

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: __-_____<br>B. WING: _____  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b>  |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</b> |   |   |
| STATE LICENSE NUMBER: <b>032902</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<br><br>SS=C                                     | INITIAL COMMENT  | E 0000  |   |   |
| E 0004<br><br>SS=C                                     | 483.73(a) Develop EP Plan, Review and Update Annually<br><br>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).<br><br>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:<br><br>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan | E 0004  | 1. Administrator and Maintenance Director conducting review and updates for emergency preparedness plan.<br>2. Emergency preparedness plan will be updated by 5/12/2025<br>3. Administrator and Maintenance Director will provide all staff education on emergency preparedness plan.<br>4. All staff education will be completed by 5/14/2025. | Completion Date:<br><b>05/14/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |

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:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>  --  </u><br>B. WING: <u>          </u>                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 0004<br><br>SS=C   | Continued from page 1<br><br>must do all of the following:<br><br>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.<br><br>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.<br><br>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.<br><br>.<br><br>This REQUIREMENT is not met as evidenced by: | E 0004  |  |  |
|  |  |   |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: == _____<br>B. WING: _____                                   | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 0004<br><br>SS=C   | Continued from page 2<br><br>Based on document review and interview, the facility failed to meet emergency preparedness guidelines for one of one program.<br><br>Findings include:<br><br>Document review on April 8, 2025, at 8:29 a.m., revealed the last annual review date for the emergency preparedness plan occurred January 17, 2019.<br><br>Interview with the maintenance director on April 8, 2025, at 8:29 a.m., confirmed the facility was unable to provide documentation for an updated annual review date at the time of the survey. | E 0004  |  |  |
| E 0006<br><br>SS=C   |   | E 0006  |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>  | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: __-_____<br>B. WING: _____                          | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>   |   |
|--|--|---|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 0006<br><br>SS=C   | Continued from page 3<br><br>483.73(a)(1)-(2) Plan Based on All Hazards Risk Assessment<br><br>§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)<br><br>[[a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*<br><br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.<br>(2) Include strategies for addressing emergency events | E 0006  | risk assessment was completed for the facility in our company's electronic system. The facility printed the assessment and has placed in our life safety binder. maintenance director and administrator will ensure that when the risk assessment is completed it is printed and placed in the life safety binder at the time of completion. | Completion Date:<br><b>05/01/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: __<br>B. WING: __  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 0006<br><br>SS=C   | Continued from page 4<br><br>identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.<br><br>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>This REQUIREMENT is not met as evidenced by: | E 0006  |  |  |
|  |  |   |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b> | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: __-_____<br>B. WING: _____                                   |                    | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|--|---|--|--------------------|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 0006<br><br>SS=C   | Continued from page 5<br><br>Based on document review and interview, the facility failed to meet emergency preparedness guidelines for one of one program.<br><br>Findings include:<br><br>Document review on April 8, 2025, at 8:31 a.m., revealed the facility was unable to provide a documented risk assessment that utilized an all-hazard approach.<br><br>Interview with the maintenance director on April 8, 2025, at 8:31 a.m., confirmed the facility was unable to provide the documentation at the time of the survey. | E 0006  |  |                    |  |



# Certified End Page

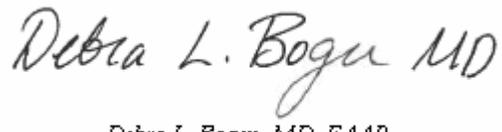
**CLEPPER MANOR**

**STATE LICENSE NUMBER: 032902**

**SURVEY EXIT DATE: 04/08/2025**

**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

|  |   |   |  |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b> | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 |
|--------------------|--|---------------|--|--------------------|
|--------------------|--|---------------|--|--------------------|

|        |   |        |  |  |
|--------|---|--------|--|--|
| K 0000 | <p>INITIAL COMMENT</p> <p>Facility ID #032902<br/>Component 01<br/>Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on April 8, 2025, it was determined that Clepper 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 two-story, Type III (211), protected, ordinary building, with a basement and unoccupied attic, that is fully sprinklered.</p> | K 0000 |  |  |
|--------|---|--------|--|--|

