

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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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
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E 0000	INITIAL COMMENT	E 0000		
E 0039	483.73(d)(2) EP Testing Requirements	E 0039		Completion Date: 02/19/2025
SS=C	<p>Based on an Emergency Preparedness Survey completed on January 15, 2025, it was determined that Edison Manor Nursing and Rehab Center had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is</p>		<p>1. Nursing home administrator/designee immediately scheduled full scale exercise with outside community resources to be completed.</p> <p>2. Regional Vice President of operations educated nursing home administrator on E0039 and the importance of yearly exorcises to test the emergency plans.</p> <p>3. Nursing Home Administrator will verify continued compliance with the EPP/tabletop exercises.</p>	Status: APPROVED Date: 02/07/2025

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

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E 0039 SS=C	Continued from page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the	E 0039		

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E 0039 SS=C	Continued from page 2 following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 0039		

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E 0039 SS=C	Continued from page 3 (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is	E 0039		

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E 0039 SS=C	Continued from page 4 community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is	E 0039		

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E 0039 SS=C	Continued from page 5 community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including	E 0039		

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E 0039 SS=C	Continued from page 6 unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the	E 0039		

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E 0039 SS=C	Continued from page 7 emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the	E 0039		

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E 0039 SS=C	Continued from page 9 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency	E 0039		

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E 0039 SS=C	Continued from page 10 events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain emergency preparedness guidelines for one of one emergency preparedness plan. Findings include: Document review on January 15, 2025, at 10:25 a.m., revealed the facility lacked records to indicate a full-scale exercise, test, and evaluation of the emergency preparedness plan was performed within the previous year. Interview with the maintenance supervisor on January 15, 2025, at 10:25 a.m., confirmed the lack of documentation.	E 0039		



Certified End Page

EDISON MANOR NURSING & REHAB CENTER

STATE LICENSE NUMBER: 025902

SURVEY EXIT DATE: 01/15/2025

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

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K 0000	INITIAL COMMENT Facility ID #025902 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on January 15, 2025, it was determined that Edison Manor Nursing and Rehab Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a three-story, Type II (000), unprotected, non-combustible building, that is fully sprinklered.	K 0000		
K 0161 SS=C		K 0161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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K 0161 SS=C	Continued from page 1 NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small	K 0161	No adverse effects occurred from the facility exceeding the height requirement for this construction type. Life Safety Consultant Peters Rice Associates conducted an FSES on 3/20/2017, which is on file with the Department of Health. Edison Manor has been working with various vendors on a construction proposal that will minimize disturbance to the residents of the facility. Once a viable proposal has been acquired the facility will submit architectural plans and determine the time frame to have the work completed to stay in compliance. 2. TLW was submitted to local department of health field office to be sent for approval. 3. FSES is being requested to be updated.	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>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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
K 0161 SS=C	Continued from page 2 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building construction type on all building levels. Findings include: Observation on January 15, 2025, at 10:52 a.m., revealed the facility exceeded the height requirement for a three-story, Type II (000), unprotected, non-combustible building. Interview with the maintenance supervisor on January 15, 2025, at 10:52 a.m., confirmed the building exceeded the height requirement for this construction type.	K 0161		

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K 0200 SS=C	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by:	K 0200	1. Evacuation Diagrams have been updated to contain the notation showing the location of the viewer on the diagram.	Completion Date: 02/10/2025 Status: APPROVED Date: 02/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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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K 0200 SS=C	Continued from page 4 Based on observation and interview, the facility failed to maintain evacuation diagrams on three of three building levels. Findings include: Observation on January 15, 2025, between 11:20 a.m. and 12:10 p.m., revealed the evacuation diagrams did not contain a notation showing the location of the viewer on the diagram. Ref: NFPA 170-11.2.4 and 11.4.1 Interview with the maintenance supervisor on January 15, 2025, at 12:10 p.m., confirmed the diagrams failed to show viewer location and exit paths.	K 0200		
K 0293 SS=B		K 0293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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K 0293 SS=B	Continued from page 5 NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	1. Nursing home administrator and/or designee immediately changed the lightbulb in the exit sign to ensure the directional arrow was on. 2. Nursing home administrator and/or designee will audit facility exit signs to ensure all directional arrows are engaged weekly x 4 weeks and monthly times 2 months.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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K 0293 SS=B	Continued from page 6 Based on observation and interview, the facility failed to maintain exit signs for one of over ten exits. Findings include: Observation on January 15, 2025, at 12:06 p.m., revealed a missing directional exit sign near the second-floor lounge that directed towards the stair towers. Interview with the maintenance supervisor on January 15, 2025, at 12:06 p.m., confirmed the missing exit sign at the time of the survey.	K 0293		
K 0324 SS=D		K 0324		

