

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

Printed: 07/18/2026
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 12/12/2025
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.			
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review, review of select facility policies and procedures, and staff and resident interview, it was determined that the facility failed to ensure that pain management was provided that was consistent with professional standards of practice for one of two residents reviewed for pain (Resident 3). Findings include: The facility policy entitled Pain-Clinical Protocol, last reviewed without changes April 2, 2025, revealed the physician and staff will identify individuals who have pain, or who are at risk for having pain. The nursing staff will assess residents for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain. The staff will reassess the individual's pain and related consequences for acute pain or significant changes in levels of chronic pain or if pain medications are not providing acceptable pain relief. If there are more than occasional analgesic requests, or the resident is not having pain relief of as needed analgesics, the physician will consider changing to regular administration of at least one analgesic with another medication for PRN (as needed) use, increasing the standing dose of an existing analgesic, switching to another analgesic, and/or adding nonpharmacological measures. If the resident's pain is complex or not responding to standard interventions, the attending physician may consider additional consultative support. Interview with Resident 3 on September 30, 2025, at 1:36 PM revealed that she has pain daily, and she stated at times the pain can be severe. Clinical record review revealed the facility admitted Resident 3 on February 27, 2025. The facility developed a care plan initiated on February 27, 2025, that noted Resident 3 has pain related to a femur fracture of her right lower extremity. Resident 3's clinical record revealed the following medications to address her pain on the July and August 2025 Medication Administration Records (MAR, a form utilized by the facility to document the administration of medications): Buprenorphine Transdermal patch (pain patch used to treat and persistent pain) weekly 10 mcg (microgram) every Tuesday Tylenol 650 milligrams (mg) every four hours as needed for mild pain (1-3) Hydromorphone HCl (opioid medication used to treat moderate to severe pain) 4 mg, one tablet every 12 hours as needed for moderate to severe pain (4-10) Resident 3 received the Hydromorphone 50 times for moderate to severe pain from July 1 to 31, 2025. The routine pain rating assessment by staff every 12 hours on these dates revealed that 32 out of the 62 times Resident 3 assessed her pain as moderate to severe at the time of the assessment. Resident 3 received the Hydromorphone 48 times for moderate to severe pain from August 1 to 31, 2025. The routine pain rating assessed by staff every 12 hours on these dates revealed that 37 out of the 62 times Resident 3 assessed her pain as moderate to severe at the time of the assessment. The facility failed to ensure Resident 3's pain was managed consistent with professional standards of practice. The surveyor reviewed the above information during an interview with the Nursing Home Administrator and Director of Nursing on December 12, 2025, at 10:37 AM 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

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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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to ensure a medication error rate below five percent (Residents 13 and 17). Findings include: The facility's medication error rate was 23 percent based on 38 medication opportunities with nine medication errors. Interview with Employee 1 (registered nurse) on December 10, 2025, at 9:24 AM during the observation of the preparation of medications for administration to Resident 17, revealed that Employee 1 did not have artificial tears (liquid medication administered in the eye for lubrication to treat dryness of the eye) or Lidocaine patches (topical anesthetic to treat pain) included with the medications for the 9:00 AM medication pass because they were not available in the medication cart. Employee 1 did not report any other medications held due to unavailability. Employee 1 verified that she prepared 11 tablets of medication for Resident 17 on December 10, 2025, at 9:26 AM, which agreed with the quantity recorded by the surveyor. Clinical record review for Resident 17 revealed active physician orders to receive the following: Pyridoxine HCL (vitamin B6 supplement) tablet 100 mg (milligrams) give one tablet by mouth one time a day Loratadine oral tablet (antihistamine used to relieve