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:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|--|---|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0100<br><br>SS=C   | NFPA 101 General Requirements - Other<br><br>General Requirements - Other<br>List in the REMARKS section any LSC Section 18.1 and 19.1 General 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.<br><br>This REQUIREMENT is not met as evidenced by: | K 0100  | Maintenance Director and Administrator will update floor plan with clear description of<br>a. smoke barrier walls (outside wall to outside wall)<br>b. fire barrier walls (1-2 hour walls)<br>c. horizontal exits<br>d. rated rooms (storage rooms, soiled utility rooms, designated medical gas rooms)<br>e. exits noted<br>f. shaft walls<br>g. door schedule<br>this will be completed by 5/13/2025 | Completion Date:<br><b>05/13/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |
|  |  |   |  |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>  | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____                         | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>   |                    |
|--|--|---|--|--------------------|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 |
| K 0100<br><br>SS=C   | <p>Continued from page 2</p> <p>Document review on April 8, 2025, at 8:45 a.m., revealed the facility failed to provide a set of accurate, portable floor plans. The Division of Safety Inspection is requiring that all facilities under its jurisdiction provide a portable, accurate floor plan on-site, to be used during the Life Safety Code Survey.</p> <p>Observation on April 8, 2025, at 9:01 a.m., revealed there were multiple areas without doors and smoke detection leading to the corridor. The facility was also unable to provide accurate rating information for the dining room doors leading to the entertainment area.</p> <p>The Life Safety Code Floor Plan shall include the following:</p> <ol style="list-style-type: none"> <li>a. Smoke barrier walls (outside wall to outside wall);</li> <li>b. Fire barrier walls (1-2 hour walls);</li> <li>c. Horizontal exits;</li> <li>d. Rated rooms (storage rooms, soiled utility rooms, designated medical gas rooms) will be</li> </ol> | K 0100  |  |                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0100<br><br>SS=C   | Continued from page 3<br><br>clearly designated. It is the facility's responsibility to have all rated rooms indicated on its Life Safety Code Floor Plan;<br>e. Required exits should be clearly noted;<br>f. Shaft walls;<br>g. Door schedule.<br><br>Interview with the maintenance director on April 8, 2025, at 8:45 a.m., confirmed the facility's Life Safety Code Floor Plan was not accurate at the time of the survey. | K 0100  |  |  |
| K 0111<br><br>SS=F   |  | K 0111  |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>   | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____                         | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |   |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0111<br><br>SS=F   | Continued from page 4<br><br>NFPA 101 Building Rehabilitation<br><br>Building Rehabilitation<br>Repair, Renovation, Modification, or Reconstruction<br>Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following:<br>* Requirements of Chapter 18 and 19<br>* Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6<br>18.1.1.4.3, 19.1.1.4.3, 43.1.2.1<br>Change of Use or Change of Occupancy<br>Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2<br>18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7)<br>Additions<br>Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8.<br>18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) | K 0111  | maintenance director and administrator will obtain the appropriate plans and H number for the outside generator installation from the contractor and submit to the state by 5/13/2025<br><br>maintenance director and administrator will obtain plans for the fire alarm panel that was replaced from the contractor and submit to the state by 5/13/2025 | Completion Date:<br><b>05/13/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |

