

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395103	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/07/2025
NAME OF PROVIDER OR SUPPLIER: ELAN SKILLED NURSING AND REHAB, A JEWISH SENIOR LIFE COMMUNI		STREET ADDRESS, CITY, STATE, ZIP CODE: 1101 VINE STREET SCRANTON, PA 18510		
STATE LICENSE NUMBER: 360402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on January 7, 2025, at Elan Skilled Nursing and Rehab, a Jewish Senior Life Community, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 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.



Certified End Page

ELAN SKILLED NURSING AND REHAB, A JEWISH SENIOR LIFE COMMUNI

STATE LICENSE NUMBER: 360402

SURVEY EXIT DATE: 01/07/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID #360402 Component 01 Main Building 01 Based on a Medicare/Medicaid Recertification Survey completed on January 7, 2025, it was determined the Elan Skilled Nursing and Rehab, a Jewish Senior Life Community, was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a five story, Type II (000), unprotected, noncombustible building, that is fully sprinklered.	K 0000		
K 0161 SS=C		K 0161		

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TITLE:

(X6) DATE:

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K 0161 SS=C	Continued from page 1 NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small	K 0161	Elan Skilled Nursing and Rehab would like PA DOH, DSI to complete the FSES on our behalf. We would like to request a TLW.	Completion Date: 02/14/2025 Status: APPROVED Date: 01/24/2025

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K 0161 SS=C	Continued from page 2 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility exceeded the maximum allowable story height for this type of construction, affecting six of six floors. Findings include: 1. Observation on January 7, 2025, between 10:30 a.m., and 11:00 a.m., revealed the facility exceeded the maximum allowable story height for an unprotected, noncombustible building by three stories. Exit interview on January 7, 2025, with the Facility Administrator and the Facilities Manager, between 12:15 p.m., and 12:20 p.m., confirmed the building construction deficiency.	K 0161		

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K 0311 SS=C	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by:	K 0311	Elan Skilled Nursing and Rehab would like PA DOH, DSI to complete the FSES on our behalf. We would like to request a TLW.	Completion Date: 02/14/2025 Status: APPROVED Date: 01/24/2025

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K 0311 SS=C	Continued from page 4 Based on observation, documentation review and interview, it was determined the facility failed to maintain multiple vertical enclosures, affecting six of six floors. Findings include: 1. Observation on January 7, 2025, at 11:00 a.m., revealed the following: a. Vertical enclosures protecting heating, cooling, and ventilation (HVAC) shafts, adjacent to the exit stair towers, lacked the required two-hour fire resistance rating. b. The fourth and fifth floor construction of the Clay Street exit stair tower consisted of two sheets of drywall on the inside and one sheet of drywall on the corridor and resident room side of metal studs, as well as unprotected steel beams included as part of the enclosure. Exit interview on January 7, 2025, with the Facility	K 0311		

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K 0311 SS=C	Continued from page 5 Administrator and the Facilities Manager, between 12:15 p.m., and 12:20 p.m., confirmed the vertical openings deficiency.	K 0311		
K 0353 SS=E		K 0353		

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K 0353 SS=E	Continued from page 6 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	Observation 1: The make-up air room, located at the basement level, lacked a suspended ceiling assembly (surface-mounted sprinkler heads) 1) What systematic changes will be put into place to ensure that the deficiency does not recur, and how the corrective action(s) will be monitored? The current 2 sprinkler heads in the air make-up room are scheduled to be inverted to upright heads. The remainder of the drop ceiling will be removed. Sprinkler head and in house fire inspections will be completed quarterly. The Director of Facilities Management will report the inspection findings to the QAPI committee. Observation 2: Plastic bag material was affixed to an automatic sprinkler head, located within the fifth floor Personal Laundry. 1) What systematic changes will be put into place to ensure that the deficiency does not recur, and how the corrective action(s) will be	Completion Date: 02/14/2025 Status: APPROVED Date: 01/24/2025

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K 0353 SS=E	Continued from page 7	K 0353	<p>monitored?</p> <p>Plastic bag material was removed from automatic sprinkler head in fifth floor personal laundry area. Sprinkler head and in house fire inspections will be completed quarterly. The Director of Facilities Management will report the findings to the QAPI committee.</p> <p>Observation 3: A sprinkler head assembly, located within the first floor Dietary Office, lacked an escutcheon plate.</p> <p>1) What systematic changes will be put into place to ensure that the deficiency does not recur, and how the corrective action(s) will be monitored?</p> <p>The escutcheon plate on the sprinkler assembly in the Dietary Office was replaced Sprinkler head and in house fire inspections will be completed quarterly. The Director of Facilities Management will report the findings to the QAPI committee.</p>	

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K 0353 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in three locations, affecting three of six floors. Findings include: 1. Observation on January 7, 2025, between 10:22 a.m. and 11:40 a.m., revealed the following: a. 10:22 a.m., the make-up air room, located at the basement level, lacked a suspended ceiling assembly (surface-mounted sprinkler heads). b. 10:44 a.m., plastic bag material was affixed to an automatic sprinkler head, located within the fifth floor Personal Laundry. c. 11:40 a.m., a sprinkler head assembly, located within the first floor Dietary Office, lacked an escutcheon plate. Exit interview on January 7, 2025, with the Facility Administrator and the Facilities Manager, between 12:15 p.m., and 12:20 p.m., confirmed the	K 0353		

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K 0353 SS=E	Continued from page 9 automatic sprinkler system deficiencies.	K 0353		
K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	Observation 1: Observation revealed the fifth floor, Clay Street smoke barrier separation doors required adjustment to fully latch. 1) What systematic changes will be put into place to ensure that the deficiency does not recur, and how the corrective action(s) will be monitored; The Smoke Barrier Separation Door was adjusted to fully closed by the Assistant Director of Maintenance. All Barrier separation doors will be inspected to ensure proper closing during all fire drills by the members of our Maintenance team on their assigned floors during the fire drills. Barrier Separation door inspections will be submitted to QAPI Committee Quarterly by the Director of Maintenance and presented for review/discussion.	Completion Date: 02/14/2025 Status: APPROVED Date: 01/24/2025

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K 0374 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain one set of smoke barrier separation doors, affecting one of six floors. Findings include: 1. Observation on January 7, 2025, at 11:07 a.m., revealed the fifth floor, Clay Street smoke barrier separation doors required adjustment to fully latch. Exit interview on January 7, 2025, with the Facility Administrator and the Facilities Manager, between 12:15 p.m., and 12:20 p.m., confirmed the smoke barrier separation door deficiency.	K 0374		



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