

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Edinboro Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies and documents, and staff interviews, it was determined that the facility failed to provide housekeeping services necessary to maintain a clean environment and clean equipment for two of four resident halls (Resident rooms 32, 34, 35, 38, 40, 41, 43 on C Hall and rooms 56, 57, 58, 59, 60, and 62 on D Hall). Findings include: Review of facility policy entitled Equipment Cleaning and Maintenance dated 12/3/25, indicated IV and enteral poles clean poles thoroughly Review of policy entitled Housekeeping and Maintenance Services dated 12/3/25, indicated Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping residents' care equipment clean. Review of facility Daily resident room cleaning and disinfecting checklist indicated toilet cleaned/disinfected inside and outside, dust mop/mop floor, IV/tube feed poles cleaned and disinfected, and list any maintenance repairs. Review of facility wheelchair cleaning schedule indicated that wheelchairs are to be cleaned per schedule and initial when completed. Observations on 1/12/26, between 12:20 p.m. - 4:00 p.m., and on 1/13/26, between 9:30 a.m. - 10:30 a.m., of resident rooms on C unit revealed: room [ROOM NUMBER]- an IV pole with a thick yellow dried liquid substance covering the base, under the bed a large amount of gray fluffy substance. room [ROOM NUMBER]- an IV pole with a yellow dried liquid substance covering the legs. room [ROOM NUMBER]- a wheelchair with food crumbs on the seat cushion, a white dried liquid substance running down the legs of the wheelchair and under both beds a large amount of fluffy gray substance. room [ROOM NUMBER]- a wheelchair with chunks of food stuck to the cushion, and under both beds a large amount of gray fluffy substances. room [ROOM NUMBER]- a wheelchair with pieces of vinyl covering on the armrest peeling off, a second wheelchair with a cushion that had a large brown stain and the vinyl cover peeling off, under both beds a large amount of fluffy gray substance, food crumbs against the walls and paper and used (continued on next page)		

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff interview, it was determined that the facility failed to assure physician's orders and resident's Physician Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent for one of 24 residents reviewed (Resident R96). Findings include: Resident R96's clinical record revealed an admission date of [DATE], with diagnoses including ankylosing spondylitis of the mid-lower back (inflammatory arthritis that affects the spine, causing stiffness and pain), chronic obstructive pulmonary disease (COPD- group of lung diseases that make it hard to breathe and get worse over time), respiratory failure, irregular heartbeat, and kidney disease. Resident R96's clinical record contained: a physician's order dated [DATE], for a code status of Do Not Resuscitate (instructing healthcare providers not to perform cardiopulmonary resuscitation [CPR- emergency treatment that's done when someone's breathing or heartbeat has stopped] if a patient's heart or breathing stops).a POLST dated [DATE], which indicated that Resident R96 wished to have CPR performed if he/she has no pulse and is not breathing. During an interview on [DATE], at 12:56 p.m. the Director of Nursing confirmed that Resident R96's physician's order and POLST were not consistent with each other. 28 Pa. Code 201.18 (b)(1)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f)(i)(vii) Medical records		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of clinical records and facility policy, and staff interview, it was determined that the facility failed to provide evidence that a gradual dose reduction (GDR) was attempted and a clinical rationale for the continued use of a psychoactive (affecting the mind) medication for one of five residents reviewed for psychoactive medications (Resident R4). Findings include: Review of policy entitled Psychotropic Drugs dated 12/3/25, revealed residents that use psychotropic drugs receive gradual dose reduction. and A physicians note indicating that the use of the drug, or continued use of the drug is clinically appropriate, and the reason why. Review of Resident R4's clinical record revealed an admission date of 10/8/22, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically) and delusional disorder (a mental disease that includes delusions a false belief based on an incorrect interpretation of reality). Resident R4's clinical record revealed a physician's order dated 7/12/24, for Aripiprazole (medication to treat behavioral disturbance in dementia) two milligrams by mouth one time a day. The clinical record lacked evidence of an attempt of a GDR and/or rationale for continued use. During an interview on 1/14/26, at 11:50 a.m. the Director of Nursing confirmed that Resident R4's physician's order for Aripiprazole lacked evidence of a GDR attempt or a clinical rationale for continued use. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 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 one of four residents reviewed (Residents R6).Findings include: Review of facility policy entitled Admission, Transfer, Discharge, and Room Change dated 12/3/25, indicated The Manor is required to provide sufficient preparation and orientation to resident to ensure safe and orderly transfer. Review of Resident R6's clinical record revealed an admission date of 1/13/16, with diagnoses that included diabetes (a health condition that is caused by the body's inability to produce enough insulin), chronic kidney disease (a disease that affects the kidney's ability to filter waste products and extra fluid from the body), and hypertension (high blood pressure). Resident R6's progress notes revealed a note dated 9/27/25, indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. During an interview on 1/14/26, at 1:32 p.m. the Director of Nursing confirmed that Resident R6's clinical record lacked evidence that the necessary clinical information was provided to the receiving healthcare provider upon transfer and when the transfers occurred clinical information should have been provided to the receiving healthcare provider. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights		