allergy symptoms, no milligram dose specified; however, is provided as a stock over-the-counter medication as a 10 mg per tablet dose) one tablet by mouth one time a day Fluticasone Propionate (Flonase, steroidal nasal spray used to treat allergy symptoms) nasal spray give two sprays in both nostrils every day Fluticasone-Umeclidin-Vilant (Trelegy Ellipta, combination steroidal medication inhaled to open airways and treat obstructive lung disease) inhalation aerosol powder one inhalation one time a day Review of Resident 17's medication administration record (MAR, electronic system used by the facility to document the administration of medications) revealed that the above four medications were scheduled for 9:00 AM daily. Interview with Employee 1 on December 10, 2025, at 11:40 AM confirmed that she did not initial the administration of the four above medications for Resident 17, she did not give them. Employee 1 indicated that the electronic medication administration system automatically entered, U-SA, for the administration of the Flonase nasal spray as it is indicated as self-administered by Resident 17 and kept at her bedside. Observation of Resident 17's bedside stand and interview with Resident 17 on December 10, 2025, at 11:53 AM revealed that she did not have the Flonase medication in her room. Resident 17 stated that she did not take the Flonase medication that morning. Employee 1 located a bottle of Ipratropium Bromide (generic Atrovent, short-acting anticholinergic medication used to dilate airways) nasal spray in an unlocked drawer in Resident 17's bedside stand. Resident 17 stated that she would use that nasal spray if she needed it. Review of Resident 17's clinical record revealed no physician orders for Resident 17 to self-administer the Ipratropium Bromide nasal spray. The surveyor reviewed the above four medication errors for Resident 17 during an interview with the Nursing Home Administrator and the Director of Nursing on December 10, 2025, at 2:00 PM. Interview with the Director of Nursing on December 11, 2025, at 12:20 PM revealed that the facility had no evidence of an assessment completed to confirm Resident 17 was capable of self-administration of medications. The interview confirmed that the maintenance staff supplied Resident 17 a key to a lockable drawer in her bedside stand after the surveyor's medication administration observation. The Ipratropium Bromide medication was removed from Resident 17's room. Observation of the medication administration pass for Resident 13 on December 10, 2025, at 9:42 AM revealed Employee 1 prepared medications that included: Amlodipine Besylate (medication used to lower blood pressure, hypertension) 10 mg, one tablet Carvedilol (medication used to lower blood pressure) 6.25 mg, one tablet Acetaminophen arthritis pain (Tylenol, extended release over-the-counter pain medication) 650 mg, two tablets Sodium bicarbonate (chemical compound that neutralizes stomach acid and acts as an antacid) 325 mg, one tablet Iron 65 Fe (iron supplement that contains 65 mg of elemental iron which is equivalent to 325 mg of ferrous sulfate), five tablets Interview with Employee 1 on December 10, 2025, at 9:52 AM verified that she prepared a total of 25 tablets of medication, which agreed with the number recorded by the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor. Resident 13 then took the medications handed to her. Clinical record review for Resident 13 revealed the following active physician orders: Tylenol Eight Hour Arthritis Pain Oral Tablet Extended Release 650 mg one tablet by mouth twice daily for pain management.Sodium Bicarbonate Oral Tablet 650 mg give one tablet by mouth two times daily for hyperkalemia (elevated potassium levels in the blood)Ferrous Sulfate Tablet 325 (65 Fe) mg give one tablet by mouth one time a day for supplementationCarvedilol Tablet 6.25 mg give one tablet by mouth two times a day for hypertension; hold if systolic blood pressure (the top number in a blood pressure reading, representing the pressure in your arteries when your heart beats) is less than 100Amlodipine Besylate Tablet 10 mg give one tablet by mouth one time a day for hypertension; hold if systolic blood pressure is less than 100 Interview with Employee 1 on December 10, 2025, at 11:47 AM revealed that she did not have a blood pressure assessment for Resident 13 as required by the physician orders for the Amlodipine and Carvedilol medications. Employee 1 stated that the electronic medication administration system typically requires her to enter an assessment if ordered as a parameter by the physician; however, for the two medications administered that morning for Resident 13, it did not. Employee 1 also confirmed that she administered two tablets of the Tylenol arthritis medication instead of the one tablet ordered by