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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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K 0324 SS=D	Continued from page 7 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	1. Nursing home administrator and/or designee will educate dietary staff on the location of the hood fire suppression system's manual activation pull station. 2. Nursing home administrator and/or designee will educate all new dietary staff during orientation on the location of the hood fire suppression system's manual activation pull station. 3. Nursing home administrator and/or designee will audit 2 dietary staff weekly to ensure they are aware of the location of the hood fire suppression system's manual activation pull station.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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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K 0324 SS=D	Continued from page 8 Based on observation and interview, the facility failed to maintain cooking equipment in one of one kitchen. Observation and interview on January 15, 2025, at 11:28 a.m., revealed kitchen staff members interviewed were uncertain of the location and operation of the hood fire suppression system's manual activation. Interview with the maintenance supervisor on January 15, 2025, at 11:28 a.m., confirmed the cooking equipment deficiency.	K 0324		
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 0353	1. Nursing home administrator/designee cleaned the sprinkler heads in the main floor laundry room. 2. Nursing home administrator and/or designee will audit sprinkler heads weekly times 4 weeks and monthly times 2 months for cleanliness and debris.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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K 0353 SS=F	Continued from page 9 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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K 0353 SS=F	Continued from page 10 Based on observation and interview, the facility failed to maintain the sprinkler system for one of one system. Findings include: Observation on January 15, 2025, at 10:23 a.m., revealed the main floor laundry room corridor had three dust-covered and dirty sprinkler heads. Dirty sprinkler heads can delay and/or limit sprinkler activation during an emergency. Interview with the maintenance supervisor on January 14, 2025, at 10:23 a.m., confirmed the sprinkler head deficiencies existed at the time of the survey.	K 0353		
K 0372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for	K 0372	1. Missing ceiling tiles were replaced in the emergency stock room. 2. Third floor roof access room loose and ensealed ceiling tiles were replaced and repaired. 3. facility maintenance/NHA will audit ceiling tiles weekly times 4 weeks then monthly times 2 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 02/05/2025

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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
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K 0372 SS=D	Continued from page 11 smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372		

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K 0372 SS=D	Continued from page 12 Based on observation and interview, the facility failed to maintain smoke barrier requirements in two of over ten rooms. Findings include: Observation on January 15, 2025, between 11:33 a.m. and 11:52 a.m., revealed the following smoke barrier deficiencies: A. (11:33 a.m.) Main floor, emergency stock room, had loose and missing ceiling tiles; B. (11:52 a.m.) Third floor, roof access room had loose, missing, and unsealed ceiling tiles. Interview with the maintenance supervisor on January 15, 2025, at 11:52 a.m., confirmed the above smoke barrier deficiencies existed at the time of the survey.	K 0372		
K 0911 SS=D		K 0911		

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K 0911 SS=D	Continued from page 13 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	1. Oxygen cylinder carts have been removed from blocking the access to the electrical panels. 2. Nursing home administrator and/or designee will educate all facility staff on maintaining a clear pathway to the electrical panels. 3. Maintenance/nursing home administrator will audit access to the electrical panels is maintained daily times 5 days, weekly times 3 weeks, and monthly times 2 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 02/07/2025

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K 0911 SS=D	Continued from page 14 Based on observation and interview, the facility failed to maintain and inspect electrical system requirements per NFPA 70 and NFPA 99, in one of over ten rooms. Findings include: Observation on January 15, 2025, at 12:04 p.m., revealed the third floor, electrical room, had several oxygen cylinder carts blocking off access to the electrical panels. Reference: NFPA70 110.26(a) Interview with the maintenance supervisor on January 15, 2025, at 12:04 p.m., confirmed the electrical system deficiency.	K 0911		

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K 0912 SS=B	<p>NFPA 101 Electrical Systems - Receptacles</p> <p>Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0912	<ol style="list-style-type: none"> Facility immediately contacted a third-party contractor to evaluate outlets with need for GFCI and replace the outlets identified with GFIC outlets to include the employee lounge for the ice machine and the main floor dishwashing receptacle area. GFCI receptacles have been replaced. 	<p>Completion Date: 02/19/2025 Status: APPROVED Date: 02/10/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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K 0912 SS=B	Continued from page 16 Based on observation and interview, the facility failed to maintain electrical receptacles in two of over twenty rooms. Findings include: Observation on January 15, 2025, between 11:21 a.m. and 11:31 a.m., revealed the facility failed to ensure ground fault circuit interrupter (GFCI) protection in the following areas: A. (11:21 a.m.) Main floor employee lounge ice machine receptacle; B. (11:31 a.m.) Main floor kitchen dishwashing area receptacle. Interview with the maintenance supervisor on January 15, 2025, at 11:31 p.m., confirmed the electrical outlet deficiencies.	K 0912		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025	
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(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
K 0918 SS=F	Continued from page 17 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	1. Facility had third party Generator Specialist Inc. complete the 4 hour load test of the generator on 2/3/2025. 2. Facility contracts with Generator Specialist Inc to ensure that the 4 hour load test is completed every three years as required.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395536	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
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
K 0918 SS=F	Continued from page 18 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on the document review and interview, the facility failed to meet electrical system requirements for one of one generator. Findings include: Document review on January 15, 2025, at 10:50 a.m., revealed the facility was unable to provide documentation for the three-year, four-hour load test. Interview with the maintenance supervisor on January 15, 2025, at 10:50 a.m., confirmed the documentation was unavailable at the time of the survey.	K 0918		



Certified End Page

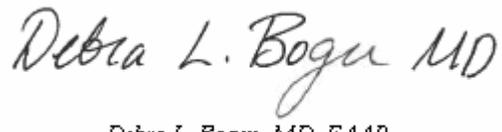
EDISON MANOR NURSING & REHAB CENTER

STATE LICENSE NUMBER: 025902

SURVEY EXIT DATE: 01/15/2025

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