

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 04/17/2026
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on review of clinical records, facility documents, facility policy, and staff and resident interviews, it was determined that the facility failed to complete a thorough investigation regarding an elopement for one of four residents reviewed (Resident R1). Findings include: A facility policy entitled, Pennsylvania Resident Abuse Policy dated 9/02/25, indicated The facility will investigate all allegations of neglect immediately and report all such allegations to the Administrator (NHA) and the NHA will immediately begin an investigation. The facility defines neglect as the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or coercion. Once the Nursing Home Administrator (NHA) and Director of Nursing (DON) are notified, an investigation of the allegation will be conducted. Conduct interviews with the resident, and all witnesses. Witnesses include anyone who witnessed or heard of the incident, anyone who came in close contact with the resident the day of the incident (including other residents). Obtain written statements from the resident, if possible, and each witness. Evidence of the investigation should be documented. A final report will be submitted to applicable state agency, after the investigation is completed, but no later than five working days after the alleged occurrence. Review of facility documents provided on 4/16/26, revealed evidence that Resident R1 eloped from the facility on 4/14/26, at approximately 5:30 a.m. During an interview on 4/16/26, at 7:25: a.m. Resident R1 stated that he/she walked to end of the hall and the door was unlocked, he/she just pushed on it, there was no alarm, so he/she went down the stairs, saw cars outside, so went outside. There wasn't an alarm on that door either, because if an alarm goes off you stop dead in your tracks. There were a couple of people who came up to him/her and next thing he/she knew there were lots of people there. Review of witness statements provided by the facility on 4/16/26, and dated 4/14/25, revealed lack of handwritten statements from all staff involved in the incident. Interviews with staff on 4/16/26, between 6:45 a.m. and 9:30 a.m. confirmed that not all witnesses were required to submit a handwritten witness statement at the time of the elopement and that Resident R1 was observed to have eloped from the facility on the above stated date and time. There was no evidence that the facility thoroughly investigated Resident R1's elopement in the required time frame following the incident which occurred on 4/14/26, or two days prior to the on-site survey. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(5) Nursing services</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on review of facility policy and documentation, clinical records, and resident and staff interviews, it was determined that the facility failed to implement sufficient safety interventions and supervision to prevent elopement (unauthorized leave from the facility). This failure placed residents at the facility in an Immediate Jeopardy situation for one of four residents reviewed who were at risk for elopement from the facility (Resident R1). Findings include: Review of the facility policy entitled, Elopement Unauthorized Absence Policy, dated 9/02/25, defined elopement as leaving the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. The policy also indicated that the facility would: identify residents with potential and/or actual risk factors for elopement and protect the residents through development and implementation of safety interventions. Resident R1's clinical record revealed an admission date of 8/03/23, with diagnoses that included encephalopathy (generalized dysfunction of the brain), stroke, Bipolar disorder (chronic mental health condition characterized by extreme mood swings, alternating between high-energy manic or hypomanic episodes and deep depressive lows), and Epilepsy (chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, excessive electrical discharges in brain cells). Review of an elopement assessment completed on 3/17/26, indicated that Resident R1 was at risk for elopement. Review of a care plan entitled, At risk for injury related to elopement/wandering dated 9/15/25, included interventions to apply a Wander guard bracelet (wearable devices designed for senior care facilities to prevent residents with cognitive impairments from wandering off), check placement, functioning, and skin integrity, and follow facility elopement procedures. A Brief Interview for Mental Status (BIMS) dated 2/06/26, indicated he/she had a score of 10 (moderately impaired cognition). Review of facility documentation dated 4/14/26, revealed the following information: A witness statement typed by the Nursing Home Administrator (NHA) dated 4/14/26, indicated that Employee E2 pulled in the parking lot, heard an alarm; opened the door to stairwell; observed Resident R1 in the doorway; walked with Resident R1 to the parking lot and Employee E1 stayed with Resident R1 while he/she got the nurse. A witness statement typed by the NHA dated 4/14/26, indicated that Resident R1 walked down the long hallway to the door at the end of the hall and went down the stairs; got to the end of the stairwell; while trying to decide which way to go some b**** stopped [Resident R1] before he/she could go anywhere and turned him/her in; and took him/her back upstairs. A handwritten witness statement from Employee E3 dated 4/14/26, indicated he/she observed Resident R1 walking around his/her room; did not realize Resident R1 had left the floor; when the nurse returned from smoking 45 minutes later, he/she proceeded to go down stairs; observed