

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2024
NAME OF PROVIDER OR SUPPLIER Edison Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 222 West Edison Avenue New Castle, PA 16101	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655</p> <p>Based on a review of facility policy and clinical records, and review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual 2019 (RAI-assessment guide used to plan the provision of care for residents), and resident and staff interviews, it was determined that the facility failed to provide a bath/shower as resident preference for six of six residents reviewed (Residents R1, R2, R4, R5, R6, and R7).</p> <p>Findings include:</p> <p>Review of facility policy, Resident Bath Showering/Scheduling Policy dated 1/17/23, revealed Residents will be bathed or showered according to their preferences in order to maintain healthy hygiene and skin condition. Staff who have demonstrated competence may bathe the resident via shower, tub bath, whirlpool bath, or bed bath. Bed linens will be changed on baths days and as needed, but minimally once weekly. (A) Each resident will be asked about his/her bathing preferences upon admission (type of bath, preferred days and times). (B) Each resident will be scheduled to receive bathing a minimum of two times per week unless they prefer less frequent baths or state regulation requires more frequent bathing. (C) The facility will develop and maintain a bathing/shower schedule for each unit. (D) At the beginning of each shift, the Charge Nurse will review the bathing schedule for that day and shift with the nursing assistants. (E) When the bath or shower is complete, the nursing assistant will document the activity on the shower sheet or in Point of Care section of the electronic record. (F)The nursing assistant will look at all areas of the resident's skin and indicate abnormalities or changes by marking the shower sheet body diagram the location and description of the skin condition. If bathing activity is documented in the electronic health record, the nursing assistant will verbally notify the charge nurse of any abnormalities or changes. (G) The nurse will address any findings in the clinical record and appropriate interventions will be initiated. (H) If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report this to the Charge Nurse. (I) The Charge Nurse will speak with the resident who refuses to ascertain why they are refusing and to determine if alternative arrangements that suit the resident can be made. If the resident continues to refuse the Charge Nurse document the resident's refusal in the medical record. (J) If used, Shower Sheets will be submitted to the DON/Designee.</p> <p>Review of the RAI manual instructions for Section C0500 Brief Interview for Mental Status (BIMS) revealed that a score of 13-15 identified a resident as cognitively intact and a score of 8-12 identified a resident as moderately impaired, and a score of 0-7 as severely impaired.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident R1 was alert and oriented with a BIMS score of 13/15. Resident R1's Section GG0130 dated 11/24/23, for Functional Abilities and Goals and Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub shower revealed that Resident R1 needs substantial/maximal assistance - Helper does more than half the effort; Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>Review of Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included Chronic Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should), Type 2 Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugar resulting in too much sugar in the blood), Muscle Weakness, and Unsteadiness on Feet.</p> <p>Review of Resident R1's bath/shower records from 11/01/23, through 1/10/24, revealed a bed bath was provided on 12/05/23, 12/26/23, 12/29/23, and 1/01/24.</p> <p>During an interview on 1/10/24, at 2:00 p.m., Resident R1 indicated he/she hardly ever received a bath/shower, but staff would say that he/she refused, when he/she was never asked.</p> <p>Resident R2 was alert and oriented with a BIMS score of 15/15. Resident R2's Section GG0130 Self-Care dated 11/04/23, for Functional Abilities and Goals and Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub shower revealed that Resident R1 needs partial/moderate assistance - Helper does less than half the effort; Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.</p> <p>Review of Resident R2's clinical record revealed an admitted [DATE], with diagnoses that included presence of left artificial elbow joint, history of falling, muscle weakness, and other reduced mobility.</p> <p>Review of Resident R2's bath/shower records from 11/01/23, through 1/10/24, revealed a shower was provided on 11/29/23, 12/02/23, 12/09/23, 12/16/23, 12/27/23, 1/01/24, and 1/03/24.</p> <p>During an interview on 1/10/24, at 11:45 a.m., Resident R2 indicated he/she does not receive a shower as often as he/she prefers.</p> <p>Review of Resident R4's clinical record revealed an admitted [DATE], with diagnoses that included Pneumonia, Syncope (fainting or passing out), Hyperlipidemia (high cholesterol in the blood), and High Blood Pressure. Resident R4 was alert and oriented with a BIMS score of 15/15.