|  |   |   |  |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b> | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 |
|--------------------|--|---------------|--|--------------------|
| K 0111<br><br>SS=F | Continued from page 5<br><br>This REQUIREMENT is not met as evidenced by:  | K 0111        |  |                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0111<br><br>SS=F   | Continued from page 6<br><br>Based on observation and interview, the facility failed to comply with building rehabilitation requirements for one of one facility.<br><br>Findings include:<br><br>Observation on April 8, 2025, between 8:45 a.m. and 10:20 a.m., revealed the following projects had been completed without plans submitted to State Plan Review and a granted occupancy from the Division of Safety Inspection;<br>A. (8:45 a.m.) Outside generator was installed in November 2023. The facility did not provide plans or an H number;<br>B. (10:20 a.m.) Fire alarm panel was replaced.<br><br>Interview with the maintenance director on April 8, 2025, at 10:20 a.m., confirmed the facility was unable to provide plans documentation at the time of the survey. | K 0111  |  |  |
|  |  |   |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>  | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____                         | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>   |                    |   |   |                                      |   |   |   |          |   |         |   |                                       |   |                                     |        |   |   |
|--|--|---|--|--------------------|---|---|--------------------------------------|---|---|---|----------|---|---------|---|---------------------------------------|---|-------------------------------------|--------|---|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 |   |   |                                      |   |   |   |          |   |         |   |                                       |   |                                     |        |   |   |
| K 0161<br><br>SS=F   | <p>NFPA 101 Building Construction Type and Height</p> <p>Building Construction Type and Height<br/>2012 EXISTING<br/>Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7<br/>19.1.6.4, 19.1.6.5</p> <table border="0"> <tr> <td style="padding-left: 40px;">1</td> <td style="padding-left: 40px;">Construction Type<br/>I (442), I (332), II (222) Any number of stories<br/>non-sprinklered and sprinklered</td> </tr> <tr> <td style="padding-left: 40px;">2</td> <td style="padding-left: 40px;">II (111) One story non-sprinklered<br/>Maximum 3 stories sprinklered</td> </tr> <tr> <td style="padding-left: 40px;">3</td> <td style="padding-left: 40px;">II (000) Not allowed non-sprinklered</td> </tr> <tr> <td style="padding-left: 40px;">4</td> <td style="padding-left: 40px;">III (211) Maximum 2 stories sprinklered</td> </tr> <tr> <td style="padding-left: 40px;">5</td> <td style="padding-left: 40px;">IV (2HH)</td> </tr> <tr> <td style="padding-left: 40px;">6</td> <td style="padding-left: 40px;">V (111)</td> </tr> <tr> <td style="padding-left: 40px;">7</td> <td style="padding-left: 40px;">III (200) Not allowed non-sprinklered</td> </tr> <tr> <td style="padding-left: 40px;">8</td> <td style="padding-left: 40px;">V (000) Maximum 1 story sprinklered</td> </tr> </table> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>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 floor plan of the building as appropriate.</p> <p>This REQUIREMENT is not met as evidenced by:</p> | 1   | Construction Type<br>I (442), I (332), II (222) Any number of stories<br>non-sprinklered and sprinklered | 2                  | II (111) One story non-sprinklered<br>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 | K 0161 | <p>Maintenance Director has replaced latch on fire door separating component 01 from component 02, located next to the resident entertainment room on 4/12/2025. The door now properly latches when released.</p> <p>Maintenance director will audit twice a week Monday through Friday - ongoing<br/>The results of the audit will be reviewing in quality assurance committee monthly to determine if quality assurance plan is required.</p> | <p>Completion Date:<br/><b>04/12/2025</b><br/>Status:<br/><b>APPROVED</b><br/>Date:<br/><b>05/06/2025</b></p> |
| 1  | Construction Type<br>I (442), I (332), II (222) Any number of stories<br>non-sprinklered and sprinklered   |   |  |                    |   |   |                                      |   |   |   |          |   |         |   |                                       |   |                                     |        |   |   |
| 2  | II (111) One story non-sprinklered<br>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  |   |  |                    |   |   |                                      |   |   |   |          |   |         |   |                                       |   |                                     |        |   |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0161<br><br>SS=F   | Continued from page 8<br><br>Based on observation and interview, the facility failed to comply with building construction type requirements for two of two components.<br><br>Findings include:<br><br>Observation on April 8, 2025, at 9:00 a.m., revealed the fire door separating component 01 from component 02, located next to the resident entertainment room, failed to positively close or latch when released.<br><br>Interview with the maintenance director on April 8, 2025, at 9:00 a.m., confirmed the door failed to latch at the time of the inspection. | K 0161  |  |  |
| K 0345<br><br>SS=C   |   | K 0345  |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0345<br><br>SS=C   | Continued from page 9<br><br>NFPA 101 Fire Alarm System - Testing and Maintenance<br><br>Fire Alarm System - Testing and Maintenance<br>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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br><br>This REQUIREMENT is not met as evidenced by: | K 0345  | Maintenance director contacted summit fire regarding the trouble signal listed for communication error. summit came out on 4/29/2025, reset the panel and the issue was temporarily corrected. Summit ordered part needed to repair completely and it is scheduled to be in and repaired at the latest 5/12/2025 | Completion Date:<br><b>05/12/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |
|  |   |   |  |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0345<br><br>SS=C   | Continued from page 10<br><br>Based on observation and interview, the facility failed to meet fire alarm system maintenance and testing requirements for one of one panel.<br><br>Findings include:<br><br>Observation on April 8, 2025, at 10:45 a.m., revealed the fire alarm panel had a trouble signal listed for a communication error at the time of the survey.<br><br>Interview with the maintenance director on April 8, 2025, at 10:45 a.m., confirmed the communication error. | K 0345  |  |   |
| K 0351<br><br>SS=E   | NFPA 101 Sprinkler System - Installation<br><br>Spinkler System - Installation<br>2012 EXISTING<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.   | K 0351  | Maintenance Director to contact Mike at the department of labor elevator division and tony from schindler elevator to determine/obtain documentation of the requirement needed for the elevator sprinkler. | Completion Date:<br><b>05/15/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0351<br><br>SS=E   | Continued from page 11<br><br>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br><br>This REQUIREMENT is not met as evidenced by: | K 0351  |  |  |
|  |   |   |  |  |

