STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395355	A. BLDG: 00 B. WING:	12/06/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PAVILION AT BRMC, THE STATE LICENSE NUMBER: **024702**	**200 PLEASANT STREET** **BRADFORD, PA 16701**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and a Civil Rights Compliance Survey completed on December 6, 2024, it was determined that The Pavilion at Bradford Regional Medical Center (BRMC), was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0600 SS=G		F 0600		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0600 SS=G	Continued from page 1 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On 9/27/24, The DON (Director of Nursing) met with Employee 1, Employee 2 and the staff on 2nd floor and educated them not to leave Resident R5 on the toilet unattended. The residents care plan was reviewed and updated to reflect new toileting status. - How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with a BIMS (Brief Interview for Mental Status) of less than eight (8) have the potential to be impacted. On 10/16/2024 the facility completed staff training regarding the safety risks associated with leaving residents unattended while on the toilet. A whole house resident BIMS audit was completed by the DON on 12/17/2024 to identify residents considered to have severe impairment (a BIMS	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/02/2025**

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F 0600 SS=G	Continued from page 2	F 0600	score of 0-7). Any current resident, new admissions, or resident reviewed during the care planning process identified with a BIMS of 0-7 will have their care plans updated to reflect supervision while on the toilet. -What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? The facility will identify those residents with severe impairment and the DON will place a GOLD star on the nameplate outside of the resident room and with a GOLD star above the resident bed. The facility will update the Fall Prevention and Investigation Policy to reflect the addition of the star. Whole house staff education on the change will be completed by the DON. The updated fall policy will be reviewed during our New Employee Orientation. The facility will continue to monitor its fall prevention program during weekly fall prevention meetings to ensure proper fall prevention procedures are in line with the	

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F 0600 SS=G	Continued from page 3	F 0600	facility fall protocol to include utilizing the stars on the door nameplate and above the headboard. The facility will continue to provide staff education on Abuse, Neglect, Exploitation and Misappropriation of Property through our online education portal while also offering an in-person Abuse education on January 14th, 2025 provided by the Pavilion's Social Service Director and on February 25th, 2025 with the Department of Human Services Area Agency on Aging. - How the corrective action will be monitored to ensure that the deficient practice will not recur: i.e., what quality assurance programs will be accomplished? The prior week's resident fall event reports will be audited at the weekly fall prevention meeting to assess for resident care plan compliance and if modifications are needed. Audit results will be reported at the facility Quality Assurance Performance Improvement and Kaleida Health Quality Improvement Patient Safety monthly committees.	

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F 0600 SS=G	Continued from page 4	F 0600	Weekly audits will continue until 12 consecutive weeks of 90% compliance has been achieved. Modification may be made to the plan of correction to improve compliance. Changes will be reported to the facility QAPI monthly meeting.	

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F 0600 SS=G	Continued from page 5 Based on review of facility policies, facility documentation and clinical record, and resident and staff interviews, it was determined that the facility failed to ensure that one of 19 residents reviewed was free of neglect during care (Resident R5). Findings include: Review of facility policy entitled "Resident abuse, neglect, exploitation, and misappropriation of resident property policy," last reviewed 12/28/2023, revealed "Neglect: The indifference or disregard for resident care, comfort or safety, resulting in or may result in physical harm, pain, mental anguish, or emotional distress. neglect occurs when the facility is aware of, or should have been aware of goods or services that a resident requires but the facility fails to provide them to the resident resulting in, or may result in physical harm, pain, mental anguish, or emotional distress." Review of facility policy entitiled "Fall Protocol," with a policy review date of 12/28/2023, revealed	F 0600		

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F 0600 SS=G	Continued from page 6 that it is the policy of the Pavilion at BRMC to make every attempt at preventing residents from falling. Review of Resident R5's clinical record revealed an admission date 2/14/2011, with diagnoses that included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), major depressive disorder (a mental disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), history of seizures, muscle weakness, hearing loss, chronic pain, history of falling, age related physical debility, and macular degeneration (an eye disease that causes vision loss). Review of Resident R5's Activities of Daily Living (ADL) related care plan originally dated 5/4/2020 and last reviewed 7/24/2024, revealed "resident has an ADL self-care performance deficit related to confusion, poor vision, and extreme hard of hearing (HOH)." Toilet transfer is dependent. Transfers requires extensive assistance of two staff members.	F 0600		

