

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/31/2025
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NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR STATE LICENSE NUMBER: 282702	STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0000	INITIAL COMMENT	F 0000		
F 0628 SS=D	Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on July 31, 2025, it was determined that Bradford Manor, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0628		

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 0628 SS=D	Continued from page 1 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) Discharge Process §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 0628	This plan of correction has been prepared and executed because the law requires it. This plan does not constitute an admission that any of the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract obligation or position. Bradford Manor reserves the right to raise all possible contestations and defenses in any civil, criminal, claim, action or proceeding. Please accept this plan of correction as Bradford Manor's credible allegation of compliance. Contacted the hospital that a current resident is admitted to and confirmed that they have received all of the resident's medical record information as required. For the identified residents, we interviewed the nurses that transferred them out and confirmed that all required information was communicated and sent with the resident at time of transfer. Those nurses were immediately educated. The E-interact (transfer document used in	Completion Date: 09/29/2025 Status: APPROVED Date: 08/22/2025

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F 0628 SS=D	Continued from page 2 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c) (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i) (A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 0628	our electronic health records) is processed and it includes all of the resident's medical records as well as a checklist of all required documents that are to be sent when resident is transferred. This checklist will be signed by the nurse completing the transfer and then placed in the resident's chart. Director of Nursing or designee will provide education to all registered nurses on the requirements of providing and documenting that all necessary resident information sent and communicated with the receiving healthcare provider upon transfer by 8/30/2025. DON will audit 100% of transfers for the past one month then 50% of transfers for the past one month and then 25% of transfers for the past one month. All findings will be reviewed at monthly Quality Assurance and Performance Improvement meetings.	

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F 0628 SS=D	Continued from page 3 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 0628		

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F 0628 SS=D	Continued from page 4 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 0628		

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F 0628 SS=D	Continued from page 5 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 0628		

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F 0628 SS=D	Continued from page 6 This REQUIREMENT is not met as evidenced by:	F 0628		
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F 0628 SS=D	Continued from page 7 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for three of four residents reviewed (Residents R2, R6, and R84). Findings include: Review of facility policy entitled Admission, Transfer, Discharge and Room Change Policy dated 12/8/24, indicated The Manor is required to provide sufficient Preparation ... to ensure safe and orderly transfer ... and transfers ... are documented in the residents clinical record. Review of Resident R2s clinical record revealed an admission date of 7/23/23, with diagnoses that included diabetes (a health condition that is caused by the bodys inability to produce enough insulin), and chronic obstructive pulmonary disease (COPD-when your lungs do not have adequate air	F 0628		

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F 0628 SS=D	Continued from page 8 flow). Resident R2s clinical record revealed a progress note dated 4/16/25, at 8:31p.m. indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Review of Resident R6s clinical record revealed an admission date of 10/18/23, with diagnoses that included peripheral vascular disease (a condition in the circulatory system which reduces blood flow to the limbs due to narrowing vessels), hyperlipidemia (high cholesterol), and hypertension (high blood pressure). Resident R6s clinical record revealed progress notes dated 6/5/25, at 6:20 a.m. and 6/28/25, at 6:06 p.m. indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider.	F 0628		

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F 0628 SS=D	<p>Continued from page 9</p> <p>Review of Resident R84s clinical record revealed an admission date of 11/10/23, with diagnoses that included COPD, hypertension, and heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues).</p> <p>Resident R84s clinical record revealed a progress note dated 6/24/25, at 1:12p.m. indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider.</p> <p>During an interview on 7/30/25, at 1:30 p.m. the Director of Nursing confirmed that the clinical records for Residents R2, R6 and R84 lacked evidence that the necessary clinical information was provided to the receiving healthcare provider upon transfer and when transfers occur clinical information should be provided to the receiving healthcare provider.</p> <p>28 Pa. Code 201.18(e)(1) Management</p>	F 0628		

