

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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NAME OF PROVIDER OR SUPPLIER: EDISON MANOR NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 222 WEST EDISON AVENUE NEW CASTLE, PA 16101
STATE LICENSE NUMBER: 025902	

(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
F 0000	INITIAL COMMENT	F 0000		
F 0565	Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey and an Abbreviated Complaint Survey completed on January 9, 2025, it was determined that Edison Manor Nursing and Rehabilitation Center, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0565		
SS=E				

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.

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F 0565 SS=E	Continued from page 1 483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 0565	a. Emergency Resident Council meeting help on January 21st to address all concerns b. Nursing Home Administrator/designee educated Activity Director on resident council process and concern forms to be completed with each concern. c. Resident Council Concern form template update and given to Activity director to use with resident council concerns. d. Nursing Home Administrator /designee will meet with Resident Council president within 3 days of resident council meeting monthly (starting Jan 2025) times 3 months to verify completion of new concern forms are completed from the meeting and to discuss resolutions. Concerns will be reviewed in the old business of the next meeting. e. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/11/2025

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F 0565 SS=E	Continued from page 2 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 0565		

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F 0565 SS=E	Continued from page 3 Based on review of facility policy and documents, and resident and staff interviews, it was determined that the facility failed to ensure that the residents are able to voice their concerns at the meetings, and that the meeting concerns are recorded for timely follow-up and resolutions to resident concerns for seven of seven Resident Council attendants (Residents R9, R14, R56, R62, R67, R73, and R85). Findings include: Review of a facility policy entitled "Resident Council Policy" dated 9/2024, indicated that the Life Enrichment Director or designee may attend the Resident Council Meeting to act as a liaison between the group and the facility if requested by the Council. Any additional facility personnel will attend the meeting upon request of the residents. The Activity Director will attempt to accommodate the resident recommendations to the extent practicable and provide follow-up to the Resident Council. Resident Council will document minutes of	F 0565		

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F 0565 SS=E	Continued from page 4 each meeting along with attendance on the Resident Council Meeting Minutes Form. Resident issues or concerns will be documented on the Resident/Family Concern Form and forwarded to the facility Administrator for the appropriate follow-up. If a particular resident is voicing a concern versus a group concern, the resident may or may not include their name. Once the respective department has addressed the Resident/Family Concern and document the outcome, the form is returned to the Life Enrichment Director to file with the Resident Council Minutes. Resident Council minutes from 10/28/24, revealed no concerns with administration, nursing, dining services, maintenance, laundry, social services, therapy, business office, life enrichment. Food committee-"residents stated they would like to have different snacks available. We now have more option for snack now *Nutri grain bars *Fig bars." Resident Council minutes from 11/25/24, revealed resolutions old business-Review of Previous	F 0565		

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F 0565 SS=E	Continued from page 5 Meeting, Outstanding Issues and Resident Council Departmental Response Forms Resolutions from last meeting (from the concern forms): Administration issue/concern: No issues. Resolution: No concern. Nursing issue/concern: Cellphones in hallways. Resolution: No issues, residents stated they have not been seeing staff on their phones. Dining Services issue/concern: Resolution: No issues residents stated they enjoy eating in the dining room. Maintenance issue/concern: No issues. Laundry issue/concern: Resolution: No issues. New Business Administration-Residents stated the administrator is great. Nursing-No concerns. Residents stated staffing is better, aids should knock before entering rooms stated residents. Most aids do knock on the doors. Dining Services-Residents stated they enjoy eating in dining room. Maintenance-Residents stated he is great, doing a	F 0565		

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F 0565 SS=E	Continued from page 6 great job, no complaints. Laundry-no concerns resident stated there not missing any items this month. Social Services-no concerns. Therapy-Residents stated therapy is good at what they do. Business office-No concerns. Food Committee-residents stated they're happy to now get chef salads as a substitute. Resident Council minutes from 12/30/24, revealed resolutions old business-Review of Previous Meeting, Outstanding Issues and Resident Council Departmental Response Forms Resolutions from last meeting (from the concern forms): Administration issue/concern: No issues. Nursing issue/concern: Cellphones use in hallways. Resolution: No cell phone use in hallways. Dining Services issue/concern: Residents stated they want more residents to eat in the dining area. Resolution: We have more residents eating in dining area at this current time.	F 0565		

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F 0565 SS=E	Continued from page 7 Maintenance issue/concern: No issues. Laundry issue/concern: No issues. New Business Administration-No concerns. Residents stated the administrator is doing great. Nursing-No concerns. Residents stated staffing is better. Call lights are getting better. Resident did state there is some use of cell phones in hallways staff mostly agency aids. Dining Services-no concerns residents enjoy eating in dining room. Residents stated there are more residents that come down to dining area feels like family eating together. Maintenance-No concerns. Residents are sad to see him leave. Laundry-No concerns. Residents stated laundry is not an issue this month. Social Services-No concerns. Therapy-No concerns. Residents state therapy is great. Business office-No concerns. Life Enrichment-Residents would like to change evening bingo times. Life enrichment director will	F 0565		