|  |   |   |  |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b> | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 |
|--------------------|--|---------------|--|--------------------|
| K 0351<br><br>SS=E | <p>Continued from page 12</p> <p>Based on observation and interview, the facility failed to maintain sprinkler system requirements for one of two components.</p> <p>Findings include:</p> <p>Observation on April 8, 2025, at 12:00 p.m., revealed the hydraulic elevator pit did not have a sidewall sprinkler installed within two feet of the floor.</p> <p>Interview with the maintenance director on April 8, 2025, at 12:00 p.m., confirmed the elevator pit did not have a sidewall sprinkler installed.</p> | K 0351        |  |                    |



# Certified End Page

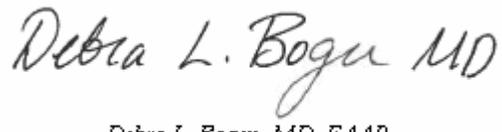
**CLEPPER MANOR**

**STATE LICENSE NUMBER: 032902**

**SURVEY EXIT DATE: 04/08/2025**

**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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0000   | <p>INITIAL COMMENT</p> <p>Facility ID #032902<br/>Component 02<br/>Building 02</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on April 8, 2025, it was determined that Clepper 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 II (000), unprotected, non-combustible building, with a basement, that is fully sprinklered.</p> | K 0000  |  |  |