</p> <p>Review of Resident R4's bath/shower records from 11/01/23, through 1/10/24, revealed a shower provided on 12/26/23, 12/29/23.</p> <p>During an interview on 1/09/24, at 1:15 p.m. Resident R4 indicated he/she receives a shower only when everyone shows up, referring to staff.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident R5 was alert and oriented with a BIMS score of 13/15. Resident R5's Section GG0130 dated 11/05/23, for Functional Abilities and Goals for Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub shower revealed Resident R1 needs substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>Review of Resident R5's clinical record revealed an admitted [DATE], with diagnoses that included Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors), Post Menopausal Bleeding (vaginal bleeding that occurs a year or more after your last menstrual period), History of Falling, and High Blood Pressure.</p> <p>Review of Resident R5's bath/shower records from 11/01/23, through 1/10/24, revealed a tub bath provided on 11/25/23, shower 11/30/23, bed bath 12/07/23, shower 12/28/23, and bed bath 1/02/24.</p> <p>Resident R6's BIMS indicated a severely impaired cognition status. Resident R1's Section GG0130 dated 11/10/23, for Functional Abilities and Goals for Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub shower revealed Resident R1 needs maximal assistance - Helper does all the effort; Resident does none of the effort to complete the activity; Or the assistance of two or more helpers is required for resident to complete the activity.</p> <p>Review of Resident R6's clinical record revealed an admitted [DATE], with diagnoses that included Convulsions (rapid involuntary muscle contractions that cause uncontrollable shaking and limb movement), Human Immunodeficiency Virus (HIV - a virus that attacks cells that help the body fight infection), History of Falling, and Muscle Weakness.</p> <p>Review of Resident R6's bath/shower records from 11/01/23, through 1/10/24, revealed a shower provided on 12/15/23, bed bath refused 12/26/23, shower 12/29/23, and shower 1/05/24.</p> <p>Resident R7 was alert and oriented with a BIMS score of 15/15. Resident R7's Section GG0130 Self-Care dated 12/15/23, for Functional Abilities and Goals for Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub shower revealed that Resident R1 needs assistance for setup or clean up - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following activity.</p> <p>Review of Resident R7's clinical record revealed an admitted [DATE], with diagnoses that included Central Cord Syndrome (a traumatic injury to the cervical spinal cord that includes disproportionate impairment of the upper extremity motor function compared to the lower extremities), Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should), Difficulty in Walking, and Muscle Weakness.</p> <p>Review of Resident R7's bath/shower records from 11/01/23, through 1/11/24, revealed one bed bath for 1/11/24.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/12/24, at approximately 3:00 p.m. the Interim Nursing Home Administrator confirmed there was no evidence to indicate Resident R1, Resident R2, Resident R4, Resident R5, Resident R6, and Resident R7 received a bath/shower twice a week as resident preference and facility policy.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655</p> <p>Based on a review of clinical records, resident and staff interviews, and observations, it was determined that the facility failed to ensure residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, for two of two resident bathing rooms observed (Floors 2 and 3).</p> <p>Findings include:</p> <p>No water temperature policy for bathing was provided by the facility.</p> <p>Review of Resident R2's clinical record revealed an admitted [DATE], with diagnoses that included presence of left artificial elbow joint, history of falling, muscle weakness, and other reduced mobility.</p> <p>During an interview on 1/10/24, at 11:45 a.m. Resident R2 indicated he/she does not receive showers often, but when he/she does, the water is hot, then cold, making the shower a horrible experience. Resident R2 indicated he/she received a shower earlier in the day and the water temperature went from hot to cold and stayed cold for the rest of the shower. Resident R2 indicated he/she told staff to stop and give him/her a bed bath, because he/she could not stand the cold water.</p> <p>Observations with the Maintenance Director on 1/10/24, at approximately 3:00 p.m. revealed water temperatures in the Second Floor Bathing/Shower Room reached a maximum of 73 degrees and water temperatures of the Third Floor Bathing/Shower Room reached a maximum of 94 degrees after a minimum of 10 minutes allowing the water temperature to rise. The Third Floor Bathing/Shower Room water temperature stayed at 94 degrees only for a brief period then fluctuated to lower temperatures.</p> <p>During an interview on 1/10/24, at approximately 3:00 p.m. the Maintenance Director indicated that the water temperatures have been a consistent problem and continue to fluctuate with the residents receiving cold showers often.</p> <p>During an interview on 1/12/24, at 11:10 a.m. the Nursing Home Administrator confirmed the water temperatures are too low for comfortable bathing experiences for residents, and the facility failed to ensure residents receive the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being related to bathing.