

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701		
STATE LICENSE NUMBER: 282702				
(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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on August 5, 2025, at Bradford Manor, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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.



Certified End Page

BRADFORD MANOR

STATE LICENSE NUMBER: 282702

SURVEY EXIT DATE: 08/05/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701		
STATE LICENSE NUMBER: 282702				
(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
K 0000	INITIAL COMMENT Facility ID #282702 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on August 5, 2025, it was determined that Bradford Manor was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type V (000), unprotected, wood frame building, with a partial basement, that is fully sprinklered.	K 0000		
K 0911 SS=D		K 0911		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR STATE LICENSE NUMBER: 282702		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701		
(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
K 0911 SS=D	Continued from page 1 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	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. Education was provided to the Maintenance department by the Nursing Home Administrator regarding safety concerns with using outlet multipliers and its unacceptable practice. Heat tape was unplugged from outlet multiplier on day of survey. All other areas where heat tape is used were checked to ensure that no outlet multipliers were being used, none were identified. Ongoing compliance will be monitored through daily	Completion Date: 09/30/2025 Status: APPROVED Date: 08/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR STATE LICENSE NUMBER: 282702		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701		
(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
K 0911 SS=D	Continued from page 2 Based on observation and interview, the facility failed to maintain electrical system requirements for one of four smoke compartments. Findings include: Observation on August 5, 2025, at 11:12 a.m., revealed the heat tape used on the building was plugged in outlet multipliers outside of the main entrance. Interview with the maintenance supervisor on August 5, 2025, at 11:12 a.m. confirmed the deficiency at the time of the survey.	K 0911	rounding by the Environmental Service Supervisor or designee 3x weekly for 2 weeks.	
K 0912 SS=B		K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR STATE LICENSE NUMBER: 282702		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701		
(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
K 0912 SS=B	Continued from page 3 NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0912	Education was provided to the Maintenance department by the Nursing Home Administrator regarding the requirement of having power receptacles to have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. All identified outlets were changed over to GFCI outlets on day of survey. A whole house observation of all outlets near water sources were inspected with no others identified. Ongoing compliance will be maintained through daily rounding by the Environmental Service Supervisor or designee 3x weekly for 2 weeks.	Completion Date: 09/30/2025 Status: APPROVED Date: 08/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR STATE LICENSE NUMBER: 282702		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701		
(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
K 0912 SS=B	Continued from page 4 Based on observation and interview, the facility failed to maintain electrical receptacles for three of over fifty receptacles. Findings include: Observation on August 5, 2025, between 10:19 a.m. and 11:27 a.m., revealed the following electrical receptacle deficiencies: A. (10:19 a.m.) Main floor Sweet Shop café had a receptacle that was not ground fault circuit interrupter (GFCI) protected within six feet of a sink basin; B. (10.30 a.m.) Main floor center core, near nurse station, had a water fountain that was not connected to a GFCI protected receptacle; C. (11:27 a.m.) The main floor kitchen had a juice machine that was not connected to a GFCI protected receptacle; Interview with the maintenance supervisor on August 5, 2025, at 11:27 a.m., confirmed the	K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR STATE LICENSE NUMBER: 282702		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701		
(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
K 0912 SS=B	Continued from page 5 electrical outlet deficiencies.	K 0912		
K 0923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K 0923	Education was provided to all staff regarding the requirements of storing gas equipment. The two unsecured tanks identified during survey were immediately placed in a secured storage holder at time of survey. Ongoing compliance will be maintained by observations during daily rounding by the Environmental Service Supervisor or designee 3x weekly for 2 weeks then 1x weekly for 1 month.	Completion Date: 09/30/2025 Status: APPROVED Date: 08/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR STATE LICENSE NUMBER: 282702		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701		
(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
K 0923 SS=D	Continued from page 6 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395700	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: BRADFORD MANOR STATE LICENSE NUMBER: 282702		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 LANGMAID LANE BRADFORD, PA 16701		
(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
K 0923 SS=D	Continued from page 7 Based on observation and interview, the facility failed to maintain gas equipment requirements for two of over twenty cylinders. Findings include: Observation on August 5, 2025, at 11:02 a.m., revealed the oxygen storage room, located near the generator, had two unsecured full cylinders. Interview with the maintenance supervisor on August 5, 2025, at 11:02 a.m., confirmed the deficiency and secured the cylinders during the survey.	K 0923		



Certified End Page

BRADFORD MANOR

STATE LICENSE NUMBER: 282702

SURVEY EXIT DATE: 08/05/2025

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