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F 0600 SS=G	Continued from page 7 Toilet use: is an extensive assist of 1-2 assist for toileting and has stress incontinence. Review of R5's Minimum Data Set (MDS-a periodic assessment of resident care needs) Assessment Section GG Functional Abilities and Goals last updated 7/16/2024, revealed that Section GG0130 Self-care revealed Toileting Hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement, identified that Resident R5 required Substantial/maximal assistance; Section GG0170 F: toilet transfer: the ability to get on and off a toilet or commode revealed that Resident R5 required partial/moderate assistance. Section C Cognitive Patterns revealed that section C0500 brief interview for mental status (BIMS) summary score revealed a score of 01, indicating cognitive impairment. Review of Resident R5's progress notes from 9/26/2024, at 3:05 p.m. revealed, "This writer called to second floor for resident observed on bathroom floor. Resident assessed and found to	F 0600		

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F 0600 SS=G	Continued from page 8 have bruising to front and back of head, and both knees, with the left knee being significantly swollen. MD [Medical Doctor] notified and orders obtained to send resident to ER [Emergency Room] for evaluation. Son notified and agreeable. Report called to ER, and resident transported to ER via stretcher." Review of Resident R5's CT scan report of the cervical spine without contrast dated 9/26/2024, at 4:24 p.m. revealed an acute nondisplaced (broken bone where pieces of bone didn't move far enough to be out of alignment) type 2 dens fracture (Fracture at the base of the odontoid process [also called the dens] which is a bony projection on the C2 vertebrae in the neck) During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 12/5/2024, at approximately 1:30 p.m., it was confirmed that a Nurse Aide (NA) employee assisted Resident R5 into the restroom to use the toilet. Resident R5 was assisted onto the toilet and	F 0600		

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F 0600 SS=G	Continued from page 9 was left unattended in the restroom. Employees were at change of shift and report was given to the next shift. The resident was found on the floor in the restroom by the next shift staff members. Review of a witness statement to the DON and NHA on 9/27/2024 by NA Employee E1, revealed the following information: it was at the end of the shift and Resident R5 came out from the activity and asked if she could be taken to the bathroom. On coming NA's and off going NA's were at the nurse's station and were giving one another report prior to the end of the shift. NA Employee E1 took Resident R5 to the bathroom and stood in the doorway of the bathroom. NA Employee E1 then proceeded to the room doorway and told the evening shift staff members that Resident R5 was on the toilet in the bathroom and would need assisted off. Staff acknowledged that Resident R5 was on the toilet in the bathroom and NA Employee E1 stated that she was going to go home. Interviews with staff members by the DON and	F 0600		

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F 0600 SS=G	Continued from page 10 NHA that worked the evening shift did acknowledge that NA Employee E1 did pass along that Resident R5 was in the bathroom. Review of a witness statement dated 9/26/2024, from NA Employee E2, who found Resident R5 in the bathroom on 9/26/2024, revealed, "I came onto the floor got report, and started getting my list of residents up and ready for dinner. When I entered Room 224, I heard groaning in the bathroom and upon entering saw [Resident R5] on his/her front on the floor with head and shoulders under the wheelchair, not stuck on anything. I called for the nurse without leaving the resident. Found [Resident R5] on the floor at 2:40 p.m." Review of a witness statement dated 9/27/2024, from NA Employee E3, revealed "I worked 6-2 Thursday, 9/26/2024. [Resident R5] got up for lunch. She was in the dining room for lunch. Then when bingo began, [Resident R5] told the activities director that she needed to go to the bathroom. [NA Employee E1] said he/she would take	F 0600		

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F 0600 SS=G	Continued from page 11 [Resident R5] to the bathroom. Second shift came in and was given report and told that [Resident R5] was on the toilet. The day shift NA's left the floor." During interviews on 12/6/2024, at 9:45 a.m. with NA Employee E4, NA Employee E5, NA Employee E6, and NA Employee E3 it was confirmed that the nursing staff was re-educated regarding fall safety and assisting residents when in the restroom. Resident plans of care are reviewed for levels of assistance and care with baths. All employees interviewed revealed that residents are not to be left unmonitored in the restroom for safety purposes. An interview conducted with Licensed Practical Nurse (LPN) Employee E7 on 12/6/2024, at 10:00 a.m. revealed that it is not the practice of the nursing staff to leave residents in the bathroom unattended. Staff should always be aware someone is in the bathroom to watch or monitor resident for safety. Resident plans of care are reviewed for levels of assistance and care with toileting.	F 0600		