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F 0565 SS=E	Continued from page 8 work on doing that. Food Committee-No complaints for food committee residents stated food is good. During a Resident Council meeting on 1/07/25, between 1:00 p.m. and 1:35 p.m., seven resident council attendants (Residents R9, R14, R56, R62, R67, R73, and R85) elicited concerns that their Resident Council monthly meeting concerns are not followed up by each department. Residents further indicated they never hear back from the facility and/or see any positive resolution from their concerns. Residents revealed in the past three months (October, November, and December of 2024) concerns for call bell response times (times revealed by residents ranged between 30 minutes and one hour time period for staff to respond to a call bell), snack availability (residents revealed that snacks are not available often, either the dietary department does not supply them to the floors and/or staff state there are none available and will not bring any to the residents' rooms), food quality, palatability, and temperature of resident meals, linen	F 0565		

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F 0565 SS=E	<p>Continued from page 9</p> <p>and resident care supplies availability (residents revealed wash cloths, towels, sheets, paper towels, soap, and incontinence products are not available daily) and housekeeping do not clean their rooms often enough due to lack of staff, ...were voiced each month and not addressed by the facility and/or resolutions communicated back to the Resident Council residents.</p> <p>During an interview on 1/07/25, at 3:00 p.m. the Activity Director revealed that no concerns, other than some dietary issues, were ever mentioned by the residents in the past three months of Resident Council (October, November, and December of 2024).</p> <p>During an interview on 1/08/25, at 3:00 p.m. the Social Services Director revealed that no concerns from Resident Council were provided to him/her to follow up with each department for the past three months (October, November, and December of 2024). The Nursing Home Administrator indicated on 1/08/25, at 2:10 p.m. that the Social Services</p>	F 0565		

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F 0565 SS=E	Continued from page 10 Director would be the facility person to follow up on Resident Council concerns. Review of Resident Council meeting notes from October, November, and December 2024, revealed a lack of evidence of resident contribution and/or participation in the Resident Council meetings and evidence regarding how the facility responded to any resident concerns. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1)(4) Management	F 0565		
F 0584 SS=E		F 0584		

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F 0584 SS=E	Continued from page 11 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	Facility immediately addressed Rooms 207, 209, 210, 217, 220, 223, 224, 226, 303, 307, 310, 319, 321, and 325 and cleaned all rooms to include the bathrooms and replenishing the toilet paper. Facility immediately implemented a cleaning schedule to include common areas/dining rooms and thorough cleans for each floor and patient rooms to protect residents in similar situations. Administrator/designee will educate all staff on F584, facility cleanliness and supplies. Administrator/designee will re-educate housekeeping staff on daily checklist which include replenishing supplies and cleaning compliance Administrator/designee will begin daily audits of 2 rooms per floor verifying compliance/thorough cleans and replenishing supplies were completed using the housekeeping checklists for 5 days and then audit 2 rooms/areas	Completion Date: 02/19/2025 Status: APPROVED Date: 02/11/2025

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F 0584 SS=E	Continued from page 12 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	3x/week for 2 weeks and then audit 10 rooms/areas monthly x 2 months Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.	

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F 0584 SS=E	Continued from page 13 Based on review of facility policy, staff and resident interviews and observations, it was determined that the facility failed to provide adequate housekeeping services to maintain a clean and sanitary environment for 14 of 94 resident rooms (Rooms 207, 209, 210, 217, 220, 223, 224, 226, 303, 307, 310, 319, 321, and 325), and for one of two dining rooms. Findings include: Facility policy, "General/Routine Environmental Cleaning and Disinfection Policy" dated 9/2024, revealed proper cleaning and disinfecting of environmental surfaces is necessary to break the chain of infection. Cleaning refers to the removal of visible soil from surfaces through the physical action of scrubbing with detergents/surfactants and rinsing with water. Process for Environmental cleaning and disinfection includes: working from clean to dirty; working from top to bottom. Cleaning and disinfection of environmental surfaces immediately if surface(s) are visibly soiled. Daily cleaning and	F 0584		