the physician. Employee 1 confirmed that she administered one tablet of the Sodium Bicarbonate when she should have administered two to equal the 650 mg dose ordered. Employee 1 confirmed that she believed that she needed to administer five tablets of the 65 Fe supplement to equal 325 mg of iron as she did not review the labeling on the bottle that noted there was 65 mg of elemental iron extracted from 325 mg of ferrous sulfate; or noted that the physician's order that instructed to administer one tablet included both the 325 mg and 65 mg labeling. Employee 1 administered five tablets of the iron supplement instead of one tablet to Resident 13.The surveyor reviewed the above five medication errors for Resident 13 during an interview with the Nursing Home Administrator and the Director of Nursing on December 10, 2025, at 2:00 PM. 483.45(f)(1) Free of Medication Error Rates Five Percent or MorePreviously cited deficiency 11/22/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, clinical record review, and staff interview, it was determined that the facility failed to ensure a resident's rights to secure and confidential personal and medical information for one of six units reviewed for privacy concerns (Nursing Unit Two East; Resident 93). Findings include: Clinical record review for Resident 93 revealed an order for silver sulfadiazine cream one percent (a topical cream used to treat various skin wounds). The physician order instructed staff to apply the cream to bilateral lower extremities topically every day and night shift for wound care. The order was marked as discontinued. A nursing progress note for Resident 93 dated October 17, 2025, at 11:34 PM revealed a new order for silver sulfadiazine cream one percent; apply bilaterally to lower extremity topically every day and night shift for wound care and cleanse area; apply Silvadene cream to bilateral lower extremity rashes. Observation on the Nursing Unit Two East on December 12, 2025, at 10:30 AM revealed two wound care carts near the nurse's station. A plastic trash receptacle with a lid was affixed to the side of both carts. There were clear garbage bags in each receptacle that were partially filled with trash. One cart had the trash receptacle lid most of the way open and a discarded sulfadiazine box was visible with the pharmacy label still attached. Resident 93's name and order instructions for Resident 93 were visible. An interview with Employee 4, nurse aide, on December 12, 2025, at 10:34 AM confirmed the bins were used for regular garbage. Employee 4 was unclear if the medication box for Resident 93 should be in the trash because the employee reported that the nurses deal with the resident medications. The Nursing Home Administrator (NHA) was shown the cart by the surveyor on December 12, 2025, at 10:35 AM and the NHA informed the surveyor that Resident 93's labeled medication should not be in the regular garbage receptacle and the label should be shredded. 28 Pa. Code: 201.18(e)(1) Management		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to investigate and report to the appropriate agencies an allegation of potential resident-to-resident sexual abuse for three of three records reviewed for abuse (Residents 26, 43, and 49). Findings include: The facility policy entitled Resident Abuse and Neglect Prevention Program, last reviewed without changes April 2, 2025, revealed immediately upon discovery of an allegation of abuse or situation with the potential for abuse or harm, the facility will take reasonable measures to separate the alleged perpetrator from access to the alleged victim. Upon receiving a report of abuse or alleged abuse, the registered nurse supervisor, Director of Nursing, assistant director of nursing, or Nursing Home Administrator will begin the investigation. Upon receiving information concerning a report of abuse, the Director of Nursing or assistant director of nursing will inform the social service department. A representative from social services will visit the resident immediately to provide reassurance, support, and address the resident's psychosocial needs related to the alleged incident. The interdisciplinary team will initiate a plan of care addressing the impact of the incident on the resident's psychosocial status. The facility will report alleged and substantiated incidents to the Pennsylvania Department of Health, additional state agencies, and/or local authorities per federal and state requirements. Clinical record review revealed the facility admitted Resident 43 on March 17, 2025. Review of Resident 43's most recent MDS (Minimum Data Set, an assessment tool completed at specific interval to determine care needs) dated November 18, 2025, revealed nursing staff assessed Resident 43 as severely cognitively impaired. Nursing documentation dated July 28, 