STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395586	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradford Hills Nursing & Rehabilitation Center	15900 Route 6 Troy, PA 16947

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 29512 Based on observation, and staff interview, it was determined that the facility failed to ensure resident's privacy on one of five nursing units (2 [NAME] Nursing Unit). Findings include: Observation of the 2 [NAME] nursing unit on October 31, 2024, revealed the following: At 12:21 PM, Employee 1 returned to the medication cart, poured resident medications, and left again to go down the hallway. Employee 1 left a resident clinical record open and in full view/access to anyone choosing to access said record. At this time, one non-licensed staff member was in the vicinity of the medication cart and several residents were congregated near the medication cart and nurse's station. At 12:22 PM, Employee 1 returned to the medication cart, poured resident medications, and immediately left the vicinity of the medication cart. Employee 1 again left a resident's clinical record open and in full view/access to anyone. At 12:24 PM, Employee 1 returned to the medication cart and poured resident medications. At 12:37 PM, Employee 1 left the medication cart, walked to a resident sitting near the nurse's station, but out of sight of the medication cart. Employee 1 again left a resident's clinical record open and in full view/access to anyone. Employee 1 administered the resident's medication, returned to the medication cart, and poured more medications. At 12:38 PM, Employee 1 left the medication cart. Employee 1 again left a resident's clinical record open and in full view/access to anyone. Non-licensed staff were at the nurse's station at the time of the observation. At 12:44 PM, while Employee 1 was away from the medication cart in a resident's room the Nursing Home Administrator (NHA) approached the nurse's station and medication cart. The NHA observed and acknowledged that at resident's clinical record was open, in full view/access to anyone without any licensed staff in the vicinity. There were several residents and staff were nearby and had access/could potentially access the resident's clinical record. The NHA located Employee 1 in a resident's room and informed them that the resident's clinical was in full view while they were not in the vicinity of the cart. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:45 PM, Employee 1 returned to the medication cart. Interview and concurrent observation on October 31, 2024, at 12:44 PM, with the Nursing Home Administrator and confirmed the above findings. 28 Pa. Code 201.29 (c.3)(4) Resident rights

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 29512 Based on observation and staff interview, it was determined that the facility failed to ensure appropriate medication security on one of five nursing units (2 [NAME] nursing unit). Findings include: Observation of the 2 [NAME] nursing unit on October 31, 2024, revealed the following: At 11:12 AM upon arrival to the 2 [NAME] nursing unit the surveyor observed the unit's medication cart was unlocked while it was near the nurse's station. No licensed staff were observed in the vicinity. There were several residents congregated near the nurse's station. At 11:13 AM Employee 1, licensed practical nurse, returned to the medication cart from down the hallway and out of view of the medication cart. At 12:02 PM the surveyor observed the unit's medication cart unlocked in the same location as above. No licensed staff were observed in the vicinity. There were several residents congregated near the nurse's station. At 12:04 PM Employee 1 returned to the medication cart from down the hallway and out of view of the medication cart, removed medications, and left the vicinity of the medication cart. At 12:11 PM Employee 1 returned to the medication cart, identified a residents call bell was ringing across from the nurse's station, immediately responded to the call bell, went to the nursing unit's kitchen area, then returned to the medication cart. At 12:13 PM Employee 1 poured resident medications and went down the hallway out of sight of the medication cart. At 12:16 PM Employee 1 returned to the medication cart. At 12:19 PM Employee 1 poured resident medications and went down the hallway out of sight of the medication cart. At this time four non-licensed staff were in in the vicinity of the medication cart. At 12:21 PM Employee 1 returned to the medication cart, poured resident medications, and left again to go down the hallway out of sight of the medication cart. At this time, one non-licensed staff member was in the vicinity of the medication cart. At 12:22 PM Employee 1 returned to the medication cart, poured resident medications, and immediately left the vicinity of the medication cart. At 12:24 PM Employee 1 returned to the medication cart and poured resident medications. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:37 PM Employee 1 left the medication cart, walked to a resident sitting near the nurse's station, but out of sight of the medication cart, administered their medication, returned to the medication cart, and poured more medications. At 12:38 PM Employee 1 left the medication cart. Non-licensed staff were at the nurse's station at the time of the observation. At 12:44 PM while Employee 1 was away from the medication cart in a resident's room the Nursing Home Administrator (NHA) approached the nurse's station and medication cart. The NHA observed and acknowledged that the 2 [NAME] nursing unit's medication cart was unlocked without any licensed staff in the vicinity while several residents and staff were nearby and had access to medications. The NHA located Employee 1 in a residents room and informed them that the medication cart was unlocked when they were not in the vicinity of the cart. At 12:45 PM Employee 1 returned to the medication cart and locked the cart. From 12:02 PM to 12:45 PM (43 minutes) Employee 1 left the 2 [NAME] nursing unit's medication cart unlocked while they poured and passed medications to residents located away from the medication cart. Employee 1 did not have direct visualization of the medication cart for 23 minutes of this observation. 28 Pa. Code 211.9(k) Pharmacy services 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services