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F 0584 SS=E	Continued from page 14 disinfection for high touch surfaces in resident rooms. Household surfaces should be cleaned on a regular basis, when spills occur, and when surfaces are visibly soiled (floors, tabletops, resident care areas, dining rooms, common areas, shared shower rooms and bathrooms, hair salons, activities, etc). Horizontal surfaces with infrequent hand contact (e.g., windowsills and hard-surface flooring) in routine patient care areas require cleaning on a regular basis, when soiling or spills occur, and when a patient is discharged from the facility. Cleaning of walls, blinds, and window curtains is recommended when they are visibly soiled. Interviews with Residents R9, R56, R62, R67, R73, and R85 on 1/07/25, at 1:00 p.m revealed the residents feel the facility and their rooms are unsanitary and not cleaned sufficiently and/or often enough. Observations on 1/06/25, from 11:25 a.m. through 2:30 p.m. of resident rooms revealed the following:	F 0584		

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F 0584 SS=E	Continued from page 15 Rooms 220, 223, 224 and 226: the floors were dirty with dried stains, debris, trash and what appeared to be food particles. The bathroom of Room 220 was noted to be without toilet paper. Observations on 1/06/25, 1/07/25, and 1/08/25, at approximately 11:30 a.m of Room 303 revealed a lancet (a small medical device that releases a needle to prick the skin and obtain a blood sample), medication cup, used band-aid, gauze with blood stain, and a wound vac strap laying on the floor under and near the window bed. A dried brown liquid was also observed on the wall and floor near the window bed. Observations of Room 321, on same dates as noted above, revealed brown stains on the privacy curtain, and Room 325 with a lancet, nebulizer, and a yellowish-brown dried liquid under the resident's bed by the door. The Nursing Home Administrator (NHA) confirmed the above observations in Rooms 303, 321, and 325 on 1/08/25, at 11:55 a.m. that were unsanitary, and the rooms were not cleaned sufficiently.	F 0584		

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NAME OF PROVIDER OR SUPPLIER: EDISON MANOR NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 222 WEST EDISON AVENUE NEW CASTLE, PA 16101		
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F 0584 SS=E	Continued from page 16 Review of housekeeping form entitled "housekeeping resident room checklist," which all housekeeping staff fill out ensuring all rooms get cleaned and stocked completely, revealed that housekeeping staff should refill paper towels and soap dispensers. Observations on the second floor east hall resident care area on 1/06/25, at about 4:15 p.m. revealed that 2 east hallway hand sanitizer dispensers were empty. Observation of Room 207 restroom revealed no paper towels or toilet paper, Room 209 had no soap in the soap dispenser, Room 210 had no paper towels or toilet paper, and Room 217 had no paper towels. During an interview with Licensed Practical Nurse Employee E2, at the time of the observations, it was confirmed that the restrooms observed and hallway hand sanitizer were not stocked with the supplies for resident use. Observations of the 3rd floor east hall resident care	F 0584		

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F 0584 SS=E	Continued from page 17 area on 1/07/25, at about 9:30 a.m., revealed that the 3 east hallway hand sanitizer dispensers were empty. Observation of Room 307 restroom revealed no paper towels in the dispenser, Room 310 had no toilet paper or paper towels, and Room 319 had no paper towels. During an interview with Registered Nurse Employee E3 at the time of observations, it was confirmed that the restrooms observed and hallway hand sanitizer dispensers were not stocked with the supplies for resident use. An interview conducted with the NHA 1/08/25, at approximately 2:30 p.m. revealed that supplies should be stocked for resident use in resident rooms, restrooms, and resident care areas. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(2.1) Management	F 0584		

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F 0686 SS=D	<p>483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0686	<p>a. Resident 42 No longer resides in the facility.</p> <p>b. Director of Nursing/Designee will audit all residents with pressure ulcers to verify the last assessment and MDS are consistent for accuracy in a 90 day look back period.</p> <p>c. Director of Nursing/designee will educate nursing staff on pressure ulcer documentation, staging and F686.</p> <p>d. Director of Nursing/designee will audit 5 random pressure ulcers to ensure documentation in assessments and MDS are consistent with the documentation from the wound nurse practitioner and accurate weekly times 4 weeks and monthly times 2 months.</p> <p>e. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.</p>	<p>Completion Date: 02/19/2025</p> <p>Status: APPROVED</p> <p>Date: 02/11/2025</p>

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F 0686 SS=D	Continued from page 19 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to comprehensively assess pressure ulcers/injuries (injury to skin and underlying tissue resulting from prolonged pressure on the skin) for one of 21 residents reviewed (Resident R42). Findings include: A facility policy "Pressure Injury Prevention and Treatment Policy" dated 9/2024, revealed Residents admitted with existing pressure injuries will receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection. New pressure injuries will not develop unless the individual's clinical condition demonstrates that they were unavoidable. Pressure injuries identified will be assessed initially and at least weekly thereafter, until closed. All assessments will include the following elements: Location and stage [Stage one-nonblanchable redness of an area. Stage Two-shallow open ulcer	F 0686		

