

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Bradford Hills Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on clinical record review and staff and resident interview, it was determined that the facility failed to ensure self-determination for resident's choices related to shower preference for bathing for one of four residents reviewed (Resident 1). Findings include: A review of the census revealed that Resident 1 was admitted to the facility on [DATE]. An interview with Resident 1 on February 18, 2025, at 12:20 PM revealed that the resident stated that he had not received a shower since arrival in the facility and he and staff utilize wipes to bathe him. Clinical record review for Resident 1 revealed an admission Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated January 8, 2025, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 14, which indicated no cognitive impairment. The MDS revealed that the resident was dependent on staff for bathing. Further review of the MDS noted that the resident indicated that choosing between a tub bath, shower, bed bath, or sponge bath, was somewhat important. Review of the current care plan for Resident 1 revealed an activities of daily living (ADL) self-care deficit. The care plan noted that the resident is total dependence on staff for bathing and listed an intervention as a Shower Tuesday and Saturday during the day. Nursing documentation dated January 7, 2025, at 7:44 AM noted the resident prefers a shower Tuesday and Saturday. The task list (located in the electronic health record where staff document specific care related events for a resident) for Resident 1 indicated shower/bath on Tuesdays/Saturdays and the resident's preference is a shower. A review of the task list for Resident 1 for the last 30 days revealed staff documented the resident as receiving a Bed/Towel Bath on the following dates: January 21, 2025, at 5:23 AM (continued on next page)		

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
FORM CMS-2567 (02/99) Event ID: Facility ID: If continuation sheet Previous Versions Obsolete 395586 Page 1 of 3		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	January 23, 2025, at 3:29 PM January 25, 2025, at 3:29 PM January 26, 2025, at 3:29 PM February 2, 2025, at 2:42 PM February 6, 2025, at 10:51 PM February 9, 2025, at 2:56 PM February 17, 2025, at 11:29 PM There were no showers given, as per resident preference, documented under the task list. Further review of the clinical record revealed no evidence was documented to indicate Resident 1 refused a shower, there was a wound preventing a shower, an injury preventing a shower, or any other rationale. An interview with the Director of Nursing on February 18, 2025, at 2:05 PM revealed that the facility could not provide any evidence why Resident 1's preference for a shower was not honored. The Nursing Home Administrator and Director of Nursing were informed of the above findings on February 18, 2025, at 3:45 PM. 28 Pa. Code 201.29 (a) Resident rights 28 Pa. Code 211.12 (d)(5) Nursing services		

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure complete and accurate clinical documentation for one of seven residents reviewed (Resident CR1). Findings include: Closed clinical record review for Resident CR1 revealed the resident was admitted to the facility on [DATE], at 4:30 PM and signed out of the facility against medical advice on January 26, 2025, at 9:13 PM. Closed clinical record review for Resident CR1 revealed a diagnosis list that included Type Two Diabetes Mellitus (a condition where the body cannot properly regulate blood sugar which results in an abnormally high blood sugar levels). Clinical record review for Resident CR1 revealed a physician's order on the Medication Administration Record and Treatment Administration Record (MAR/TAR where staff document the administration of medications and treatments) dated January 26, 2025, at 9:00 AM that instructed staff to obtain a blood sugar four times a day for diabetes monitoring. Further review of the MAR/TAR revealed that staff documented with a checkmark (which indicated completed) on January 26, 2025, at 9:00 AM, 12:00 PM, and 5:00 PM. However, there were no values noted. Facility documentation titled Weights and Vitals Summary, noted a blood sugar documented as 210 mg/dL(milligrams per deciliter) on January 26, 2025, at 6:15 PM. However, the facility could not provide any evidence of the values of the other two blood sugars that were documented as obtained. An interview with the Nursing Home Administrator on February 18, 2025, at 12:15 PM revealed that the facility could not provide documentation on the additional two missing blood sugar values that were documented as obtained. An interview with Employee 1, licensed practical nurse, on February 18, 2025, at 12:32 PM revealed Employee 1 had documented the blood sugars as measured, which was indicated with a checkmark on the MAR/TAR at the specified times in the electronic health record. However, was unable to pull up the values of the missing blood sugar measurements that Employee 1 also stated were entered at the specified times. The facility failed to ensure a complete and accurate clinical record for Resident CR1. The Nursing Home Administrator and Director of Nursing were informed of the above on February 18, 2025, at 3:45 PM. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		