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:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|--|---|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0100<br><br>SS=C   | NFPA 101 General Requirements - Other<br><br>General Requirements - Other<br>List in the REMARKS section any LSC Section 18.1 and 19.1 General 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.<br><br>This REQUIREMENT is not met as evidenced by: | K 0100  | Maintenance director and Administrator will update the portable floor plan to keep in life safety manual to include:<br>a. smoke barrier walls (outside wall to outside wall)<br>b. fire barrier walls (1-2 hour walls)<br>c. Horizontal exits<br>d. rated rooms (storage rooms, soiled utility rooms, designated medical gas rooms) and they will be clearly designated<br>e. required exits clearly noted<br>f. shaft walls<br>g. door schedule<br>this will be completed by 5/14/2025 | Completion Date:<br><b>05/14/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |
|  |  |   |  |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>  | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                         | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>   |                    |
|--|--|---|--|--------------------|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 |
| K 0100<br><br>SS=C   | Continued from page 2<br><br>Document review on April 8, 2025, at 8:45 a.m., revealed the facility failed to provide a set of accurate, portable floor plans. The Division of Safety Inspection is requiring that all facilities under its jurisdiction provide a portable, accurate floor plan on-site, to be used during the Life Safety Code Survey.<br><br>The Life Safety Code Floor Plan shall include the following:<br>a. Smoke barrier walls (outside wall to outside wall);<br>b. Fire barrier walls (1-2 hour walls);<br>c. Horizontal exits;<br>d. Rated rooms (storage rooms, soiled utility rooms, designated medical gas rooms) will be clearly designated. It is the facility's responsibility to have all rated rooms indicated on its Life Safety Code Floor Plan;<br>e. Required exits should be clearly noted;<br>f. Shaft walls;<br>g. Door schedule. | K 0100  |  |                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>  | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                         | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |   |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0100<br><br>SS=C   | Continued from page 3<br><br>Interview with the maintenance director on April 8, 2025, at 8:45 a.m., confirmed the facility's Life Safety Code Floor Plan was not accurate at the time of the survey.  | K 0100  |   |   |
| K 0111<br><br>SS=F   | NFPA 101 Building Rehabilitation<br><br>Building Rehabilitation<br>Repair, Renovation, Modification, or Reconstruction<br>Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following:<br>* Requirements of Chapter 18 and 19<br>* Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6<br>18.1.1.4.3, 19.1.1.4.3, 43.1.2.1<br>Change of Use or Change of Occupancy<br>Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2<br>18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7)<br>Additions<br>Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition.<br>Communicating openings occur only in corridors and are | K 0111  | maintenance director and administrator will obtain the appropriate plans and H number for the outside generator installation from the contractor and submit to the state by 5/13/2025<br><br>maintenance director and administrator will obtain plans for the fire alarm panel that was replaced from the contractor and submit to the state by 5/13/2025 | Completion Date:<br><b>05/15/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0111<br><br>SS=F   | Continued from page 4<br><br>protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8.<br>18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)<br><br>This REQUIREMENT is not met as evidenced by: | K 0111  |  |  |
|  |   |   |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0111<br><br>SS=F   | Continued from page 5<br><br>Based on observation and interview, the facility failed to comply with building rehabilitation requirements for one of one facility.<br><br>Findings include:<br><br>Observation on April 8, 2025, between 8:45 a.m. and 11:00 a.m., revealed the following projects had been installed without plans submitted to State Plan Review and a granted occupancy from the Division of Safety Inspection:<br>A. (8:45 a.m.) Outside generator was installed in November 2023. The facility did not provide plans or an H number;<br>B. (10:20 a.m.) Fire alarm panel was replaced;<br>C. (11:00 a.m.) The automatic fire detection system and sprinkler head were removed from the elevator pit.<br><br>Interview with the maintenance director on April 8, 2025, confirmed the facility was unable to provide plans documentation at the time of the survey. | K 0111  |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0111   | Continued from page 6  | K 0111  |  |  |
| SS=F   |  |   |  |  |
| K 0161   | NFPA 101 Building Construction Type and Height   | K 0161  |  | Completion Date:                                     |
| SS=F   | Building Construction Type and Height<br>2012 EXISTING<br>Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7<br>19.1.6.4, 19.1.6.5   |   | Maintenance Director has replaced latch on fire door separating component 01 from component 02, located next to the resident entertainment room on 4/12/2025. The door now properly latches when released. | <b>05/15/2025</b>                                    |
|  | Construction Type  |   |  | Status:  |
|  | 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered   |   | Maintenance director will audit twice a week Monday through Friday - ongoing   | <b>APPROVED</b>                                      |
|  | 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered   |   | The results of the audit will be reviewing in quality assurance committee monthly to determine if quality assurance plan is required.  | Date:  |
|  | 3 II (000) Not allowed non-sprinklered   |   |  | <b>05/06/2025</b>                                    |
|  | 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)<br>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 |   |  |  |