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F 0686 SS=D	Continued from page 20 with a red or pink wound bed without slough or bruising. Stage Three-full thickness tissue loss, subcutaneous fat may be visible but bone, tendon, or muscle is not exposed and slough (yellow, white, or gray material that can be dry or moist and is a result of dead cells and bacteria accumulating in a wound) may be present but does not hide the depth of tissue loss. Stage 4-full thickness loss with exposed bone, tendon, or muscle. Unstageable-slough and/or eschar (dead tissue that eventually will fall off from the skin), pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar]. (if pressure injury), Size (perpendicular measurements of the greatest extent of length and width of the ulceration) depth and the presence, location and extent of any undermining of tunneling/sinus tract, Exudate if present: type (such as purulent/serous), color, odor and appropriate amount, Pain, if present: nature and frequency (e.g., whether episodic or continuous), Wound bed: Color and type of tissue/character including evidence of healing (e.g., granulation [new tissue that forms in the body during the healing	F 0686		

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F 0686 SS=D	Continued from page 21 process of wounds] tissue, maceration [process of softening or breaking down]) as appropriate, Any evidence of infection. Resident R42's clinical record revealed an admission date of 6/05/24, with diagnoses that included osteomyelitis of left ankle (inflammation of ankle bone caused by infection), gangrene (dead tissue caused by an infection or lack of blood flow), bacteremia (bloodstream infection), and urinary tract infection. Resident R42's hospital records dated 5/28/24, revealed Resident R2 had a stage three pressure injury to the coccyx (a small triangular bone at the base of the spinal column) with assessment documented as "2 cm diam [centimeter diameter], 0.2 cm deep with areas of scattered moist yellow and tan slough on red base small amt serous [clear or slightly yellow fluid] tan drainage, wound located with in bright red macerated, weeping skin, solid redness with macules [a flat, distinct discolored area of skin less than 1 cm wide] and papules [a small,	F 0686		

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F 0686 SS=D	Continued from page 22 raised, solid pimple or swelling] around the edges." Resident R42's clinical record for the day of admission to the facility, 6/05/24, revealed Resident R42's pressure injury to the coccyx assessment documented as "Stage 2 to Coccyx 1.5 cm x 0.5 cm." Resident R42's clinical record dated 6/11/24, by a Certified Registered Nurse Practitioner (CRNP) revealed Resident R42's pressure injury to the coccyx/sacrum assessment documented as "Stage/Severity: Unstageable, Wound Status: Present on Admission, Odor Post Cleansing: None, Size: 7 cm x 7 cm x 0.1 cm. Calculated area is 49 sq cm. Wound Base: 50-74% granulation, 50-74% eschar, Wound Edges: Attached, Periwound: Macerated, Exudate: Moderate amount of Serosanguineous [drainage containing blood and serum, the clear liquid part of blood]. During an interview on 1/09/25, at 10:40 a.m. the Infection Control Licensed Practical Nurse	F 0686		

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F 0686 SS=D	Continued from page 23 (ICLPN) confirmed the facility failed to accurately assess and document Resident R42's coccyx on admission to the facility 6/05/24. The ICLPN further confirmed Resident R42's coccyx wound was inaccurately documented as a stage two pressure ulcer, and lacked a comprehensive assessment of the pressure injury as noted prior, "Stage 2 to Coccyx 1.5 cm x 0.5 cm," due to the resident was documented with a stage three coccyx pressure ulcer with macerated, weeping skin and macules, papules around the edges at the hospital prior to admission. 28 Pa. Code 211.5 (f)(ii)(iii)(ix) Medical records 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0686		
F 0725 SS=E		F 0725		

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F 0725 SS=E	Continued from page 24 483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 0725	a. Facility completed a random audit of 15 residents to for call bell response times and to verify needs are being met with no adverse affects to any residents. b. Emergency Resident council meeting held on January 21st to address all concerns and nursing home administrator/designee will follow up with resident council president to ensure concerns are addressed and resolved. c. Nursing home Administrator/designee will educate facility staff of F725 d. Facility management team/designee will complete 6 random call bell audits over all 3 shifts for timeliness and resident satisfaction with needs being met daily times 5 days, weekly x 3 weeks, and monthly x 2 months. e. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/13/2025