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F 0628 SS=D	Continued from page 10 28 Pa. Code 201.29(c.3) (2) Resident rights	F 0628		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 11 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Director of Nursing or Designee will provide education to the Interdisciplinary Team on the requirements of developing and implementing a comprehensive person-centered care plan for each resident reflecting their specific needs by 08/30/2025. R8's care plan was updated to reflect that he has PTSD, goals and interventions specific to him. R84's care plan was updated to reflect her respiratory plan of care. An audit of all current residents with an order for oxygen to ensure that they have a respiratory care plan. An audit of all current residents with a diagnosis of PTSD will be reviewed to ensure that they have person-centered care plan completed. Ongoing compliance will be maintained by Director of Nursing or designee checking 10% of current residents' care plans weekly for one month and then 5% weekly for one month to ensure that the care plans are person centered for each resident that includes measurable objective and timetables to meet a resident's medical, nursing, and mental and	Completion Date: 09/29/2025 Status: APPROVED Date: 08/22/2025

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F 0656 SS=D	Continued from page 12 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	psychosocial needs. Findings of these audits will be reviewed in monthly Quality Assurance and Performance Improvement meetings.	

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F 0656 SS=D	Continued from page 13 Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive person-centered care plans for a resident with Post Traumatic Stress Disorder (PTSD), and for a resident requiring oxygen therapy that included measurable objectives and timetables to meet a resident's needs for two of 20 residents reviewed (Residents R8 and R84). Findings include: A facility policy entitled, "Care Plan," dated 12/08/24, indicated the facility will develop a comprehensive person centered care plan for each resident that includes measurable objective and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, and include: services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; be developed within seven	F 0656		

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F 0656 SS=D	Continued from page 14 days after the completion of the comprehensive assessment, prepared by the interdisciplinary team, be periodically reviewed and revised by a team of qualified personal after each assessment, and provide services that meet professional standards of quality. Review of Resident R8's clinical record revealed an admission date of 4/08/25, with diagnoses that included Parkinson's disease, PTSD, anxiety, and depression. Review of Resident R8's person centered plans of care lacked evidence that a plan of care for PTSD was developed. During an interview on 7/30/25, at 11:45 a.m. the Nursing Home Administrator confirmed that a PTSD care plan was not developed for Resident R8. Review of Resident R84's clinical record revealed an admission date of 11/10/23, with diagnoses that	F 0656		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0656 SS=D	Continued from page 15 include chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), hypertension (high blood pressure), and heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues). Review of Resident R84's person centered plans of care lacked evidence that a plan of care for respiratory care with use of oxygen was developed. During an interview on 7/30/25, at 1:30 p.m. the Director of Nursing (DON) confirmed that a plan of care for respiratory care with use of oxygen was not developed for Resident R84. He/she also confirmed that a respiratory plan of care with use of oxygen should have been developed. 28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 201.18 (b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0656		

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F 0656 SS=D	Continued from page 16	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 17 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Director of Nursing or Designee will provide education to the Interdisciplinary Team on the requirements of developing a comprehensive person-centered care plan within 7 days after completion of the comprehensive assessment and then ongoing review/revise after each assessment including comprehensive and quarterly reviews by 08/30/2025. Residents R4, R11, R78 and R84 had completed care plan reviews. All other residents, triggering with late review dates will be reviewed and updated by 09/15/2025. Ongoing compliance will be maintained by Director of Nursing or designee checking 10% of current residents' care plans weekly for one month and then 5% weekly for one month to ensure that care plans have been reviewed/revised within the target date. All findings will be reviewed in monthly Quality Assurance and Performance Improvement meetings.	Completion Date: 09/29/2025 Status: APPROVED Date: 08/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/31/2025	
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F 0657 SS=D	<p>Continued from page 18</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans by the target date and to reflect the current necessary care and services for four of 20 residents reviewed (Resident R4, R11, R78, and R84).</p> <p>Findings include:</p> <p>Review of facility policy entitled Care Plan Policy dated 12/8/24, indicated The Manor will develop a comprehensive person centered care plan for each resident ... and Periodically reviewed and revised ...</p> <p>Review of Resident R4s clinical record revealed an admission date of 6/10/25, with diagnoses that included chronic obstructive pulmonary disease (COPD-when your lungs do not have adequate air flow), and hypertension (high blood pressure).</p> <p>Review of Resident R4s person centered care plans revealed a care plan for catheter with a target date (a date on which the care plan should have been</p>	F 0657		