</p> <p>28 Pa. Code 205.37(e) Equipment for bathrooms</p> <p>28 Pa. Code 211.10(a) Resident care policies</p> <p>28 Pa. Code 211.10(d) Resident care policies</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655</p> <p>Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to follow physician orders for one of four residents reviewed (Resident R3).</p> <p>Findings include:</p> <p>Resident's R3's clinical record revealed an admitted [DATE], with diagnoses that included urinary tract infection, neuromuscular dysfunction of the bladder (a urinary condition involving bladder control due to a brain, spinal cord or nerve problem), diabetes mellitus (a disease that affects how blood sugar is regulated in the blood), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>Review of Resident R3's Medication Administration Record (MAR) revealed a physician order with start date of 5/18/23, for Anoro Ellipta (umeclidinium-vilanterol--medicines to treat Chronic Obstructive Pulmonary Disease [COPD-progressive lung disease]) blister with device; 62.5-25 microgram (mcg)/actuation one puff, inhale orally one time a day for wheezing.</p> <p>Observation of the 2 [NAME] Medication Cart on 1/09/24, at 12:15 p.m. revealed there not any Anoro Ellipta inhalers for Resident R3. At the time of this observation, Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R3 did not receive his/her Anoro Ellipta inhaler on 1/08/24, and 1/09/24, per physician order due to the medication was not available.</p> <p>During an interview on 1/10/24, at 2:50 p.m. LPN Employee E1 further confirmed that he/she documented in error on Resident R3's MAR for 1/08/24, that the inhaler was administered to Resident R3. LPN Employee E1 confirmed he/she placed the medication on hold 1/09/24, but did not communicate to the physician that the inhaler could not be administered per Resident R3's physician order due to not being available.</p> <p>During an interview on 1/10/24, at 1:57 p.m. the Director of Nursing confirmed the medication, Anoro Ellipta inhaler, was not administered per physician order for Resident R3 on 1/08/24 and 1/09/24.</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>42655</p> <p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on review of facility records, observations, and staff interviews, it was determined that the facility failed to ensure nursing staff possessed the training to properly care for resident's needs for one of 21 days reviewed (12/29/23).</p> <p>Findings include:</p> <p>Review of the Job Description for Charge Nurse RN/LPN/VN, dated 11/25/23, for RN Employee E4, and 11/27/23, for RN Employee E5 indicated the primary purpose of your job position is to provide direct nursing care to the residents, and to supervise the day-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing Services or Nurse Supervisor to ensure that the highest degree of quality care is maintained at all times. As Charge Nurse you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. You are responsible for the independent supervision of the delivery of care to a group of residents within a nursing unit.</p> <p>Review of the Job Description for RN Supervisor, dated 4/28/11, for RN Supervisor E3 indicated the primary purpose of your job position is to supervise the day-to-day nursing activities of the facility during your tour of duty. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing Services, to ensure that the highest degree of quality care is maintained at all times. As Nurse Supervisor you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Responsible for the independent supervision of the delivery of care by all nursing staff within the facility and those who deliver services to the residents.</p> <p>Review of the daily deployment sheet for 12/29/23, revealed RN Supervisor Employee E3 scheduled for 7:00 a.m. to 7:00 p.m. shift, then RN Med Nurse Employee E4 scheduled at 7:00 p.m. to 3:00 a.m., and RN Med Nurse Employee E5 scheduled at 11:00 p.m. to 7:00 a.m. The facility lacked evidence that an RN Supervisor was scheduled for the time period 7:00 p.m. to 7:00 a.m. on 12/29/23 into 12/30/23.</p> <p>Review of daily Employee Punch Reports for 12/29/23 and 12/30/23, revealed RN Supervisor Employee E3 did not punch in/out for 7:00 a.m. to 7:00 p.m. shift as indicated on the 12/29/23, deployment sheet. RN Supervisor Employee E6 was scheduled and reported to work at 7:30 a.m. on 12/30/23 as identified in the 12/30/23 Employee Punch Report. Furthermore, the facility lacked an RN Supervisor for 12/29/23, 7:00 a.m. to 7:30 a.m. 12/30/23.</p> <p>Observations of the nursing staff on 1/09/24, and 1/10/24, revealed an RN Supervisor and four med nurses RN/LPN on medication carts. The RN Supervisor was communicating with physician providers, completing an admission, transferring a resident to the hospital, reconciling narcotic medications to ensure availability on each medication cart throughout the facility and supervising RNs, Licensed Practical Nurses (LPN), and Nurse Aides (NA). The RN/LPN med nurses were observed administering medications and completing treatments to their group of residents within the nursing unit.