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F 0725 SS=E	Continued from page 25 Based on resident interviews and observations, it was determined that the facility failed to provide sufficient nursing staff to promote the physical and mental well-being and meet the needs of nine of 24 residents interviewed (Residents R149, R19, R226, R9, R56, R67, R62, R73, and R85). Findings include: During interviews on 1/06/25, from 10:05 a.m. through 1:00 p.m. revealed that Residents R149, R19 and R226 expressed concerns of poor call bell response times, indicating that they often had to wait nearly an hour after activating the call bell, to have their needs met. Observations on 1/06/25, at 2:17 p.m. revealed an activated call light for Resident R226. The call light remained unaddressed until 2:30 p.m. During interview at 2:25 p.m., Resident R226 stated they activated the call light as they had been left on a bedpan which was causing considerable discomfort while waiting for assistance. At this time, staff	F 0725		

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F 0725 SS=E	Continued from page 26 members were observed seated at the nursing station where the call bell system was alarming audibly and visually lighted. Interviews during the Resident Council meeting on 1/07/25, between 1:00 p.m. and 1:30 p.m., revealed six out of seven alert and oriented residents in attendance with concerns related to staff not responding to their call bells timely. Resident R62 indicated that it could take 45 minutes for his/her call bell to be answered and, staff are typically outside or near his/her door due to he/she can hear them. Resident R9 indicated that he/she will wait for 30 minutes to receive incontinence care after placing his/her call bell on. Resident R9 further indicated if he/she does not get his/her call bell answered by the end of dayshift, it could take longer due to the new shift coming on. Residents R56, R67, R73, and R85 indicated they wait 30 minutes when their call bell is placed on to be responded to by staff. 28 Pa. Code 201.18(b)(1) Management	F 0725		

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F 0725 SS=E	Continued from page 27 28 Pa. Code 211.12(d)(4)(5) Nursing services	F 0725		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 28 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	a. R72 was assessed for adverse effects with no concerns and scripts were obtained for reorder of medication immediately. Facility completed an initial audit of all med carts to ensure that all medications were available as ordered which includes Furosemide with no issues or concerns. b. Director of Nursing/Designee completed a whole house audit to verify all ordered meds in facility are present for like residents—any medications not present will be addressed and resident will be assessed for adverse effects and physician/resident representative will be notified c. Director of Nursing/designee will educate licensed nursing staff on F761 and obtaining new scripts and reordering of medications when needed. d. Director of Nursing/designee will audit 2 of 4 medication carts each week to verify medications ordered by the physician were not missed on the MAR and are readily available for each resident on the	Completion Date: 02/19/2025 Status: APPROVED Date: 02/13/2025

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F 0761 SS=D	Continued from page 29	F 0761	unit weekly x 4 weeks and monthly x 2 months. e. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.		

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F 0761 SS=D	Continued from page 30 Based on review of clinical records and facility policy, observations, and staff interviews, it was determined that the facility failed to properly reorder and store medications for two of eight residents reviewed during medication pass observations (Residents R72 and R73). Findings include: Review of the facility policy entitled "Medication Shortages/Unavailable Medications" last revised 8/01/2024, revealed that upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from the pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately notify the pharmacy. Resident R72's clinical record revealed an admission date of 7/23/24, with diagnoses that included history of falls, fracture of the left femur, and aftercare for joint replacement therapy. R72 had a physician's	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: EDISON MANOR NURSING & REHAB CENTER STATE LICENSE NUMBER: 025902		STREET ADDRESS, CITY, STATE, ZIP CODE: 222 WEST EDISON AVENUE NEW CASTLE, PA 16101		
(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
F 0761 SS=D	<p>Continued from page 31</p> <p>order for Oxycodone (pain medication) 5 milligrams (mg) every 6 hours as needed for pain with a start date of 10/14/24, and last administered 11/04/24.</p> <p>Observation of medication administration on 1/06/25, at 3:55 p.m. revealed that Licensed Practical Nurse (LPN) Employee E2 attempted to obtain oxycodone for Resident R72 for pain upon resident request. Upon attempting to administer oxycodone per order, there was no medication card in the cart to fulfill the order.</p> <p>During an interview at that time, LPN Employee E2 confirmed that there was no medication card, the medication would have to be obtained through the Omnicell machine. The last time the medication was administered per record was 11/04/24, and the order was not resubmitted to the pharmacy for use.</p> <p>Resident R73's clinical record revealed an admission date of 8/13/22, with diagnoses that included Type 2 Diabetes (a long term condition in which the body</p>	F 0761		

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F 0761 SS=D	Continued from page 32 has trouble controlling blood sugar levels due to the pancreas not making enough insulin), depression, heart failure, and history of a cerebral infarction (blocked blood flow to the brain causing brain tissue to die). R73 had a physician's order for Furosemide (medication to help excrete fluids) 20 mg by mouth daily. Observation of medication administration on 1/07/25, at 9:15 a.m. revealed that Registered Nurse (RN) Employee E3 attempted to administer Furosemide 20 mg per physician's order during morning routine medication pass. The medication cart did not contain Furosemide for resident use and the medication was not reordered from the pharmacy after the last medication was administered. During an interview at that time, RN Employee E3 confirmed that there was no medication card for Furosemide because it was not reordered from the pharmacy after the last pill was given from the card. The medication would have to be obtained through	F 0761		

