6:15 p.m. LPN Unit Manager E27 confirmed that the facility failed to properly store soiled linens, make certain that sinks are accessible to perform handwashing and maintain a clean environment which created the potential for cross-contamination, spread of diseases and infections. 28 Pa. Code

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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