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 1/09/24, at 2:00 p.m. with RN Med Nurse Employee E2 confirmed that specific training with specific keys to areas of the facility, specific passwords to access resident information, reports and complete reports is provided for the RN Supervisor's job duties and he/she did not receive that training and is only responsible for being a Med Nurse. RN Med Nurse Employee E2 indicated he/she would not feel comfortable, nor safe, doing the RN Supervisor position due to lack of training relating to the responsibilities and importance of the RN Supervisor. RN Med Nurse Employee E2 indicated he/she has no desire to be in the RN Supervisor role and was only hired to be a Med Nurse.</p> <p>An interview with the Interim Director of Nursing on 1/12/24, at 3:50 p.m. confirmed the facility lacked an RN Supervisor on 12/29/23, and an RN Med Nurse was expected to complete the RN Supervisor responsibilities but lacked the training as a RN Supervisor; furthermore, the facility failed to ensure that nursing staff possessed the training to properly care for residents' needs.</p> <p>28 Pa. Code 201.20 (b) Staff development</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655</p> <p>Based on review of facility records and policy, review of clinical record, and resident representative and staff interviews, it was determined the facility failed to provide residents with medically related social services related to the grievance process, and psychosocial services for one of ten residents interviewed (Resident representative R1).</p> <p>Findings include:</p> <p>Review of facility documentation Job Description for a Social Worker on 1/11/24, revealed that the primary purpose of the job position is to assist in planning, organizing, implementing, evaluating, and directing the overall operation of our facility's Social Services Department in accordance with current federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Director of Social Services and/or Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. Essential function, duties, and responsibilities include: participate in discharge planning, development and implementation of social care plans and resident assessments. Interview resident/families to obtain social history. Work with emotional problems including assisting resident/family with anxieties and stress caused by illness and admission to the facility, difficulties in coping with residual physical disabilities, fears related to helplessness and death, and the need for institutional and specialized care. Review departmental complaints and grievances from personnel and make written reports to the Administrator of action(s) taken. Follow facility's established procedures.</p> <p>(continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy entitled, Resident Grievances and Concerns Policy, Department: Social Services dated 1/17/23, revealed The Facility recognizes that residents have the right to voice grievances to the facility or other agencies or entities that hear grievances, without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment that has been furnished, the behavior of staff and other residents and any other concern regarding the resident's stay. Definitions - Grievance Official. The person designated by the Administrator to receive all grievances to be investigated by the Grievance Committee. Procedure - Prevent Ongoing Violations. Upon receipt of an oral, written or anonymous grievance submitted by a resident, the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, if indicated. Grievance Decision - Upon completion of the review, the Grievance Official will complete a written grievance decision that includes the following: (a) The date the grievance was received. (b) A summary of the statement of the resident's grievance. (c) The steps taken to investigate the grievance. (d) A summary of the pertinent findings or conclusions regarding the resident's concern(s). (e) A statement as to whether the grievance was confirmed or not confirmed. (f) Whether any corrective action was or will be taken. (g) If corrective action was or will be taken, a summary of the corrective action. If corrective action will not be taken, then an explanation of why such action is not necessary. (h) The date the written decision was issued. Resident Notification - The Grievance Official will meet the resident and inform the resident the results of the investigation and how the resident's grievance was resolved or will be resolved, if applicable. A copy of the written grievance decision will be provided to the resident, upon request. Administrator Notification - If the Grievance Committee determines that a resident's rights have been violated, the Grievance Official shall notify the Administrator.</p> <p>During an interview on 1/09/24, at approximately 11:30 a.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility currently does not have a licensed Social Worker and the Registered Nurse Assessment Coordinators (RNACs) were performing the responsibilities of the Social Worker position.</p> <p>A review of Grievances for the facility dated 5/31/23, through 1/10/24, revealed only nine of 36 grievances with involvement by the RNAC-Social Services designee displaying the facility failed to provide medically related social services to residents.