2025, at 10:58 AM noted Resident 43 was making out with Resident 26. Review of Resident 26's clinical record revealed her most recent MDS dated [DATE], indicated that staff assessed Resident 26 as severely cognitively impaired. Clinical record review revealed nursing documentation dated September 24, 2025, at 1:14 PM that staff noted Resident 43 had Residents 26 and 49 in his room, making out with them. Nursing documentation dated September 24, 2025, at 1:16 PM revealed Resident 43 and Resident 26 were in the back lounge making out, and when redirected Resident 43 got very upset with staff. Clinical record review revealed social service documentation dated September 25, 2025, at 10:43 AM that revealed Resident 43 may exhibit the behavior of sexual advances described as making out with female residents on his unit. Resident 43 was placed on 15-minute checks. Nursing documentation dated September 25, 2025, noted Resident 43 was reported with behaviors of making sexual advances toward others and placed on every 15-minute checks. Interview with the Nursing Home Administrator and Director of Nursing confirmed that the facility did not complete an investigation, obtain witness statements, notify law enforcement, or notify the Department of Health related to Resident 43's potential resident to resident sexual abuse. 483.12 (b) Development and Implementation of Abuse Policy Previously cited 11/22/24 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(3)(e)(1) Management 28 Pa Code 201.19(8) Personnel policies and procedures		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure assessments accurately reflected residents' status for three of 27 residents reviewed (Residents 17, 75, and 150). Findings include: Clinical record review for Resident 150 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated June 26, 2025, in which facility staff assessed the bed rails as being used as a physical restraint. Further clinical record review revealed no evidence that Resident 150 was ordered any restraints. The above information for Resident 150 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on October 1, 2025, at 2:35 PM and again on December 10, 2025, at 2:35 PM. An interview with Employee 2, registered nurse assessment coordinator, on December 12, 2025, at 9:56 AM revealed that the facility does not utilize restraints and the MDS assessment was marked as an error for Resident 150 and was corrected. Clinical record review for Resident 17 revealed a quarterly MDS assessment dated [DATE], that indicated Resident 17 received insulin (hormone injected to lower blood sugar) on three days during the seven days reviewed. A physician order dated May 1, 2025, discontinued Humalog insulin injections (fast-acting insulin used to lower blood sugar) for Resident 17 that were administered before meals based on blood glucose assessments. Review of Resident 17's clinical record revealed no evidence of an active physician's order to administer insulin in July or August 2025. The surveyor reviewed the above information for Resident 17 during an interview with the Nursing Home Administrator and the Director of Nursing on October 1, 2025, at 2:00 PM and on December 9, 2025, at 2:36 PM. Interview with Employee 2 on December 12, 2025, at 9:53 AM confirmed that any coding for insulin injections on Resident 17's quarterly MDS assessment dated [DATE], was an error. Clinical record review for Resident 75 revealed an annual MDS dated [DATE], that facility staff assessed Resident 75 as receiving an anticoagulant medication during the last seven days in the assessment period. Further clinical record review revealed no evidence that Resident 75 received an anticoagulant medication during the assessment period for the MDS noted above. Interview with Employee 2 on December 9, 2025, at 1:19 PM confirmed that Resident 75's June 16, 2025, MDS was coded in error regarding receiving an anticoagulant medication. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to develop a comprehensive care plan regarding dental needs that were identified in the comprehensive assessment for one of 27 residents reviewed (Resident 45). Findings include: Interview with Resident 45 on October 1, 2025, at 12:40 PM revealed that she had only broken natural teeth left. Observation of Resident 45's mouth on the date and time of the interview revealed several blackened pieces of teeth in her lower jaw. Clinical record review for Resident 45 revealed nursing documentation dated September 30, 2025, at 2:27 PM that staff noted Resident 45 was edentulous (no natural teeth). The surveyor requested evidence that Resident 45 received professional dental services, or declined such services, during an interview with the Nursing Home Administrator and the Director of Nursing on October 1, 2025, at 2:00 PM. Oral/Dental Inspection