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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 Based on review of facility policy and clinical record, 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 one of 24 residents reviewed (Resident R10) and failed to ensure that a baseline care plan was developed and implemented within 48 hours that included the minimum healthcare information necessary to provide proper care for one of 24 residents reviewed (Resident R110). Findings include: A facility policy entitled, Care Plan Policy dated 12/3/25, revealed .A baseline care plan will be developed within 48 hours of admission.Residents will have the opportunity to discuss their goals including their preferences for advances care planning. Resident R10's clinical record revealed an admission date of 6/10/25, with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), intellectual disabilities (limitations to cognitive functioning and skills), and chronic heart failure. Resident R10's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R10 and/or his/her representative. Resident R110's clinical record revealed an admission date of 7/8/25, with diagnoses that included heart failure, chronic obstructive pulmonary disease (a disease that obstructs air flow from the lungs), and anxiety. Resident R110's clinical record lacked evidence that a baseline care plan was developed within 48 hours that included the minimum healthcare information necessary to provide proper care. During an interview on 1/14/26, at 1:38 p.m. the Director of Nursing confirmed that the clinical record for Resident R10 lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R10 and/or his/her representative upon admission to the facility and that the clinical record for Resident R110 lacked evidence that a baseline care plan was developed within 48 hours that included the minimum healthcare information necessary to provide proper care. 28 Pa. Code 201.18 (b)(1) Management		

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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** Based on review of facility policies and clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for one of 24 residents reviewed (Resident R10). Findings include: Review of facility policy entitled Care Plan Policy dated 12/3/25, revealed Periodically reviewed and revised by a team of qualified persons after each assessment. Review of facility policy entitled Care Plan Revision dated 12/3/25, revealed The Interdisciplinary Team must update and review the care plan: At least Quarterly, in conjunction with the required quarterly MDS (Minimum Data Set-periodic assessment of resident care needs) assessment. Resident R10's clinical record revealed an admission date of 6/10/25, with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), intellectual disabilities (limitations to cognitive functioning and skills), and chronic heart failure. Review of Resident R10's admission MDS dated [DATE], Section H - Bladder and Bowel category H0400. Bowel Continence was marked 2 Frequently Incontinent, the Quarterly MDS dated [DATE], Section H - Bladder and Bowel category H0400. Bowel Continence was marked 0 Always Continent, and the Quarterly MDS dated [DATE], Section H - Bladder and Bowel category H0400. Bowel Continence was marked 0 Always Continent. Review of Resident R10's 30-day task record revealed he/she was always continent of bowel. Review of Resident R10's care plan for bowel created on 6/23/25, with a target date of 3/10/26, indicated Resident R10 was frequently incontinent of bowel. During an interview on 1/15/26 at 9:40 a.m. the Director of Nursing confirmed that Resident R10's bowel care plan was not reviewed/revised to reflect current resident care and that care plans should be reviewed and revised as necessary. 28 Pa. Code 211.5(f)(iii) 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for one of one residents reviewed for respiratory care (Resident R3). Findings include: Review of policy entitled Oxygen Concentrators dated 12/3/25, indicated If there are external cabinet filters present, these are to be cleaned weekly. Review of Resident R3's clinical record revealed an admission date of 11/3/23, with diagnoses that included multiple sclerosis (a disease where the body's immune system attacks the nerves which can cause vision problems, muscle weakness, numbness, feeling tired, difficulty thinking and bowel and bladder dysfunction.), chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and respiratory failure (a condition where your lungs don't exchange air properly). Review of Resident R3's physician orders revealed an order dated 8/7/25, for titrate (to adjust the flow rate of the oxygen) O2 (oxygen) to maintain sats (saturation) at or greater than 90 percent every shift. Observation on 1/12/26, at 12:05 p.m. and 2:30 p.m. revealed an oxygen concentrator with a large amount of fluffy white substance covering the filters. Observation on 1/13/26, at 9:30 a.m. revealed the large amount of fluffy white substance remained on the filters of the oxygen concentrator. During an interview on 1/13/26, at 10:15 a.m. the Director of Nursing confirmed that there was a large amount of fluffy white substance on Resident R3's oxygen concentrator filters and also confirmed that the filters should be clean. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to have complete and accurate documentation regarding skin check/wound documentation for one of six residents reviewed with wounds (Resident R9), and one of nine residents receiving enteral feedings (liquid nutrition delivered through a flexible tube inserted through the stomach wall into the digestive tract) (Resident R94). Findings include: Review of facility policy entitled Documentation, dated 12/03/25, revealed The Manor will provide a complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care. Review of Resident R9's clinical record revealed an admission date of 1/17/23, with diagnoses that included cancer of the pancreatic duct, chronic pain syndrome, diabetes, Parkinson's disease and high blood pressure. The clinical record revealed that on 12/18/25, Resident R9's skin/wound note revealed that Resident R9 had open areas on the left glute and right calf, open areas have been resolved. Skin check notes dated 12/21/25, 12/29/25 and 1/08/26, all indicated that Resident R9 had Stage 3 pressure ulcers (full thickness skin loss) to the left glute and the right calf. During an interview on 1/13/2026, at 9:25 a.m. the Director of Nursing (DON) confirmed that Resident R9's clinical record documentation for the skin check's on the above dates were inaccurate and that the wounds were resolved on those dates. Resident R94's clinical record revealed an admission date of 12/10/25, with diagnoses including stroke, malnutrition, difficulty swallowing, presence of a gastrostomy (g-tube-artificial opening into the stomach to administer nutritional supplement), and prostate cancer. Resident R94's clinical record revealed the following physician's orders dated 12/10/25: document the total intake of enteral feeding and water flushes through the g-tube every shift; flush g-tube with 20-30 mL (milliliters) of water before and after administration of medication; Iso-Source (nutritional supplement) 1.5 at 55 mL/hour through the g-tube every shift; and free water flushes of 100 mL every four hours for hydration. A nutrition progress note dated 12/18/25, indicated that Resident R94 was to receive a total of 1210 mL of feeding and 919 mL of free water in 24 hours. A physician's order dated 12/19/25, identified to disconnect the feeding for up to two hours to allow for personal care (down at 10:00 a.m. and restarted at 12:00 p.m.) Review of Resident R94's medication administration record revealed omitted and inconsistent documentation of the amount of nutritional feeding and water administered through his/her g-tube each shift, and failure to ensure that Resident R94 received the recommended 1210 mL of enteral feeding and 919 mL of free water in 24-hour period. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/2026, at 9:30 a.m. the DON confirmed that documentation of nutritional feeding totals and free water was not complete and accurate to ensure that Resident R94 was receiving the required nutrition and hydration. 28 Pa. Code 211.5(f)(xiii)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, review of facility policy, and staff interview, it was determined that the facility failed to implement measures to prevent the potential for cross contamination (transfer of germs from one location to another) for a gastric feeding tube (a medical device used to provide nutrition and/or medications when a person cannot swallow or take anything by mouth) for one of three residents observed regarding feeding tubes (Resident R3). Findings include: Review of facility policy entitled Tube Feedings dated 12/3/25, indicated Cover the end of the feeding tube with its plug or cap to prevent leakage and contamination of the tube and Store clean equipment away from potential sources of contamination. Review of policy entitled Housekeeping and Maintenance Services dated 12/3/25, indicated Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping residents' care equipment clean and properly stored. Review of Resident R3's clinical record revealed an admission date of 11/3/23, with diagnoses that included multiple sclerosis (a disease where the body's immune system attacks the nerves which can cause vision problems, muscle weakness, numbness, feeling tired, difficulty thinking and bowel and bladder dysfunction), chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and respiratory failure (a condition where your lungs don't exchange air properly). Review of Resident R3's physician orders revealed an order dated 1/25/24, for enteral feed Nurten 1.5 (type of feeding formula) at 65 cc (cubic centimeters) per hour via pump to provide 1300 daily volume and 1905 calories per day to be down from 8:00 a.m. to 12:00 p.m. daily. Observations on 1/13/26, at 9:38 a.m. and again at 10:15 a.m. revealed Resident R3's tube feeding connection (the part that connects to the resident's gastric feeding tube) was hanging over his/her feeding tube pump and the feeding tube connection was not covered. During an interview on 1/13/26, at 10:15 a.m. the Director of Nursing confirmed that the feeding tube connection was hanging over the feeding pump uncovered and that the feeding tube connection should be covered when it is not connected to Resident R3's gastric feeding tube. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services		