</p> <p>During an interview with the NHA on 1/10/24, at approximately 2:00 p.m. he/she indicated that the Grievance Officer for the facility is the Social Worker. The NHA further indicated that he/she attempts to fill the void of the absence of a Social Worker by increased involvement in the grievance process, but his/her last day is 1/12/24, and also verified the facility failed to provide medically related services consistently to residents.</p> <p>Review of Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included Chronic Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should), Type 2 Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugar resulting in too much sugar in the blood), Muscle Weakness, and Unsteadiness on Feet.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2024
NAME OF PROVIDER OR SUPPLIER Edison Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 222 West Edison Avenue New Castle, PA 16101	

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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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Resident R1's representative on 1/10/24, at approximately 7:00 p.m., it was revealed that he/she had a history of very aggressive behaviors related to the care of Resident R1. Resident R1's representative indicated he/she was not allowed to enter the nearby hospital when Resident R1 was admitted there related to Resident R1's representative's extreme aggressive behavior. The NHA was in attendance during the interview with Resident R1's representative and confirmed that the facility was aware of Resident R1's representative's aggressive behavior and was witness to the negative behavior on several occasions regarding the facility's care of Resident R1.</p> <p>Review of Resident R1's progress notes dated 9/25/23, 11:52 a.m. revealed that the NHA had spoken to an RN at a local hospital regarding Resident R1 and Resident R1's representative being trespassed from the hospital. The note further revealed that the NHA explained that if Resident R1 were to decline that they permit him/her to accompany Resident R1's representative into see Resident R1 so that Resident R1 would not be alone at his/her time of passing; NHA had provided cell number to be reached if something happened and it was after hours. The note also identified that the hospital RN stated that Resident R1's representative had been banned since February of 2023.</p> <p>The facility lacked evidence of social, psychological, and emotional consultations to community social, health and welfare agencies to meet the needs of the Resident R1's representative. No evidence of a facility plan was provided to protect the facility resident population and/or facility staff of a person with aggressive behavior, Resident R1's representative.</p> <p>During an interview on 1/17/24, at 10:17 a.m. the Interim NHA confirmed that no evidence of medically related social services were provided to Resident R1 and Resident R1's representative related to the pattern of aggressive behavior and psychosocial needs.</p> <p>28 Pa. Code 201.29(a) Resident Rights</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2024
NAME OF PROVIDER OR SUPPLIER Edison Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 222 West Edison Avenue New Castle, PA 16101	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655</p> <p>Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to ensure medical records on each resident were accurately documented for one of four residents reviewed (Resident R3).</p> <p>Findings include:</p> <p>Resident's R3's clinical record revealed an admitted [DATE], with diagnoses that included urinary tract infection, neuromuscular dysfunction of the bladder (a urinary condition involving bladder control due to a brain, spinal cord or nerve problem), diabetes mellitus (a disease that affects how blood sugar is regulated in the blood), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>Review of Resident R3's Medication Administration Record (MAR) revealed a physician order with start date of 5/18/23, for Anoro Ellipta (umeclidinium-vilanterol--medicines to treat Chronic Obstructive Pulmonary Disease [COPD-progressive lung disease]) blister with device; 62.5-25 microgram (mcg)/actuation one puff, inhale orally one time a day for wheezing.</p> <p>Observation of the 2 [NAME] Medication Cart on 1/09/24, at 12:15 p.m. revealed there were no Anoro Ellipta inhalers for Resident R3. At the time of this observation, Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R3 did not receive his/her Anoro Ellipta inhaler on 1/08/24, and 1/09/24, per physician order due to the medication not available.</p> <p>During an interview on 1/10/24, at 2:50 p.m. LPN Employee E1 confirmed that he/she documented in error on Resident R3's Medication Administration Record 1/08/24, that the inhaler was administered to Resident R3 when it was not.</p> <p>During an interview on 1/10/24, at 1:57 p.m. the Director of Nursing confirmed Resident R3's medication, Anoro Ellipta inhaler, was not administered per physician order on 1/08/24, and was documented in error by the nurse that it was administered.</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		