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F 0761 SS=D	Continued from page 33 the Omnicell machine. During an interview on 1/08/25, at approximately 1:30 p.m. the Director of Nursing, and Nurse Supervisor confirmed that the medications were not reordered from the pharmacy as they should have been and were not available for use as required in the medication carts for Residents R72 and R73. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0761		
F 0809 SS=B		F 0809		

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F 0809 SS=B	Continued from page 34 483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by:	F 0809	a. Nursing home administrator/designee immediately audit nursing units to ensure nutritious snacks were available on the units for residents and there were no adverse effects to residents related to snacks. b. Nursing home administrator/designee educated dietary and nursing department staff on F809 and nutritious snack availability on the units and daily during the evening. c. Nursing home administrator/designee will randomly audit 3 residents on each unit daily x 5 days; weekly x3 weeks; monthly x2 months to ensure snacks are available/offered and that enough snacks are available on the unit. e. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/11/2025

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F 0809 SS=B	Continued from page 35 Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to routinely offer nutritious snacks as desired for six of seven residents interviewed about snacks (Residents R9, R14, R56, R67, R73, and R85). Findings include: A facility policy, "Meal Times and Frequency Policy," dated 9/2024, revealed there will be no more than 14 hours between a substantial evening meal (dinner) and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal (dinner) and breakfast the following day if a resident group agrees to this meal span. A nourishing snack means items from the basic food groups, either singly or in combination with each other. Adequacy of the snack will be determined both by individuals in the group and evaluating the overall nutritional status of those in the	F 0809		

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F 0809 SS=B	Continued from page 36 facility. Interviews with alert and oriented Residents R9, R14, R56, R67, R73, and R85 on 1/07/25, at 1:00 p.m. revealed that snacks are not routinely offered in the evening, and they would like to receive an evening nutritious snack. Observations on 1/07/25, at 9:45 a.m. revealed one fruit bar, five oatmeal cookies, one single serve applesauce container, and one can of chicken soup in the third-floor cupboard at the nurses station. Nursing Assistant Employee E1 confirmed that these were the snacks available for the 54 residents who reside on the third floor for the past midnight shift and current day shift. 28 Pa. Code 211.12 (d)(1) Nursing services	F 0809		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 37 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	a. Resident 42 No longer resides in the facility. b. Director of nursing/designee completed a whole house audit to verify any resident requiring enhanced barrier precautions has personal protective equipment readily available outside of room c. Nursing home administrator/designee educated all facility staff and wound nurse practitioner on personal protective equipment, enhanced barrier precautions and F880 d. Nursing home administrator/designee will audit personal protective equipment availability and use for 3 enhanced barrier precautions residents per floor daily x 5 days; weekly x 3 weeks; monthly x 2 months e. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/11/2025

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F 0880 SS=E	Continued from page 38 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=E	Continued from page 39	F 0880		

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F 0880 SS=E	Continued from page 40 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) for two of two resident units (200 and 300 units). Findings include: A facility policy, "Transmission-Based Precautions and Isolation Policy," dated 9/2024, revealed Enhanced Barrier Precautions (EBP) - EBP are intended to prevent transmission of multi-drug resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high risk residents. EBP are indicated for high contact care activities for residents with chronic wounds and indwelling devices (such as central lines, urinary catheters, and trachs) and for all those colonized or infected with a MDRO currently targeted by the CDC. Other MDROs may be included at the discretion of the facility Infection Control Committee	F 0880		

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F 0880 SS=E	Continued from page 41 unless required by state guidance. Observations on 1/07/25, at 12:05 p.m. revealed Certified Registered Nurse Practitioner (CRNP) completing a wound assessment in Resident R42's room without donning (putting on) a gown. An interview with the Infection Control Licensed Practical Nurse (LPN) confirmed the CRNP should have donned the appropriate Personal Protective Equipment (PPE), gowns and gloves, prior to entering Resident R42's room to provide the assessment and care due to Resident R42 being in EBP for having a chronic stage four (full thickness loss of skin and bone exposed) coccyx pressure ulcer and foley catheter (tubing entering the bladder to drain urine). Observations on 1/06/25, at 12:45 p.m. and 1/07/25, at 12:00 p.m., revealed no PPE available at the doorway or in the hallways for EBP for Room 303 (resident with a foley catheter and chronic wound), Room 321 (resident with colostomy-artificial opening from the colon that	F 0880		

