

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  02/10/2026
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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>Based on closed clinical record review and staff interview, it was determined that the facility did not honor the right of a resident representative to make decisions regarding a residents transfer to the hospital for one of three residents reviewed (Resident CR1). Findings include: Closed clinical record review for Resident CR1 revealed the resident had an MDS (Minimum Data Set, an assessment completed at periodic intervals of time to determine care needs) completed on November 18, 2025, in which facility staff assessed the resident has having a BIMS (brief interview of mental status) score of seven, indicating severe cognitive impairment. Review of a court order in Resident CR1's closed record dated December 23, 2025, revealed the resident was noted as an incapacitated (not able to make decisions for himself) person and the resident's son was the permanent guardian for the resident. The son was listed as the resident's responsible party. Resident CR1 sustained a fall on December 25, 2025, at 9:16 AM. The resident was found sitting on the floor in his room and indicated he was attempting to go to the bathroom. The resident requires the use of an assistive device and one person assistance. It was noted that the resident attempted to self-transfer. Assessments were noted as completed on Resident CR1 with no injuries noted. Nursing documentation revealed that staff left a message for Resident CR1's responsible party regarding the fall at 11:21 AM on December 25, 2025. It was later noted the responsible party returned the call to the facility at 12:00 PM, and he had no questions regarding the incident. At 12:45 PM on December 25, 2025, facility staff received a call from the 911 dispatch center indicating Resident CR1's responsible party had called 911 indicating the resident had a fall earlier that day and felt the resident needed checked on. Facility staff indicated the resident was being monitored per protocol and upon checking on the resident the resident denied any pain or hurts. The 911 facility did not dispatch to the facility nor was the resident transferred to the hospital. There was no evidence of any follow up or attempted communication from facility staff to Resident CR1's responsible party after the call from the 911 center to discuss the resident condition or desire for the resident to receive emergency services/transfer to the hospital as the responsible party self-initiated for the resident. There was no evidence that facility staff provided the right to the resident's responsible party to transfer the resident to the hospital as desired. The above information was reviewed with the Nursing Home Administrator on February 9, 2026, at 5:15 PM. 28 Pa. Code 201.14(a) Responsibility of licensee</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
---	-------	-----------