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F 0657 SS=D	Continued from page 19 revised) of 6/30/25. Review of Resident R11s clinical record revealed an admission date of 12/17/24, with diagnoses that included hyperlipidemia (high cholesterol) and hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones). Review of Resident R11s person centered care plans revealed all his/her care plans with a target date of 6/26/25. Review of Resident R78s clinical record revealed an admission date of 6/7/24, with diagnoses that included COPD, hyperlipidemia, and type II diabetes (the pancreas does not make enough insulin to control blood sugar levels). Review of Resident R78s person centered care plans revealed all his/her care plans with a target date of 7/17/25. Review of Resident R84s clinical record revealed an	F 0657		

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F 0657 SS=D	Continued from page 20 admission date of 11/10/23, with diagnoses that included COPD, hypertension (high blood pressure), and heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues). Review of Resident R84s person centered care plans revealed all his/her care plans with a target date of 7/10/25. During an interview on 7/30/25, at 1:30 p.m. the Director of Nursing confirmed that Residents R4, R11, R78, and R84s care plans were beyond their target dates and that the care plans should have been updated by the target dates. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0657		

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F 0695 SS=D	<p>483.25(i) Respiratory/Tracheostomy Care and Suctioning</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.</p> <p>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0695	<p>Director of Nursing or designee will provide education to all nurses on the policy of providing oxygen and changing and dating oxygen tubing and humidifier bottles according to physician's orders by 08/30/2025. The identified resident's, R84, oxygen tubing and humidifier water bottle was replaced immediately. All other residents with oxygen orders had their tubing and bottles checked to ensure we were in compliance with the required changing date. Ongoing compliance will be monitored by Director of Nursing or designee by ensuring that all residents with oxygen orders have tubing and humidifier bottles changed weekly per policy and physician order, one time per day weekly for one month, one time per day every other week for one month and then monthly for two months. All findings will be reviewed in monthly Quality Assurance and Performance Improvement meetings.</p>	<p>Completion Date: 09/29/2025 Status: APPROVED Date: 08/22/2025</p>

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F 0695 SS=D	Continued from page 22 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen and change/date oxygen tubing and humidifier bottle according to physician's orders for one of two residents reviewed for respiratory services (Resident R84). Findings include: Review of facility policy entitled Respiratory Services dated 12/8/24, indicated oxygen cannulas [oxygen tubing that has prongs that go into the nostrils and loops around the ears to secure in place to ensure adequate oxygen delivery] frequency of change weekly or PRN (as needed), prefilled humidifier bottles frequency of change weekly or PRN when empty. Review of Resident R84s clinical record revealed an admission date of 11/10/23, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow),	F 0695		

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F 0695 SS=D	<p>Continued from page 23</p> <p>hypertension (high blood pressure), and heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues).</p> <p>Review of Resident R84s physician's orders revealed orders for oxygen at two liters per minute per nasal cannula as needed and oxygen maintenance change O2 [oxygen] tubing and supply bag weekly ... change water jug weekly.</p> <p>Review of Resident R84s vital sign records revealed that he/she used his/her oxygen 21 times between 6/23/25, and 7/29/25.</p> <p>Observations on 7/28/25, at 2:00 p.m. revealed a nasal cannula attached to an oxygen tank on the back of Resident R84's wheelchair with no date and a humidifier water bottle attached to an oxygen concentrator that was dated 6/23/25. Further observations on 7/29/25, at 8:30 a.m., 9:28 a.m., and again at 12:25 p.m. revealed the nasal cannula remained attached to the oxygen tank with no date and the humidifier water bottle attached to the</p>	F 0695		

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F 0695 SS=D	Continued from page 24 concentrator remained dated 6/23/25. During an interview on 7/29/25, at 12:25 p.m. Licensed Practical Nurse Employee E2 confirmed that Resident R84s nasal cannula lacked a date, and the humidifier water bottle was dated 6/23/25. He/she also confirmed that the nasal cannula and the humidifier water bottle should have been changed. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0695		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 25 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Director of Nursing or designee will provide education to all nursing staff on Infection Control and Enhanced Barrier Precautions. Education will include catheter care and placement. All education will be completed by 08/30/2025. Identified resident's, R4, catheter bag was removed from the floor immediately and staff working the hall were educated. All residents with a catheter were checked to ensure that their catheter bag was properly placed. Nurse that provided wound care was immediately educated. Resident R9 was monitored for signs and symptoms of infection for five days. Ongoing compliance will be monitored by Director of Nursing or designee by observing nursing staff following enhanced barrier requirements on 10% of residents with orders for enhanced barrier precautions one time per day 3x week for 2 weeks, one time per day weekly for 2 weeks and one time per day monthly for 2 months. Audits shall cover all shifts and all residents with orders for enhanced barrier	Completion Date: 09/29/2025 Status: APPROVED Date: 08/22/2025