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F 0880 SS=E	Continued from page 42 permits passage of intestinal contents), Room 325 (resident with foley catheter), 324 (resident with foley catheter). An interview on 1/07/25, at 12:10 p.m. with Nursing Assistant Employee E2 confirmed the facility did not have PPE readily available for staff to utilize for residents that are in EBP. During an interview on 1/07/25, at 2:10 p.m. the Director of Nursing confirmed that employees should be wearing appropriate PPE, such as gloves and gowns, when providing care for residents who are in EBP, and the PPE should be readily available. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0880		

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P 3690	<p>Bathing facilities.</p> <p>(e) Each bathing room shall include a toilet and lavatory. If more than one tub or shower is in the bathing room, privacy shall be provided at each bathing facility and at the toilet.</p> <p>This REGULATION is not met as evidenced by:</p>	P 3690	<ol style="list-style-type: none"> 1. Facility is unable to retroactively correct not having a sink in the shower room. 2. Full house audit completed an all-other shower rooms were assessed and are equipped with a sink and needed equipment. 3. Facility hired a contractor to come and evaluate the shower room for the installation of the sink. 4. Facility will install the sink in the second-floor shower room. 5. Sanitizer station placed directly outside of the shower room for use while waiting on installation. 6. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed. 	<p>Completion Date: 02/19/2025</p> <p>Status: APPROVED</p> <p>Date: 02/13/2025</p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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P 3690	Continued from page 1 Based on observation and staff interview, it was determined that the facility failed to include a lavatory in one of two bathing rooms (second floor nursing unit). Findings include: Observations on 1/06/25, at 11:00 a.m. revealed that there was no lavatory located within the common bathing room of the second floor nursing unit. During interview and further observation on 1/08/25, at approximately 1:45 p.m. the Nursing Home Administrator confirmed that there was no lavatory located in the second floor common bathing room.	P 3690		
P 5520		P 5520		

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P 5520	Continued from page 2 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	<ol style="list-style-type: none"> 1. The facility is unable to retroactively correct the CNA staffing ratio for 11/26/24, 11/30/24, 1/3/25 and 1/6/25 2. Nursing home administrator immediately audited future schedules for compliance with regulatory guidance for staffing of nurse aides. 3. Nursing home administrator/designee will schedule CNA's to meet state ratio. Call outs will be monitored by nursing home administrator/Director of Nursing and/or designee daily. Facility staff and staffing agencies will be utilized to facilitate replacement/procurement of staff. Facility has put into place sign on bonus' to increase applicants as well as pick up bonus' to increase retention. 4. Nursing home administrator/designee will educate the scheduling coordinator, director of nursing, assistant director of nursing, and human resources on the requirements of CNAs. 5. Nursing home administrator and/or designee will monitor staffing 	Completion Date: 02/19/2025 Status: APPROVED Date: 02/11/2025

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P 5520	Continued from page 3	P 5520	ratio weekly x4 weeks. 6. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: EDISON MANOR NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 222 WEST EDISON AVENUE NEW CASTLE, PA 16101		
STATE LICENSE NUMBER: 025902				
(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
P 5520	Continued from page 4 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 11 residents on the evening shift for two of 14 days (11/30/24 and 1/06/25); and failed to ensure a minimum of one NA per 15 residents on the overnight shift for two of 14 days reviewed for staffing (11/26/24 and 1/03/25). Findings include: Review of facility nursing staffing documents for the time period of 11/24/24, through 11/30/24, and 1/01/25 through 1/07/25, revealed following NA shortages for the evening shift: 11/30/24 facility census of 100 residents 8.63 NAs worked and 9.09 were required. 1/03/25 facility census of 101 residents 8.63 NAs worked and 9.18 were required.	P 5520		

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NAME OF PROVIDER OR SUPPLIER: EDISON MANOR NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 222 WEST EDISON AVENUE NEW CASTLE, PA 16101		
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P 5520	Continued from page 5 Review of facility nursing staffing documents for the time period of 11/24/24, through 11/30/24, and 1/01/25 through 1/07/25, revealed following NA shortages for the overnight shift: 11/26/24 facility census of 100 residents 6.43 NAs worked and 6.73 were required. 1/06/25 facility census of 102 residents 6.43 NAs worked and 6.80 were required. During an interview on 1/09/25, at 9:35 a.m. the Nursing Home Administrator confirmed that the facility failed to meet the minimum NA ratio requirements on the above shifts and dates.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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P 5530	Continued from page 6 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	<ol style="list-style-type: none"> The facility is unable to retroactively correct the staffing ratio for days: 11/28/2024 Nursing home administrator immediately audited future schedules for compliance with regulatory guidance for staffing of LPN. Nursing home administrator/designee will schedule LPNs to state ratio of 1 to 25 for day shift, 1 to 30 for afternoon shifts and 1 to 40 for midnight shifts. Call outs will be monitored by nursing home administrator/Director of Nursing and/or designee daily. Facility staff and staffing agencies will be utilized to facilitate replacement/procurement of staff. Facility has put into place sign on bonus' to increase applicants as well as pick up bonus' to increase retention. Nursing home administrator/designee will educate the scheduling coordinator, director of nursing, assistant director of nursing, and human resources on the requirements of LPN ratios of 1 to 25 for day shift, 1 to 30 for 	Completion Date: 02/19/2025 Status: APPROVED Date: 02/11/2025

