STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396071	A. BLDG: 00 B. WING:	04/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CLEPPER MANOR STATE LICENSE NUMBER: **032902**	**959 EAST STATE STREET** **SHARON, PA 16146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey and an Abbreviated Complaint Survey, completed April 4, 2025, it was determined that Clepper Manor, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0625 SS=B		F 0625		

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 0625 SS=B	Continued from page 1 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	No residents negatively impacted Director of Nursing and Social Service designee did identify residents during the time of survey that were sent out to the hospital that did not receive bed hold notices. Social Service designee was able to correct by providing the notices to those residents. Regional Director of Clinical Operations educated Administrator, Social Service Designee ad Director of Nursing on bedhold letter, policy and process on 4.15.25 Administrator / designee will educate all nurses on bedhold letter, policy and process beginning 4.15.25, all education will be completed by 5.1.25 Administrator / designee will audit all resident transfers for 4 weeks to ensure notices are sent with resident (POA if applicable), at the time of transfer or within 24 hours, per regulation and the policy was followed. Audits will begin 4.15.25	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/25/2025**

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F 0625 SS=B	Continued from page 2	F 0625	Results of audit will be reviewed by QA committee to determine further need.	

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F 0625 SS=B	Continued from page 3 Based on review of clinical records and staff interviews, it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) for four of four residents reviewed for bed holds (Residents R5, R8, R15, and R40). Findings include: Resident R5's clinical record revealed that he/she was transported/admitted to the acute care hospital on 3/12/25, and returned to the facility on 3/17/25, with a diagnosis of a urinary tract infection (infection in any part of your urinary system). Resident R8's clinical record revealed that he/she was transported/admitted to the acute care hospital on 3/25/25, and returned to the facility on 3/26/25, with a diagnosis of a cardiac event and orders to be place with a cardiac monitor.	F 0625		

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F 0625 SS=B	Continued from page 4 Resident R15's clinical record revealed that he/she was transported/admitted to the acute care hospital on 3/16/25, and returned to the facility on 3/21/25, with a diagnosis of acute respiratory failure (when the lungs aren't properly exchanging gases, causing low oxygen in the blood). Resident R40's clinical record revealed that he/she was transported/admitted to the acute care hospital on 2/17/25, and returned to the facility on 2/19/25, with a diagnosis of a fractured left leg. The clinical records of Residents R5, R8, R15, and R40, lacked evidence to support that the resident and/or resident representative was provided a written notice of the bed-hold policy upon or following transfer to the hospital. During an interview on 4/3/25, at 8:30 a.m. the Administrative Nurse Employee E1 confirmed that the bed-hold policy was not provided to Residents R5, R8, R15 or R40 and/or their representative as	F 0625		

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F 0625 SS=B	Continued from page 5 required. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0625		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 6 483.80(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	No residents were negatively impacted When notified by surveyor Director of Nursing provided privacy bag to resident with foley catheter and ensured it was off the floor. Director of Nursing observed all other residents with foleys to ensure they had privacy was in place and it was not touching the floor Regional Director of Clinical Operations educated Administrator and Director of Nursing on the Catheter Care Policy and infection control policy on 4.15.25 Director of Nursing / designee will educate all direct care staff on Catheter Care policy and infection control policy beginning on 4.15.25, all education will be completed by 5.1.25 Director of Nursing / designee will audit all residents with foley catheters three times per week for four week to ensure that proper policy and infection control measures are being followed. Audits will begin 5.1.25 results of the audit will be reviewed	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/25/2025**

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F 0880 SS=D	Continued from page 7 (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	by QA committee to determine further need.	

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F 0880 SS=D	Continued from page 8	F 0880		

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F 0880 SS=D	Continued from page 9 Based on clinical record review, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices related to care and treatment of residents with urinary drainage catheters (a tube inserted into the bladder to facilitate urine drainage) for one of 12 residents observed with drainage catheters (Resident R2). Findings include: Review of Resident R2's clinical record revealed an admission date of 3/17/25, with diagnoses that included osteolysis (condition where bone tissue is broken down), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe), and urinary tract infection. Observation on 4/1/25, at 4:15 p.m. revealed Resident R2 lying in bed with his/her catheter drainage bag and tubing extended out and lying on the floor next to the bed. There was no cover over	F 0880		

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F 0880 SS=D	Continued from page 10 the drainage bag that was directly on the floor. During an interview at that time, Licensed Practical Nurse Employee E2 confirmed that the catheter drainage bag and tubing was laying on the floor without a covering on 4/1/25, at 4:16 p.m. and that the drainage bag and tubing should not be laying on the floor or touching an unclean surface. During an interview on 4/2/25, at 3:15 p.m. the Nursing Home Administrator confirmed that catheter bags should not be lying on the floor and should have a covering over the catheter drainage bag. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services	F 0880		

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P 4600	Medical Director. (c) In addition to the requirements of 42 CFR 483.70(h) (relating to administration), the medical director of a facility shall be licensed as a physician in this Commonwealth and shall complete at least four hours annually of continuing medical education (CME) pertinent to the field of medical direction or post-acute and long-term care medicine. The medical director may be designated for single or multiple facilities. There shall be a written agreement between the physician and the facility. This REGULATION is not met as evidenced by:	P 4600	Medical Director was out of the country at the time of survey - administrator to follow up with medical Director upon return and obtain certificate of completion medical Director returned from vacation week of 4/14/2025. Facility did reach out and obtained documentation of completed Continuing education which was forwarded to the field office. Administrator / designee will review in quarterly quality assurance committee meeting to ensure we have up to date documentation on hand	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/25/2025**

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

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P 4600	Continued from page 1 Based on review of facility documentation and staff interview, it was determined the facility failed to ensure the Medical Director completed at least four hours annually of continuing medical education (CME) pertinent to the field of medical direction or post-acute and long-term care medicine. Findings include: There was no available evidence that the Medical Director had completed the required annual CME hours. During an interview on 4/4/25, at 10:30 a.m. the Nursing Home Administrator was unable to provide documented evidence the Medical Director completed at least four hours of the required CME.	P 4600		

Certified End Page

CLEPPER MANOR

STATE LICENSE NUMBER: 032902

SURVEY EXIT DATE: 04/04/2025

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
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