|  |   |   |  |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b> | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 |
|--------------------|--|---------------|--|--------------------|
| K 0161<br><br>SS=F | Continued from page 7<br><br>and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.<br><br>This REQUIREMENT is not met as evidenced by: | K 0161        |  |                    |
|                    |  |               |  |                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>  | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                         | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>   |                    |
|--|--|---|--|--------------------|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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 |
| K 0161<br><br>SS=F   | Continued from page 8<br><br>Based on observation, document review, and interview, the facility failed to comply with building construction type requirements for two of two building components.<br><br>Findings include:<br><br>1. Observation on April 8, 2025, at 9:00 a.m., revealed the fire door separating component 01 from component 02, located next to the resident entertainment room, failed to positively close or latch when released.<br><br>Interview with the maintenance director on April 8, 2025, at 9:00 a.m., confirmed the door failed to latch at the time of the inspection.<br><br>2. Document review on April 8, 2025, at 11:45 a.m., revealed the facility lacked documentation that the discharge exit canopy, located near room 112, was flame retardant. This canopy extends over four feet from the building, is attached to the building, and does not have sprinkler coverage. Therefore, the canopy should be inherently flame retardant. | K 0161  |  |                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0161<br><br>SS=F   | Continued from page 9<br><br>Interview with the maintenance director on April 8, 2025, at 11:45 a.m., confirmed the flame retardant documentation was unavailable at the time of the survey.  | K 0161  |  |   |
| K 0325<br><br>SS=D   | NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)<br><br>Alcohol Based Hand Rub Dispenser (ABHR)<br>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:<br>* Corridor is at least 6 feet wide<br>* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols<br>* Dispensers shall have a minimum of 4-foot horizontal spacing<br>* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room | K 0325  | Regional Maintenance Director educated administrator on the regulation pertaining to storage of alcohol based hand rub. Administrator will educate housekeeping director and housekeeping staff of the regulation. education will be completed by 4/30/2025<br><br>Excess hand rub was removed from electric control room on 4/8/2025. There now is less than 10 gallons stored in the control room in storage cabinet | Completion Date:<br><b>04/30/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0325<br><br>SS=D   | Continued from page 10<br><br>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30<br>* Dispensers are not installed within 1 inch of an ignition source<br>* Dispensers over carpeted floors are in sprinklered smoke compartments<br>* ABHR does not exceed 95 percent alcohol<br>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)<br>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br><br>This REQUIREMENT is not met as evidenced by: | K 0325  |  |  |
|  |   |   |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0325<br><br>SS=D   | Continued from page 11<br><br>Based on observation and interview, the facility failed to meet alcohol-based hand rub dispenser requirements in one of over three smoke compartments.<br><br>Findings include:<br><br>Observation on April 8, 2025, at 10:42 a.m., revealed the basement electric control room had over 10 gallons of alcohol-based hand rub stored outside of a storage cabinet and located within feet of an ignition source. There was approximately 40, 40-ounce full containers being stored.<br><br>Interview with the maintenance director on April 8, 2025, at 10:42 a.m., confirmed the deficiency. | K 0325  |  |  |
| K 0345<br><br>SS=C   |   | K 0345  |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____   | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0345<br><br>SS=C   | Continued from page 12<br><br>NFPA 101 Fire Alarm System - Testing and Maintenance<br><br>Fire Alarm System - Testing and Maintenance<br>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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br><br>This REQUIREMENT is not met as evidenced by: | K 0345  | maintenance director contacted<br>summit fire to come out and correct fire panel communication error.<br><br>summit came out and ordered new part to fix the issue on April 31,2025.<br><br>Once the part arrives summit will be out to replace the part. | Completion Date:<br><b>05/25/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |
|  |  |   |   |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0345<br><br>SS=C   | Continued from page 13<br><br>Based on observation and interview, the facility failed to meet fire alarm system maintenance and testing requirements for one of one panel.<br><br>Findings include:<br><br>Observation on April 8, 2025, at 10:45 a.m., revealed the fire alarm panel had a trouble signal listed for a communication error at the time of the survey.<br><br>Interview with the maintenance director on April 8, 2025, at 10:45 a.m., confirmed the communication error. | K 0345  |  |  |