the clear plastic lock box over the elevator button was unlocked; when he/she arrived on the Second Floor staff had been alerted that Resident R1 was outside; he/she returned to upstairs and notified Resident R1's nurse who continued to pass medications; he/she then went outside to assist in getting Resident R1 back inside. A handwritten witness statement from Employee E4 dated 4/14/26, indicated he/she did not witness Resident R1 getting out of the building. A handwritten witness statement from Employee E5 dated 4/14/26, indicated during last rounds he/she was notified Resident R1 was found outside the facility. A handwritten witness statement from Employee E6 dated 4/14/26, indicated that he/she was notified by kitchen staff that a resident wearing a helmet was outside; Employee E6 last observed Resident R1 sitting at nurse's station 45 minutes prior; wander guard did not go off. A handwritten witness statement from Employee E7 dated 4/14/26, around 5:30 a.m. revealed a kitchen worker came to the floor and voiced there was a resident outside; exited outside followed by a maintenance worker; observed Resident R1 standing in the parking lot talking to a housekeeper; Resident R1 stated to Employee E7 that he/she walked down the stairs; wander guard was in place and alarmed when resident came in the door. Employee E1 provided a written statement to the surveyor dated 4/14/26, (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>indicated that he/she arrived at work 5:25 a.m.; observed Resident R1 by the first floor elevator; taking items to the garage then stopped at the smoking area to smoke; observed a car pulling into the parking lot and stood to put out his/her smoke; observed Resident R1 by the roll-off dumpster; as he/she approached Resident R1 the staff who had pulled in (Employee E2) also approached Resident R1; together they engaged in conversation with Resident R1; Employee E2 went to alert nursing staff that Resident R1 was in the parking lot; Employee E1 alerted his/her supervisor that Resident R1 was in the parking lot. During an interview on 4/16/26, at 7:10 a.m. Employee E7 confirmed he/she was alerted by laundry that Resident R1 was outside at 5:30 a.m. He/she went down and with the assistance of maintenance staff were able to get him/her back inside. The 3rd floor nurse did not respond. Employee E8 had stated throughout the shift that he/she was upset about being the only nurse on 3rd floor that night. When Resident R1 was brought back inside, the Wander guard system alarmed. Resident R1 stated to Employee E7 that he/she went down the stairs. Interview on 4/16/26, at 7:20 a.m. revealed Employee E9 was working on the 2nd floor and was alerted by housekeeper that Resident R1 was found in the parking lot by maintenance. Interview on 4/16/26, at 7:25 a.m. with Resident R1 revealed that he/she walked to end of the hall and the door was unlocked, he/she just pushed on it, there was no alarm, so went down the stairs, saw cars outside, then went outside. Resident R1 also stated that there wasn't an alarm on that door either, because if an alarm goes off you stop dead in your tracks. Resident R1 continued to state during the interview that there were a couple people who came up to him/her and next thing they knew there were lots of people there. Interview on 4/16/26, at 7:30 a.m. revealed Employee E1 confirmed that the only doors with Wander guard alarms are the main front door, smoking door, and the second-floor sliding door on ground level that goes to the side parking lot. Employee E1 stated that he/she got here about 5:20-5:25, entered the building and saw Resident R1 by the elevators on the ground floor. He/she punched in and went back to the maintenance garage/office to unload their personal belongings and went to have a smoke. At that time, he/she realized they didn't have a lighter and saw the nurse from 3rd floor outside smoking by the main entrance and asked them for a light. He/she went over to the smoking area near the dumpster to finish smoking. Employee E1 saw a car pull into the lot, put out the smoke, and went back into the maintenance garage. When he/she came back out, the 3rd floor nurse was gone, and then saw a housekeeper approaching Resident R1 from the parking lot near the roll off dumpster area. Employee E1 told the housekeeper to go get nursing staff while he/she waited with Resident R1. After the incident, Employee E1 and another maintenance staff did a walk-through of all the doors and found: 1) the dining room door to the outside was propped open with a rock and 2) the door at the end of the long hall on the third floor was not closed tightly and latched (stairwell that leads directly down to the area where Resident R1 was found). Employee E1 confirmed that he/she has found the locked box securing the elevator button on third floor unlocked and open when he/she comes into work at 5:30-6:00. Employee E1 provided a photocopy of the handwritten statement that was provided to facility administration. During an interview on 4/16/26, at 7:45 a.m. Employee E2 stated that when he/she was walking toward the building Resident R1 came out of the darkness on the sidewalk from between the building and dumpster area that leads to the back of the building. Employee E2 verbalized [Resident R1] scared the crap out of me because I didn't see [Resident R1] until he/she stepped out of the dark. At that same time, Employee E2 saw Employee E1 coming from the maintenance garage area. Employee E1 stayed with Resident R1 while he/she went to second floor and told nursing. Employee E2 confirmed he/she was not asked to provide a written statement about the incident. Employee E2 confirmed that he/she has found the lock box at the third-floor elevator unlocked and open, and the door propped open that leads to the laundry on and off since starting employment at the facility. During an interview on 4/16/26, at 7:53 a.m. Employee E10 confirmed that he/she has found the lock box at the third floor elevator unlocked and open, and the door propped open that leads to the laundry several times when he/she comes to work at six a.m. Observations on 4/16/26, between 7:30 a.m. and 7:45 a.m. revealed the laundry room door propped (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>open and a rock lying against the window frame near the dining room glass door. Observations and interview on 4/16/26, at 8:00 a.m. with Employee E11 confirmed that the locking mechanism and door handle for the door leading from the housekeeping hallway was broken and unable to be locked to prevent entry into the housekeeping hallway; the laundry room door from the housekeeping hallway is not locked when he/she leaves because the next shift that comes in doesn't have a key and is told by the supervisor that they don't have a key either; the door from the laundry room to the outside also has a broken handle is unable to be locked from the inside to prevent exit. Employee E11 confirmed that it is possible for a resident to get into the housekeeping hallway, through the unlocked laundry room door and outside through the unsecured laundry door to the outside of the building. Documents provided by the facility on 4/16/26, and dated 4/14/26, revealed that an elopement drill was conducted with day shift staff; and an elopement in-service was conducted with 35 facility staff on 4/15/26. Review of clinical records for four residents (Residents R1, R2, R3, and R4) identified as elopement risks revealed that elopement assessments were completed on 4/14/26. During an interview on 4/16/26, at 11:40 a.m. the NHA did not consider the incident with Resident R1 an elopement, and had no other documents to provide the surveyor. An Immediate Jeopardy (IJ) situation was identified to the NHA on 4/16/26, at 2:21 p.m. and the IJ template was provided to the NHA, related to Resident R1's elopement from the facility. The NHA was made aware that Immediate Jeopardy existed for the facility's failure to ensure implementation of all safety measures to prevent elopement for residents in the facility and an immediate action plan was requested. On 4/16/26, at 5:30 p.m. an acceptable immediate action plan was approved which included the following interventions: Resident #1 was immediately assessed and assisted back to his unit with no injury. WanderGuard in place and functioning properly by floor nurse. WanderGuard/Watchmate functionality verified by maintenance department immediately following incident on 4/14/2026 by 7am. All unsecured doors were immediately closed and secured following incident by maintenance department on 4/14/2026 by 7am. Resident #1 physician notified with no new orders at 8:55am on 4/14/2026. Resident #1 is his own responsible party. Elopement risk residents reviewed by IDT team and ensured that careplans and orders were in place and elopement binders were up to date on 4/14/26 by 10am. Door ajar alarm placed on identified doors that was propped open on 4/14/2026 by 12pm. Elopement drill completed by staff for education purposes on 4/14/2026 by 2pm. All objects able to be used to prop doors open were removed from door areas on 4/16/2026 by 3pm. All residents (4) at risk for elopement careplans and orders were reviewed and updated, if necessary, by IDT team by 4/16/2026. All staff education on door security, door propping, door codes, elevator lock box and elopement prevention beginning on 4/16/2026 prior to the start of their next shift; prn and agency staff will be educated via phone prior to the start of their shifts. Staff instructed to report malfunctioning doors immediately to maintenance director/NHA. After review of facility documentation, observations, and staff interviews, the implementation of the above stated action plan was confirmed on 4/17/26, at 2:21 p.m. and the NHA was informed that the Immediate Jeopardy situation was removed. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on review of facility records and job descriptions, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to make certain that proper supervision and elopement prevention interventions were effectively implemented in the facility. Findings include: The NHA's job description revealed that the NHA's primary purpose is to lead, direct, and manage the overall operations of the community in accordance with policies and procedures; current federal, state, and local standards, guidelines and regulations that govern the community. To organize, develop and direct resources to maintain the highest degree of quality care is maintained for each resident at all times. The DON's job description specified that the DON is responsible to organize, develop, manage, and direct the overall operations of the Nursing Department in accordance with current federal, state and local standards, guidelines and regulations that govern the community. Work directly with the Administrator and the Medical Director to ensure the highest degree of quality of care is maintained for each resident at all times. The findings in this report identified that the facility failed to consistently supervise and maintain all safety interventions to prevent elopement for their residents, and the NHA and the DON failed to fulfill their essential job duties to ensure that the federal and state guidelines and regulations were followed. Refer to F68928 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(a) Management 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c) Nursing Services 28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>