documentation signed by licensed practical nurse staff dated October 1, 2025, at 4:46 PM (following the surveyor's questioning) assessed Resident 45 as having obvious or likely cavities or broken natural teeth. An admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated September 23, 2025, revealed that on October 6, 2025, at 9:34 AM the registered nurse assessment coordinator confirmed that Resident 45 had obvious, or likely, cavities or broken natural teeth. The care assessment area related to dental concerns triggered the facility to proceed to a care plan. Review of Resident 45's plans of care revealed no plan of care to address the identified dental concern. The surveyor reviewed the above concerns regarding Resident 45's care plan with the Nursing Home Administrator on December 9, 2025, at 12:09 PM. Interview with the Nursing Home Administrator on December 12, 2025, at 9:15 AM confirmed that the facility did not develop a plan of care to address Resident 45's dental concerns until following the surveyor's questioning. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to provide care and services to maintain or improve the ability to perform activities of daily living for one of four residents reviewed for activities of daily living concerns (Resident 9). Findings include: Clinical record review for Resident 9 revealed an MDS (Minimum Data Set, assessment completed at specific intervals to determine care needs) assessment dated [DATE], that staff determined Resident 9 was independent with set up help only for bed mobility and transfers. Resident 9's next MDS assessment dated [DATE], revealed staff assessed Resident 9 as now requiring one person, limited physical assistance for bed mobility and transfers. There was no documented evidence in Resident 9's clinical record to indicate that the facility identified or assessed Resident 9's decline in his ability to perform these activities of daily living. The surveyor reviewed the above findings for Residents 9 with the Director of Nursing and the Nursing Home Administrator on December 12, 2025, at 9:42 AM. Resident 9 required staff physical assistance on four occasions for bed mobility and five occasions for transfers during the seven day look back period. The facility was unable to provide any further documentation that the facility assessed Resident 9's decline in bed mobility and transfer ability or implemented any measures to mitigate the decline. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practical care related to bowel management for one of one resident reviewed (Resident 11). Findings Clinical record review revealed the facility admitted Resident 11 on February 21, 2025. Further review of Resident 11's clinical record revealed the following physician ordered medications initiated February 21, 2025, to promote Resident 11's bowel movements: Milk of Magnesia (MOM, laxative that pulls water into bowel to soften bowel contents) give 30 ml (milliliters) by mouth as needed (PRN) for bowel management if no bowel movement in two days (evening shift). Dulcolax suppository (a laxative medication used to relieve constipation) insert one suppository rectally as needed for constipation, if MOM is ineffective and as needed for bowel management on day three (evening shift). Review of bowel elimination records for Resident 11 revealed that staff documented no bowel movements for July 5, 6, 7, 8, and 9, 2025 (5 days). There was no indication that staff offered (as per the physician orders and bowel management protocol), or Resident 11 refused, any PRN medications during this time. These findings were reviewed during an interview with the Director of Nursing on December 11, 2025, at 12:31 PM 483.25 Quality of Care Previously Cited 11/22/2024 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to provide comprehensive skin assessments that are consistent with professional standards of practice to promptly identify and promote healing of a pressure ulcer for one of four residents reviewed for pressure ulcers (Resident 1). Findings include: Clinical record review for Resident 1 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated November 11, 2025, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 7, which indicated cognitive impairment. The MDS revealed that the resident had a pressure ulcer. The MDS dated [DATE], also revealed the resident had a pressure ulcer. Current physician orders for Resident 1 dated August 21, 2025, at 8:00 AM instructed staff to treat the resident's sacral region wound every day shift every other day. A review of the Treatment Administration Record (TAR) for November 2025 revealed that staff were documenting the treatment as being completed. Resident 1's current care plan revealed that the resident has actual skin breakdown related to a right buttock pressure ulcer / sacral wound