| K 0353<br><br>SS=B   |   | K 0353  |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____   | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0353<br><br>SS=B   | Continued from page 14<br><br>NFPA 101 Sprinkler System - Maintenance and Testing<br><br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br><br>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<br><br>This REQUIREMENT is not met as evidenced by: | K 0353  | Fictional character was removed immediately when noted by life safety surveyor.<br>Regional maintenance director educated administrator on regulation on sprinkler system maintenance and testing requirements on 4/15/2025.<br>Administrator will educate housekeeping director and all housekeeping staff on sprinkler system maintenance and testing requirements by 5/14/2025.<br>Maintenance director/designee will round weekly for the next four weeks to ensure compliance.<br>results of audit will be reviewed with administrator weekly. | Completion Date:<br><b>05/14/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |
|  |  |   |   |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0353<br><br>SS=B   | Continued from page 15<br><br>Based on observation and interview, the facility failed to meet sprinkler system maintenance and testing requirements for one of over ten rooms.<br><br>Findings include:<br><br>Observation on April 8, 2025, at 10:30 a.m., revealed the basement electric control room had a fictional character figure (minion) taped to the sprinkler line.<br><br>Interview with the maintenance director on April 8, 2025, at 10:30 a.m., confirmed the deficiency. | K 0353  |  |  |
| K 0355<br><br>SS=D   |  | K 0355  |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____   | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0355<br><br>SS=D   | Continued from page 16<br><br>NFPA 101 Portable Fire Extinguishers<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br><br>This REQUIREMENT is not met as evidenced by: | K 0355  | Housekeeping Director immediately removed the janitor cart away from the portable fire extinguisher in the basement washing room.<br>regional director of maintenance educated administrator on the portable fire extinguishers on 4/14/2025<br>administrator will educate housekeeping director and all housekeeping staff of the regulation pertaining to the portable fire extinguishers<br>education will be completed by 5/13/2025<br>administrator/designee will audit weekly for four weeks to ensure that fire extinguisher regulation is followed. | Completion Date:<br><b>05/13/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |
|  |  |   |   |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0355<br><br>SS=D   | Continued from page 17<br><br>Based on observation and interview, the facility failed to meet portable fire extinguisher requirements for two of over six portable fire extinguishers.<br><br>Findings include:<br><br>Observation on April 8, 2025, between 11:00 a.m. and 11:06 a.m., revealed the following portable fire extinguisher deficiencies:<br>A. (11:00 a.m.) Basement washing room had a portable fire extinguisher blocked by a janitor cart;<br>B. (11:06 a.m.) Basement elevator control room had an outdated fire extinguisher with a November 2023 date.<br><br>Interview with the maintenance director on April 8, 2025, at 11:06 a.m., confirmed the deficiencies at the time of the survey. | K 0355  |  |  |
| K 0911<br><br>SS=D   |   | K 0911  |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____   | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b>  |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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  |
| K 0911<br><br>SS=D   | Continued from page 18<br><br>NFPA 101 Electrical Systems - Other<br><br>Electrical Systems - Other<br>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)<br><br>This REQUIREMENT is not met as evidenced by: | K 0911  | Housekeeping director immediately moved the desk that was blocking the electric panel when surveyor observed.<br>regional director of maintenance educated the administrator and maintenance director on the electrical system requirements on 4/14/2025.<br>Administrator will educate housekeeping director and all housekeeping staff.<br>education will be completed by 5/14/2025<br>administrator/designee will audit for compliance weekly for 4 weeks to ensure compliance | Completion Date:<br><b>05/14/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>05/06/2025</b> |
|  |   |   |   |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>396071</b>                     | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>02</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>04/08/2025</b> |
|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>CLEPPER MANOR</b><br><br>STATE LICENSE NUMBER: <b>032902</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>959 EAST STATE STREET<br/>SHARON, PA 16146</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                                   |
| K 0911<br><br>SS=D   | Continued from page 19<br><br>Based on observation and interview, the facility failed to maintain electrical system requirements in one of over three smoke compartments.<br><br>Findings include:<br><br>Observation on April 8, 2025, at 10:55 a.m., revealed the basement electric control room had a desk blocking access to the electric panels at the time of the survey.<br><br>Reference: NFPA 70-110.26(a)<br><br>Interview with the maintenance director on April 8, 2025, at 10:55 a.m., confirmed the deficiency. | K 0911  |  |  |



# Certified End Page

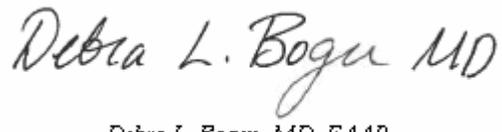
**CLEPPER MANOR**

**STATE LICENSE NUMBER: 032902**

**SURVEY EXIT DATE: 04/08/2025**

**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