

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395645</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/04/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>EDINBORO MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>419 WATERFORD STREET EDINBORO, PA 16412</b>		
STATE LICENSE NUMBER: <b>053002</b>				
(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
E 0000	INITIAL COMMENT	E 0000		
E 0039	Based on an Emergency Preparedness Survey completed on February 4, 2025, it was determined that Edinboro Manor was not in compliance with the requirements of 42 CFR 483.73.	E 0039		
SS=C				

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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E 0039  SS=C	Continued from page 1  483.73(d)(2) EP Testing Requirements  §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).  *[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]:  (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the 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 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:	E 0039	This plan of correction has been prepared and executed because the law requires it. This plan does not constitute an admission that any of the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position. Edinboro Manor reserves the right to raise all possible contestations and defenses in any civil, criminal, claim, action or proceeding. Please accept this plan of correction as Edinboro Manor's credible allegation of compliance.  The facility will ensure that there is at least one tabletop exercise, and one full-scale exercise completed annually.  The facility recently had a change in Administrators effective 12/30/2024. During the Life Safety Survey, proof of an Emergency Preparedness Tabletop discussion could not be found during the inspection. After exit, the facility located documentation of an Emergency	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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E 0039  SS=C	Continued from page 2  (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 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	E 0039	Preparedness Tabletop discussion that occurred on 03/21/2024 by past administration. Sign-in sheet and documentation will be provided with this Plan of Correction.  The facility will conduct a "full-scale exercise" by 03/13/2025.  The full-scale exercise will be reviewed at the monthly Quality Assurance and Performance improvement meeting.	

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E 0039  SS=C	Continued from page 3  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 (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	E 0039		

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E 0039  SS=C	Continued from page 4  (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 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	E 0039		

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E 0039  SS=C	Continued from page 5  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 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	E 0039		

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E 0039  SS=C	Continued from page 6  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 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.	E 0039		

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E 0039  SS=C	Continued from page 7  (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 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.	E 0039		

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E 0039  SS=C	Continued from page 8  (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 emergency plan at least annually. The HHA must do the following: (i) Participate in a 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 every 2 years; or (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA 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.	E 0039		

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E 0039  SS=C	Continued from page 9  (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 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.  *[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	E 0039		

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E 0039  SS=C	Continued from page 10  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 events, and revise the RNHCI's emergency plan, as needed.  This REQUIREMENT is not met as evidenced by:	E 0039		

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E 0039  SS=C	Continued from page 11  Based on documentation review and interview, the facility failed to full-scale exercise, test, evaluate, and table-top exercise one of one emergency preparedness plan.  Findings include:  Document review on February 4, 2025, at 1:45 p.m., revealed the facility lacked documentation needed to verify that an annual table top exercise occurred. The deficient documentation included: A. Annual full-scale exercise; B. Annual table-top exercise.  Interview with the maintenance supervisor on February 4, 2025, at 1:45 p.m., confirmed the lack of documentation.	E 0039		



# Certified End Page

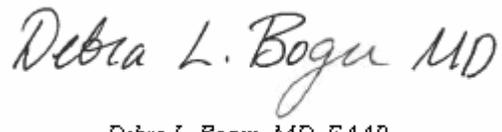
**EDINBORO MANOR**

**STATE LICENSE NUMBER: 053002**

**SURVEY EXIT DATE: 02/04/2025**

**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 #053002 Component 01 Main Building  Based on a Medicare/Medicaid Recertification Survey completed on February 4, 2025, it was determined that Edinboro Manor 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 one-story, Type V (000), unprotected, wood frame building, that is fully sprinklered.	K 0000		
K 0345  SS=F		K 0345		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395645</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/04/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>EDINBORO MANOR</b>  STATE LICENSE NUMBER: <b>053002</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>419 WATERFORD STREET EDINBORO, PA 16412</b>		
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K 0345  SS=F	Continued from page 1  NFPA 101 Fire Alarm System - Testing and Maintenance  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72  This REQUIREMENT is not met as evidenced by:	K 0345	The facility was provided with incorrect documentation by the inspection company. The company has provided the correct documentation depicting that there were/are no deficiencies present. The above-mentioned documentation will be provided upon submission of this Plan of Correction.  The Maintenance Director will be educated on the importance of ensuring that the facility receives correct/accurate reports regarding any inspections that occur.  All inspections/reports will be audited by the administrator and reviewed with the inspection companies prior to them exiting the facility. Once the written reports are obtained, the administrator and/or Maintenance Director will again review to ensure accuracy of findings.  The results of inspections will be reviewed at the facilities monthly	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395645</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/04/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>EDINBORO MANOR</b>  STATE LICENSE NUMBER: <b>053002</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>419 WATERFORD STREET EDINBORO, PA 16412</b>		
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K 0345  SS=F	Continued from page 2  Based on document review and interview, the facility failed to meet fire alarm system requirements for one of one system.  Findings include:  Document review on February 4, 2025, at 11:00 a.m., revealed the fire alarm inspection report, completed October 14, 2024, listed two deficiencies that were not corrected at the time of the survey: A. (11:00 am) DACT main did not receive signals from fire system; B. (11:00 am) DACT point did not receive signal from fire system.  Interview with the maintenance supervisor on February 4, 2025, at 11:00 a.m., confirmed the deficiencies were not corrected at the time of the survey.	K 0345	Quality Assurance and Performance Improvement Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395645</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/04/2025</b>
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K 0353  SS=B	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0353	<p>The missing escutcheon plate was ordered during the week of the inspection. The plate will be installed when it is received.</p> <p>The Maintenance Director will be educated on the importance of properly installed escutcheon plates.</p> <p>The facility will ensure that all sprinkler heads have proper escutcheon plates installed.</p> <p>Audits of all escutcheon plates will be conducted 3 times a week for 4 weeks.</p> <p>The results of the audits will be reviewed at the facilities monthly quality assurance performance improvement meeting.</p>	<p>Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b></p>