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F 0880 SS=D	Continued from page 26 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	precautions. Director of Nursing or designee will do an audit all residents with catheters will be checked to ensure the catheter bags are not placed on the floor one time per day 3x week for 2 weeks, one time per day weekly for 2 weeks and then one time per day monthly for 2 months. Audits shall cover all shifts and all residents with orders for a catheter. Findings will be reviewed in monthly Quality Assurance and Performance Improvement meetings.	

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F 0880 SS=D	Continued from page 27	F 0880		

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F 0880 SS=D	Continued from page 28 Based on review of facility policies and clinical records, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) during wound care for one of three residents that require EBPs (Resident R9) and failed to provide appropriate infection control measures regarding a urinary catheter (a tube placed and held in the bladder to drain urine) for one of three residents reviewed with a catheter (Resident R4). Findings include: Review of the facility policy entitled, "Enhanced Barrier Precautions," dated 12/08/24, are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO). It also indicated that gloves and gown are to be applied prior to performing the high contact resident care activities, which includes wound care. Review of facility policy entitled Infection Control	F 0880		

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F 0880 SS=D	Continued from page 29 dated 12/8/24, indicated implementation of control measures, the prevention and spread of health care associated infections are accomplished using standard precautions and other barriers, and staff and resident education focuses on risk of infection and practices to decrease this risk. Review of Resident R9's clinical record revealed an admission date of 3/16/23, with diagnoses that included diabetes mellitus (condition where the body doesn't produce enough insulin to control blood sugar levels), diabetic neuropathy, diabetic foot ulcer. and chronic kidney disease. Review of Resident R9's physician's orders dated 6/16/25, included an order to cleanse the right heel diabetic ulcer and apply Dakins solution gauze to the wound and cover with dry dressing. Observation of wound care on 7/29/25, at 12:20 p.m. revealed that Licensed Practical Nurse (LPN) Employee E1 entered Resident R9's room without donning (putting on) a gown. Resident R9s room	F 0880		

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F 0880 SS=D	Continued from page 30 had a sign above the bed indicating EBPs and gloves and gowns were available in the residents room. During an interview on 7/29/25, at 12:25 p.m. LPN Employee E1 confirmed he/she did not don a gown prior to entering Resident R9's room. Review of Resident R4s clinical record revealed an admission date of 6/10/25, with diagnoses that included Benign prostatic hyperplasia (a noncancerous condition that causes the prostate gland to become enlarged and cause difficulty urinating) chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and hypertension (high blood pressure). Review of Resident R4s Minimum Data Set (MDS-a mandated assessment of a residents abilities and care needs) assessment, dated 7/4/25, revealed that Resident R4 had an indwelling urinary catheter.	F 0880		

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NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR STATE LICENSE NUMBER: 282702	STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
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F 0880 SS=D	Continued from page 31 Observations on 7/29/25, at 8:35 a.m., 9:30 a.m., and again at 12:10 p.m. revealed Resident R4s urinary drainage bag lying flat on the floor with the drainage spout (the part of the urinary bag that opens to empty urine from the bag) facing down and touching the floor. During an interview on 7/29/25, at 12:26 p.m. LPN Employee E2 confirmed that the urinary drainage bag was lying on the floor face down and also confirmed that the urinary drainage bag should not be on the floor. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0880		
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Certified End Page

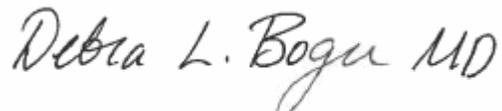
BRADFORD MANOR

STATE LICENSE NUMBER: 282702

SURVEY EXIT DATE: 07/31/2025

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, 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