that was initiated on June 26, 2025. Review of Resident 1's clinical record revealed no documentation that the resident's pressure ulcer was comprehensively assessed (i.e. wound measurements, signs of infection, drainage, appearance, etc.) on a routine basis. A request for wound assessments for Resident 1 from August 2025 to November 2025 revealed the following assessments: August 5, 2025: admission / re-admission evaluation revealed a previous sacrum / coccyx pressure wound per the documentation. There was no comprehensive evaluation documented. August 15, 2025: Skin observation / check at 3:31 AM revealed an existing area of alteration in skin integrity of the coccyx (a small bone at the base of the spine) described as small open area with treatment in place. August 19, 2025: Skin observation / check at 9:54 AM revealed an existing area of alteration in skin integrity of the coccyx described as small open area with treatment in place. August 20, 2025, at 11:45 AM revealed wound care center documentation that noted a Stage 2 (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure injury to the sacrum. The wound was measured as 2.5 centimeters (cm) by 1.6 cm x 0.1 cm (length x width x depth). There was light serous exudate (a type of wound drainage). The peri-wound (tissue surrounding a wound) skin was intact. August 26, 2025, at 1:21 PM: Skin observation / check revealed an existing area of alteration in skin integrity of the coccyx described as small open area with treatment in place. September 9, 2025, at 12:35 PM: Skin observation / check revealed an existing area of alteration in skin integrity of the coccyx described as small open area with treatment in place. September 10, 2025, at 1:30 PM revealed wound care center documentation that noted a Stage 2 pressure injury to the sacrum. The wound was measured as 1.7 cm by 1 cm x 0.1 cm. There was light serous exudate. The peri-wound skin was intact. October 8, 2025, at 9:15 AM revealed wound care center documentation that noted a Stage 2 pressure injury to the sacrum. The wound was measured as 1.5 cm by 0.5 cm x 0.1 cm. There was moderate serous exudate. The peri-wound skin was erythematous (reddened) and macerated. November 26, 2025, at 8:00 AM revealed wound care center documentation that noted a Stage 2 pressure injury to the sacrum. The wound was measured as 0.8 cm by 0.5 cm x 0.5 cm. There was moderate serous exudate. The peri-wound skin was erythematous and macerated. An interview with the Nursing Home Administrator on December 12, 2025, at 12:53 PM to discuss the findings revealed that Resident 1's pressure ulcer should have been assessed weekly by the facility. Employee 5, registered nurse, was also present and stated there was no further documentation to indicate that the resident's pressure ulcer was routinely and comprehensively assessed for the dates selected of August 2025 to November 2025. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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 12/12/2025
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure an environment free from potential accident hazards for one of one resident reviewed for smoking concerns (Resident 33). Findings include: Review of the facility policy reviewed on August 14, 2025, titled Tobacco Product Usage and Smoking Policy Posting, revealed that the facility maintains a resident's rights to smoke while ensuring activities remain safe and do not infringe upon the health, safety, welfare, or rights of others. The policy further noted that the safety delivery of quality health care is the goal of each and every employee and in order to provide for an optimum, safe environment in which to meet the goal, the facility will observe a tobacco usage and smoking policy for all residents, staff, visitors, and volunteers. Section L noted that, Smoking aprons will be worn by all residents while smoking. The smoking policy was signed and dated by Resident 33 and social services staff on September 9, 2025. Clinical record review for Resident 33 revealed a diagnosis list that included hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (weakness on one side of the body). Review of the current physician orders for Resident 33 revealed an order dated January 31, 2023, that noted the resident may smoke cigarettes with staff supervision. Resident 33's care plan revealed that the resident wishes to smoke and is at risk of injury due to the desire to smoke. Some interventions included the following: provide and review the smoking policy to the resident and clearly review the facility guidelines for smoking dated January 31, 2023; reassess the resident immediately following any violation of the smoking policy dated January 31, 2023, and revised on October 18, 2023; staff to provide adaptive safety devices when applicable and noted a