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K 0353  SS=B	Continued from page 4  Based on observation and interview, the facility failed to maintain the sprinkler system in one of more than twenty rooms.  Findings include:  Observation on February 4, 2025, at 1:10 p.m., revealed the first floor beauty salon had a missing escutcheon plate that caused an opening in the ceiling, potentially affecting sprinkler activation.  Interview with the maintenance supervisor on February 4, 2025, at 1:10 p.m., confirmed the sprinkler escutcheon plate was missing.	K 0353		
K 0741  SS=E		K 0741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395645</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>02/04/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>EDINBORO MANOR</b>  STATE LICENSE NUMBER: <b>053002</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>419 WATERFORD STREET EDINBORO, PA 16412</b>		
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K 0741  SS=E	Continued from page 5  NFPA 101 Smoking Regulations  Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4  This REQUIREMENT is not met as evidenced by:	K 0741	The cigarette butts have been removed from the ground by the exit. The facility will ensure that ashtrays being utilized properly.  The Administrator and/or designee will educate the Maintenance Director on the importance of Smoking regulations. The Maintenance Director will educate the staff on the importance of adhering to smoking regulations.  Audits will be conducted 3 times a week for 4 weeks to ensure that smoking regulations are being met.	Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>02/14/2025</b>

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K 0741  SS=E	Continued from page 6  Based on observation and interview, the facility failed to follow smoking regulations at one of over five exits.  Findings include:  Observation on February 4, 2025, at 1:15 p.m., revealed the facility had an accumulation of cigarette butts on the ground outside of the oxygen storage room and in various spots around the designated smoking area.  Interview with the maintenance supervisor on February 4, 2025, at 1:15 p.m., confirmed the cigarette butt accumulation outside of the facility.	K 0741		



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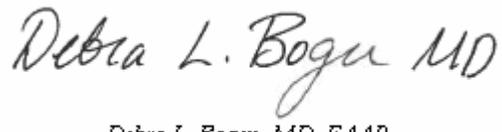
**EDINBORO MANOR**

**STATE LICENSE NUMBER: 053002**

**SURVEY EXIT DATE: 02/04/2025**

**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	<p>INITIAL COMMENT</p> <p>Facility ID #053002 Component 02 Therapy Unit</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on February 4, 2025, it was determined that Edinboro Manor 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).</p> <p>This is a one-story, Type V (111), protected, wood frame building, that is fully sprinklered.</p>	K 0000		

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

TITLE:

(X6) DATE:

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K 0345  SS=F	<p>NFPA 101 Fire Alarm System - Testing and Maintenance</p> <p>Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0345	<p>The facility was provided with incorrect documentation by the inspection company. The company has provided the correct documentation depicting that there were/are no deficiencies present. The above-mentioned documentation will be provided upon submission of this Plan of Correction.</p> <p>The Maintenance Director will be educated on the importance of ensuring that the facility receives correct/accurate reports regarding any inspections that occur.</p> <p>All inspections/reports will be audited by the administrator and reviewed with the inspection companies prior to them exiting the facility. Once the written reports are obtained, the administrator and/or Maintenance Director will again review to ensure accuracy of findings.</p> <p>The results of inspections will be reviewed at the facilities monthly Quality Assurance and Performance Improvement Meeting.</p>	<p>Completion Date: <b>03/28/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b></p>

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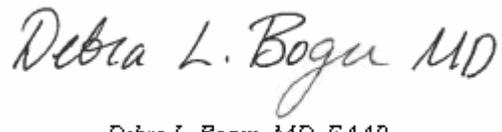
**EDINBORO MANOR**

**STATE LICENSE NUMBER: 053002**

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Secretary of Health



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