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F 0600 SS=G	Continued from page 12 During an interview with the DON and NHA on 12/5/2024, at approximately 2:30 p.m. it was confirmed that Resident R5 was placed in the restroom unattended by NA Employee E1 and then was left unattended in the bathroom of Room 224 at change of shift with Resident R5 being found on the floor resulting in a neck fracture. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0600		
F 0689 SS=G		F 0689		

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F 0689 SS=G	Continued from page 13 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On 9/27/24, The DON (Director of Nursing) met with Employee 1, Employee 2 and the staff on 2nd floor and educated them not to leave Resident R5 on the toilet unattended. The residents care plan was reviewed and updated to reflect new toileting status. - How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with a BIMS (Brief Interview for Mental Status) of less than eight (8) have the potential to be impacted. On 10/16/2024 the facility completed staff training regarding the safety risks associated with leaving residents unattended while on the toilet. A whole house resident BIMS audit was completed by the DON on 12/17/2024 to identify residents considered to have severe impairment (a BIMS	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/02/2025**

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F 0689 SS=G	Continued from page 14	F 0689	score of 0-7). Any current resident, new admissions, or resident reviewed during the care planning process identified with a BIMS of 0-7 will have their care plans updated to reflect supervision while on the toilet. -What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? The facility will identify those residents with severe impairment and the DON will place a GOLD star on the nameplate outside of the resident room and with a GOLD star above the resident bed. The facility will update the Fall Prevention and Investigation Policy to reflect the addition of the star. Whole house staff education on the change will be completed by the DON. The updated fall policy will be reviewed during our New Employee Orientation. The facility will continue to monitor its fall prevention program during weekly fall prevention meetings to ensure proper fall prevention procedures are in line with the	

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F 0689 SS=G	Continued from page 15	F 0689	facility fall protocol to include utilizing the stars on the door nameplate and above the headboard. The facility will continue to provide staff education on Abuse, Neglect, Exploitation and Misappropriation of Property through our online education portal while also offering an in-person Abuse education on January 14th, 2025 provided by the Pavilion's Social Service Director and on February 25th, 2025 with the Department of Human Services Area Agency on Aging. - How the corrective action will be monitored to ensure that the deficient practice will not recur: i.e., what quality assurance programs will be accomplished? The prior week's resident fall event reports will be audited at the weekly fall prevention meeting to assess for resident care plan compliance and if modifications are needed. Audit results will be reported at the facility Quality Assurance Performance Improvement and Kaleida Health Quality Improvement Patient Safety monthly committees.	

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PAVILION AT BRMC, THE STATE LICENSE NUMBER: **024702**	**200 PLEASANT STREET BRADFORD, PA 16701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 16	F 0689	Weekly audits will continue until 12 consecutive weeks of 90% compliance has been achieved. Modification may be made to the plan of correction to improve compliance. Changes will be reported to the facility QAPI monthly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=G	Continued from page 17 Based on review of facility policy, clinical records, facility documentation, and staff interview, it was determined that the facility failed to provide proper resident supervision during toileting that resulted in a fall with actual harm of a fracture of the neck (C2 vertebrae) for one of 19 residents reviewed (Resident R5). Findings include: Review of facility policy entitiled "Fall Protocol," with a policy review date of 12/28/23, revealed that it is the policy of the Pavilion at BRMC to make every attempt at preventing residents from falling. Review of Resident R5's clinical record revealed an admission date of 2/14/2011, with diagnoses that included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), major depressive disorder (a mental disorder characterized by persistently depressed mood or loss of interest in activities, causing	F 0689		

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F 0689 SS=G	Continued from page 18 significant impairment in daily life), history of seizures, muscle weakness, hearing loss, chronic pain, history of falling, age related physical debility, and macular degeneration (an eye disease that causes vision loss). Review of Resident R5's Activities of Daily Living (ADL) related care plan originally dated 5/4/2020 and last reviewed 7/24/2024, revealed "resident has an ADL self-care performance deficit related to confusion, poor vision, and extreme hard of hearing (HOH)." Toilet transfer is dependent. Transfers requires extensive assistance of two staff members. Toilet use: is an extensive assist of 1-2 assist for toileting and has stress incontinence. Review of Resident R5's Minimum Data Set (MDS-a periodic assessment of resident care needs) Assessment Section GG Functional Abilities and Goals last updated 7/16/2024, revealed that Section GG0130 Self-care revealed Toileting Hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a	F 0689		