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: EDISON MANOR NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 222 WEST EDISON AVENUE NEW CASTLE, PA 16101		
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P 5530	Continued from page 7	P 5530	afternoon shifts and 1 to 40 for midnight shifts. 5. Nursing home administrator and/or designee will monitor staffing ratio weekly x4 weeks. 6. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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P 5530	Continued from page 8 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one Licensed Practical Nurse (LPN) per 25 residents on the day shift, for one of 14 days reviewed for staffing (11/28/24). Findings include: Review of facility nursing staffing documents for the time period of 11/24/24, through 11/30/24, and 1/01/25 through 1/07/25, revealed following LPN shortage for the day shift: 11/28/24 facility census of 101 residents 3.67 LPNs worked and 4.04 were required. During an interview on 1/09/25, at 9:30 a.m. the Nursing Home Administrator confirmed that the facility failed to meet the minimum LPN ratio requirements on the above shift and date.	P 5530		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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P 5530	Continued from page 9	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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P 5640	Continued from page 10 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	<ol style="list-style-type: none"> The facility is unable to retroactively correct the staffing PPD of 3.2 for 11/24/24, 11/25/24, 11/26/24, 11/27/24, 11/29/24, 11/30/24, 1/2/25, 1/3/25, 1/4/25, 1/5/25, 1/6/25 and 1/7/25. Nursing home administrator immediately audited future schedules for compliance with regulatory guidance for staffing to ppd. Nursing home administrator/designee will schedule staff to meet state PPD of 3.2. Call outs will be monitored by nursing home administrator/Director of nursing and/or designee daily. Facility staff and staffing agencies will be utilized to facilitate replacement/procurement of staff. Facility has put into place sign on bonus' to increase applicants as well as pick up bonus' to increase retention. Nursing home administrator/designee will educate the scheduling coordinator, director of nursing, assistant director of nursing, and human resources on 	Completion Date: 02/19/2025 Status: APPROVED Date: 02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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P 5640	Continued from page 11	P 5640	<p>the requirements of the minimum ppd of 3.2.</p> <p>5. Nursing home administrator and/or designee will monitor staffing ppd weekly x4 weeks.</p> <p>6. Findings will be summarized and brought to the quality assurance and performance improvement committee and reviewed for any further monitoring and changes needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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P 5640	Continued from page 12 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to provide the minimum number of general nursing care hours of 3.2 hours of direct resident care hours per resident in a twenty-four-hour period for twelve of 14 days reviewed (11/24/24, 11/25/24, 11/26/24, 11/27/24, 11/29/24, 11/30/24, 1/02/25, 1/03/25, 1/04/25, 1/05/25, 1/06/25, and 1/07/25). Findings include: Review of facility nursing staffing documents for the time period of 11/24/24, through 11/30/24, and 1/01/25 through 1/07/25, revealed that the hours of direct resident care was below 3.2 minimum per patient per day (PPD) on the following dates: 11/24/24 3.01 PPD 11/25/24 3.10 PPD 11/26/24 3.10 PPD 11/27/24 3.00 PPD 11/29/24 3.00 PPD	P 5640		

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P 5640	Continued from page 13 11/30/24 2.92 PPD 1/02/25 3.10 PPD 1/03/25 3.00 PPD 1/04/25 3.00 PPD 1/05/25 3.00 PPD 1/06/25 3.05 PPD 1/07/25 3.05 PPD During a interview on 1/07/25, at 9:30 a.m. the Nursing Home Administrator confirmed that the facility did not meet the 3.2 minimum hours of direct resident care on above dates.	P 5640		



Certified End Page

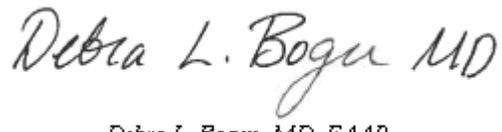
EDISON MANOR NURSING & REHAB CENTER

STATE LICENSE NUMBER: 025902

SURVEY EXIT DATE: 01/09/2025

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