smoking apron dated January 31, 2023, and revised on October 18, 2023. Clinical record review for Resident 33 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated October 30, 2025, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 8, which indicated cognitive impairment. The MDS also noted upper and lower extremity impairment on one side. Observation of Resident 33 on December 10, 2025, at 10:30 AM revealed the resident was in the facility designated smoking area (a shed located in the rear of the facility). The resident was observed sitting in a wheelchair and smoking a cigarette. The resident did not have a smoking apron on as indicated in the facility policy and resident's care plan. The smoking aprons were observed hanging on the wall of the shed. Employee 3, Director of Housekeeping, was observed standing outside the shed with the doors open. Further review of the smoking area located outside of the shed revealed multiple partially smoked cigarette butts on the ground around a smoking receptacle. The smoking receptacle had a piece of plastic discarded in the cigarette disposal receptacle, which blocked the cigarettes from entering the receptacle. Several partially smoked cigarettes were observed sitting on top of the plastic. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on December 10, 2025, at 2:35 PM. A follow-up interview with the Nursing Home Administrator on December 12, 2025, at 10:10 AM revealed that the resident should have a smoking apron and if in violation of the facility smoking policy the resident should be immediately reassessed and brought back into the building. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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

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NAME OF PROVIDER OR SUPPLIER Bradford Hills Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 15900 Route 6 Troy, PA 16947	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on a review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection related to hand hygiene for one of 27 residents reviewed (Resident 13). Findings include: The facility policy entitled, Handwashing/Hand Hygiene, last reviewed without changes on April 2, 2025, revealed that all personnel will follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62 percent alcohol; or, alternatively, soap and water after removing gloves. Hand hygiene is the final step after removing and disposing of personal protective equipment (PPE). The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. The procedural steps in the policy included performing hand hygiene before applying non-sterile gloves and after removing gloves. Observation of the medication administration pass for Resident 13 on December 10, 2025, at 9:42 AM revealed Employee 1 prepared medications that included Olopatadine Hydrochloride (Pataday, antihistamine, itch relief, liquid eye drops), artificial tears (over-the-counter liquid medication administered to the eye to relieve dryness), and Flonase (Fluticasone Propionate, steroidal nasal spray used to reduce allergy symptoms). Observation of Employee 1's administration of the eye drops and nasal spray to Resident 13 on December 10, 2025, at 9:57 AM revealed the following procedural steps: Employee 1 donned disposable gloves and administered one drop of the Olopatadine eye medication into Resident 13's right eye. Employee 1 removed the disposable gloves and donned a new pair of disposable gloves. Employee 1 did not perform hand hygiene before donning the new pair of gloves. Employee 1 administered one drop of the Olopatadine eye medication into Resident 13's left eye. Employee 1 removed her gloves. Employee 1 did not perform hand hygiene. Employee 1 donned another pair of disposable gloves and administered two sprays of the Flonase medication into Resident 13's right and left nostrils. Employee 1 removed her gloves, did not perform hand hygiene, and obtained the vial of artificial tears from the medication's box packaging. Employee 1 donned a pair of disposable gloves and administered one drop of the artificial tears into Resident 13's right eye. Employee 1 removed those gloves and donned another pair of disposable gloves without performing hand hygiene before she administered one drop of the artificial tears into Resident 13's left eye. Interview with Employee 1 on December 10, 2025, at 10:07 AM confirmed that she was aware of the steps for disposable glove use and that she should have performed some kind of hand hygiene between glove changes, however, she did not do so. The surveyor reviewed the above hand hygiene concerns with the Nursing Home Administrator and the Director of Nursing on December 10, 2025, at 2:00 PM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 11/22/24 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		