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F 0689 SS=G	Continued from page 19 bowel movement, identified that Resident R5 required Substantial/maximal assistance; Section GG0170 F: toilet transfer: the ability to get on and off a toilet or commode revealed that Resident R5 required partial/moderate assistance. Section C Cognitive Patterns revealed that section C0500 brief interview for mental status (BIMS) summary score revealed a score of 01, indicating cognitive impairment. Review of Resident R5's progress notes from 9/26/2024, at 3:05 p.m. revealed, "This writer called to second floor for resident observed on bathroom floor. Resident assessed and found to have bruising to front and back of head, and both knees, with the left knee being significantly swollen. MD [Medical Doctor] notified and orders obtained to send resident to ER [Emergency Room] for evaluation. Son notified and agreeable. Report called to ER, and resident transported to ER via stretcher." Review of Resident R5's CT scan report of the	F 0689		

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F 0689 SS=G	Continued from page 20 cervical spine without contrast dated 9/26/2024, at 4:24 p.m. revealed an acute nondisplaced (broken bone where pieces of bone didn't move far enough to be out of alignment) type 2 dens fracture (Fracture at the base of the odontoid process [also called the dens] which is a bony projection on the C2 vertebrae in the neck) During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 12/5/2024, at approximately 1:30 p.m., it was confirmed that a Nurse Aide (NA) employee assisted Resident R5 into the restroom to use the toilet. Resident R5 was assisted onto the toilet and was left unattended in the restroom. Employees were at change of shift and report was given to the next shift. The resident was found on the floor in the restroom by the next shift staff members. Review of a witness statement to the DON and NHA on 9/27/2024 by NA Employee E1, revealed the following information: it was at the end of the shift and Resident R5 came out from the activity and	F 0689		

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F 0689 SS=G	Continued from page 21 asked if she could be taken to the bathroom. On coming NA's and off going NA's were at the nurse's station and were giving one another report prior to the end of the shift. NA Employee E1 took Resident R5 to the bathroom and stood in the doorway of the bathroom. NA Employee E1 then proceeded to the room doorway and told the evening shift staff members that Resident R5 was on the toilet in the bathroom and would need assisted off. Staff acknowledged that Resident R5 was on the toilet in the bathroom and NA Employee E1 stated that she was going to go home. Interviews with staff members by the DON and NHA that worked the evening shift did acknowledge that NA Employee E1 did pass along that Resident R5 was in the bathroom. Review of a witness statement dated 9/26/2024, from NA Employee E2, who found Resident R5 in the bathroom on 9/26/2024, revealed, "I came onto the floor got report, and started getting my list of residents up and ready for dinner. When I entered	F 0689		

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F 0689 SS=G	Continued from page 22 Room 224, I heard groaning in the bathroom and upon entering saw [Resident R5] on his/her front on the floor with head and shoulders under the wheelchair, not stuck on anything. I called for the nurse without leaving the resident. Found [Resident R5] on the floor at 2:40 p.m." Review of a witness statement dated 9/27/2024, from NA Employee E3, revealed "I worked 6-2 Thursday, 9/26/2024. [Resident R5] got up for lunch. She was in the dining room for lunch. Then when bingo began, [Resident R5] told the activities director that she needed to go to the bathroom. [NA Employee E1] said he/she would take [Resident R5] to the bathroom. Second shift came in and was given report and told that [Resident R5] was on the toilet. The day shift NA's left the floor." During interviews on 12/6/2024, at 9:45 a.m. with NA Employee E4, NA Employee E5, NA Employee E6, and NA Employee E3 it was confirmed that the nursing staff was re-educated regarding fall safety and assisting residents when in	F 0689		

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F 0689 SS=G	Continued from page 23 the restroom. Resident plans of care are reviewed for levels of assistance and care with baths. All employees interviewed revealed that residents are not to be left unmonitored in the restroom for safety purposes. An interview conducted with Licensed Practical Nurse (LPN) Employee E7 on 12/6/2024, at 10:00 a.m. revealed that it is not the practice of the nursing staff to leave residents in the bathroom unattended. Staff should always be aware someone is in the bathroom to watch or monitor resident for safety. Resident plans of care are reviewed for levels of assistance and care with toileting. During an interview with the DON and NHA on 12/5/2024, at approximately 2:30 p.m. it was confirmed that Resident R5 was placed in the restroom unattended by NA Employee E1 and then was left unattended in the bathroom of Room 224 at change of shift with Resident R5 being found on the floor resulting in a neck fracture.	F 0689		

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F 0689 SS=G	Continued from page 24 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0689		

Certified End Page

PAVILION AT BRMC, THE

STATE LICENSE NUMBER: 024702

SURVEY EXIT DATE: 12/06/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY