STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395645	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edinboro Manor	419 Waterford Street Edinboro, PA 16412

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on review of clinical records and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for two of 23 residents reviewed (Residents R110 and R112). Findings include: Resident R110's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), and chronic obstructive pulmonary disease (condition when your lungs do not have adequate air flow). R110's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R110 and/or his/her representative. Resident R112's clinical record revealed an admitted [DATE], with diagnoses that included dementia hypertension (high blood pressure), and hyperlipidemia (high cholesterol). R112's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R112 and/or his/her representative. During an interview on 1/30/25, at 1:59 p.m. the Director of Nursing confirmed that the clinical records of the residents listed above lacked evidence that a written summary of the baseline care plan and order summary were provided to the resident and/or his/her representative upon admission to the facility. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 201.18(b)(1) Management

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to develop a splint care plan for one of 23 residents reviewed (Resident R27). Findings include: Review of facility policy entitled Comprehensive Care Plan dated 12/18/24, indicated. The Manor will develop a comprehensive person centered care plan for each resident . and Periodically reviewed and revise . Review of Resident R27's clinical record revealed an admitted [DATE], with diagnoses that included flaccid hemiplegia affecting left non-dominant side (a condition where a person is paralyzed and unable to move one side of their body), diabetes (a health condition caused by the body's inability to produce enough insulin), and hypertension (high blood pressure). Review of Resident R27's physician's orders revealed an order dated 12/26/24, for left resting hand splint every day/shift for left hand support; splint on during waking hours; skin to be checked frequently for signs of irritation or breakdown; may remove for hygiene. Review of Resident R27's care plans revealed no evidence of a care plan for a left resting hand splint. During an interview on 1/30/25, at 10:45 a.m. the Director of Nursing confirmed that there wasn't a care plan for Resident R27's left resting hand splint. He/she also confirmed that a care plan should have been developed for Resident R27's left resting hand splint. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(c)(d) Resident care policies

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of clinical records and facility policies, and staff interview, it was determined that the facility failed to show evidence of having resident care plan conference meetings or invitation to care plan meetings for one of 23 residents reviewed (Resident R106) Findings include: Review of facility policy entitled Comprehensive Care Plan dated 12/18/24, indicated Residents will have the opportunity to discuss their goals for care . Review of facility skills competency checklist entitled Resident Service Coordinator dated 12/18/24, indicated Demonstrates knowledge of the 72 hours care conference and care planning process. Review of Resident R106's clinical record revealed an admitted [DATE], with diagnosis that include chronic obstructive pulmonary disease (condition when your lungs do not have adequate air flow), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hypertension (high blood pressure). Review of Resident R106's clinical record lacked evidence that he/she and/or resident representative had been invited/attended a care plan conference meeting. During an interview on 1/28/25, at 2:14 p.m. Resident R106 disclosed that he/she had not attended and/or been invited to a care plan conference meeting. During an interview on 1/31/25, at 10:00 a.m. with Social Services Coordinator Employee E3, he/she confirmed there was no evidence that Resident R106 and/or his/her representative had attended and/or had been invited to a care plan conference meeting since Resident R106 was admitted to the facility. During an interview on 1/31/25, at 10:20 a.m. the Director of Nursing confirmed there was no evidence that Resident R106 and/or his/her representative had attended and/or had been invited to a care plan conference meeting. 28 Pa. Code 211.5(f)(ii) Medical records 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to ensure that a resident with limited range of motion received physician ordered treatment and services to prevent further decrease in range of motion for one of six residents reviewed (Resident R27). Findings include: Review of Resident R27's clinical record revealed an admitted [DATE], with diagnoses that included flaccid hemiplegia affecting left non-dominant side (a condition where a person is paralyzed and unable to move one side of their body), diabetes (a health condition caused by the body's inability to produce enough insulin), and hypertension (high blood pressure). Review of Resident R27's physician's orders revealed an order dated 12/26/24, for left resting hand splint everyday/shift for left hand support; splint on during waking hours; skin to be checked frequently for signs of irritation or breakdown; may remove for hygiene. Observations on 1/28/25, at 12:45 p.m. and again at 2:45 p.m. revealed Resident R27 lying in bed without a left resting hand splint (a splint placed on the hand to help with contractures) to his/her left hand and the left resting hand splint was observed laying on Resident R27's bedside table. Observations on 1/29/25, at 8:40 a.m. and again at 1:00 p.m. revealed Resident R27 was sitting in his/her wheelchair in the lounge without a left resting hand splint to his/her left hand and the left resting hand splint was observed in Resident R27's room laying on the bedside table. Observations on 1/30/25, at 9:20 a.m. and again at 10:45 a.m. revealed Resident R27 was sitting in his/her wheelchair in the lounge without a left resting hand splint to his/her left hand and the left resting hand splint was observed in Resident R27's room laying on the bedside table. During an interview on 1/30/25, at 10:45 a.m. the Director of Nursing confirmed that Resident R27 did not have a left resting hand splint on his/her left hand per physician's orders. He/she also confirmed that Resident R27 should have his/her left resting hand splint on per physician's orders. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on review of facility policies, manufacturer's guidelines, observations, and staff interviews, it was determined that the facility failed to store controlled schedule II-V medications (medications that may be abused or cause addiction that are closely monitored due to high risk of diversion) in a separately locked permanently affixed compartment and failed to ensure that medications were properly dated when opened in the main medication room, and failed to ensure an expired medication was discarded in a timely manner in one of two medication carts reviewed (A-Wing Cart). Findings include: Review of a facility policy entitled Vials and Ampules of Injectable Medications dated [DATE], indicated that, The date opened is recorded by the first person to use each multidose vial. Prior to each use, the solution in multidose vials is inspected for unusual cloudiness, precipitation, or foreign bodies. The rubber stopper is inspected for deterioration. Multi-dose vials expire 28 days after initial use, unless otherwise indicated by the manufacturer. Review of a facility policy entitled Medication Storage in the Facility dated [DATE], indicated that, Outdated, contaminated, or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, returned to ICP, and reordered from the pharmacy, if current order exists. Manufacturer's guidelines for Tubersol PPD (solution used for tuberculosis testing upon admission and for employment), indicated that vials which are entered and in use for 30 days should be discarded. Manufacturer's guidelines for Humalog insulin (a fast-acting insulin used to manage blood sugar levels in people with diabetes), indicates that after opened vials and pre-filled pens should be discarded after 28 days. Observation on [DATE], at 12:13 p.m. of the main medication room refrigerator revealed several vials of controlled scheduled II-V medications in two separately locked containers that were attached to a removeable shelf, therefore they were not permanently affixed to the refrigerator and an opened vial of Tubersol PPD without an open date, therefore the staff were unable to determine the discard date. During an interview at that time Licensed Practical Nurse (LPN) Employee E1 confirmed that the controlled scheduled II-V medications should be stored in a separately locked permanently affixed compartment, and not attached to a removeable shelf and also confirmed that the opened Tubersol PPD vial lacked an open date, and staff were unable to determine the discard date. Observation on [DATE], at 3:18 p.m. of the A-Wing medication cart revealed an open injector pen of Humalog insulin with an open date of [DATE], therefore the medication was expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at that time LPN Employee E2 confirmed that the injector pen of Humalog insulin was expired and should have been discarded. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services