

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Pavilion at Brmc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Pleasant Street Bradford, PA 16701	

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)
<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that the attending physician documented required visits by writing, signing, and dating a physician progress note for each visit for four of 14 residents reviewed (Residents R1, R2, R6, and R30). Findings include: Facility policy entitled Physician Visit Scheduled dated 11/28/25, revealed All attending physicians will visit the residents of the Pavilion at BRMC once monthly and document a progress note relative to the MD visit. Resident R1 was admitted [DATE], with diagnoses that included Dementia (loss of cognitive functioning affecting a person's memory and behaviors), Wernicke Encephalopathy (Neurological Disorder caused by severe deficiency of thiamine leading to brain dysfunction. Commonly seen in people with chronic alcohol abuse, malnutrition and conditions that impair nutrient absorption), and High Blood Pressure. Resident R1's clinical record revealed physician progress notes dated and signed by the physician for 10/23/24, 7/16/25, 8/20/25, 9/18/25, 10/15/26/25, 11/26/25, 12/22/25, and 2/11/26. Clinical record lacked evidence of any physician progress notes being completed between 10/23/24, and 7/16/25, a period of nine months. Resident R2 was admitted [DATE], with diagnoses that included Bipolar Disorder (a mental health condition where you experience extreme mood swings that include emotional highs and lows. It causes significant shifts in mood, energy, activity levels, and concentration, affecting a person's overall functioning), Obstructive and Reflux Uropathy (occurs when the urine flow is blocked due to an obstruction and the urine flows backwards from the bladder into the kidneys), and Functional Quadriplegia (the complete inability to move all both arms and both legs due to severe disability or frailty from other medication condition, without injury to the brain or spinal cord). Resident R2's clinical record revealed the last physician progress note dated and signed by the physician was on 9/28/25. Clinical record lacked evidence of any physician progress notes being completed between 9/28/25, and 4/23/26, a period of seven months. Resident R6 was admitted [DATE], with diagnoses that included Conversion Disorder (also known as functional neurological disorder, is a condition in which psychological or emotional stress manifests as real, involuntary physical symptoms that cannot be explained by neurological or medication conditions), Gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and High Blood Pressure. Resident R6's clinical record revealed the last physician progress note dated and signed by the physician on 9/18/25. Clinical record lacked evidence of any physician progress notes being completed between 9/18/25, and 4/23/26, a period of seven months. Resident R30 was admitted [DATE], with diagnoses that included Dementia, Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and High Blood Pressure. Resident R30's clinical record lacked evidence of any physician progress notes being completed between 6/17/25, and 4/23/26, a period of ten months. During an interview on 4/23/26, at 9:02 a.m. the Nursing Home Administrator confirmed that Resident R1, R2, R6, and R30's clinical records lacked evidence of the required physician progress notes at the time of review. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.2 (d)(8) Medical director 28 Pa. Code 211.5 (f)(ii)(iv) Medical records</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and staff interview, it was determined that the facility failed to maintain sanitary operations and standards for food safety in one of two resident unit freezers reviewed (Third Floor). Findings include: Observations on 4/21/26, at 11:26 a.m. of the Third Floor freezer revealed two ice packs that are used for treatments on residents stored next to frozen microwave meals. During an interview on 4/21/26, at 11:26 a.m. Certified Nursing Assistant Employee E1 confirmed that the ice packs used as treatments for residents were in the freezer with food. He/she confirmed that ice packs used as treatments should not be stored in the same unit with food. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and Minimum Data set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), and staff interview, it was determined that the facility failed to ensure that MDS assessments accurately reflected the status of three of 14 residents reviewed (Residents R1, R6, and R10). Findings include: MDS instructions for section P0200 Alarms subsection E Wander / Elopement Alarm indicated to identify all alarms that were used at any time (day or night) during the seven-day look-back period and to code the frequency of use as not used, used less than daily, or used daily. The MDS instructions further indicated that a wander / elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exits sensors worn by/attached to the resident that activates an alarm and/or alert staff when the resident nears or exits a specific area of the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings. Resident R1 was admitted [DATE], with diagnoses that included Dementia (loss of cognitive functioning affecting a person's memory and behaviors), Wernicke Encephalopathy (Neurological Disorder caused by severe deficiency of thiamine leading to brain dysfunction. Commonly seen in people with chronic alcohol abuse, malnutrition and conditions that impair nutrient absorption), and High Blood Pressure. Resident R1's clinical record revealed a physician's order dated 8/23/24, for a wanderguard bracelet (an alarming security bracelet) to be worn at all times. Review of Treatment Administration Records (TAR) for February 2025, August 2025, and March 2026, revealed staff signage indicating the placement of a wanderguard bracelet was checked every shift for the entire month. Resident R1's quarterly MDS's with Assessment Reference Dates (ARD) of 2/24/25, 8/12/25, and 3/12/26, revealed that section P0200E was coded as Not Used. Resident R6 was admitted [DATE], with diagnoses that included Conversion Disorder (also known as functional neurological disorder, is a condition in which psychological or emotional stress manifests as real, involuntary physical symptoms that cannot be explained by neurological or medication conditions), Gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and High Blood Pressure. Resident R6's clinical record revealed a physician's order dated 9/3/24, for a wanderguard bracelet to be worn at all times. Review of TAR for February 2025, August 2025, and February 2026, revealed staff signage indicating the placement of a wanderguard bracelet was checked every shift for the entire month of February 2025, January 2026, and February 2026, and from August 1, 2025, through August 8, 2025, and August 13, 2025, through August 31, 2025. Resident R6's quarterly MDS with ARD 2/25/25, significant change MDS with ARD 8/18/25, and quarterly MDS with ARD 2/5/26, revealed that section P0200E was coded as Not Used. Resident R10 was admitted [DATE], with diagnoses that included Dementia, Diabetes (a health condition caused by the body's inability to produce enough insulin), and High Blood Pressure. Resident R10's clinical record revealed a physician's order dated 8/11/25, for a wanderguard bracelet to be worn at all times. Review of TAR for September 2025, and March 2026, revealed staff signage indicating the placement of a wanderguard was checked every shift for the entire month of September 2025, and March 2026. Resident R10's quarterly MDS's with ARD's 9/24/25, and 3/12/26, revealed that section P0200E was coded as Not Used. During an interview on 4/22/26, at 12:57 p.m. Registered Nurse Assessment Coordinator Employee E2 confirmed that MDS's indicated above for Residents R1, R6, and R10 were coded incorrectly regarding the usage of a wander / elopement alarm and should have been coded as Used Daily. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical Records</p>