

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395117	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: LUTHERAN HOME AT TOPTON, THE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1 SOUTH HOME AVENUE TOPTON, PA 19562		
STATE LICENSE NUMBER: 643102				
(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 October 8, 2024, at the Lutheran Home at Topton, 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.



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LUTHERAN HOME AT TOPTON, THE
STATE LICENSE NUMBER: 643102
SURVEY EXIT DATE: 12/09/2024

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

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K 0000	INITIAL COMMENT Facility ID #643102 Component 01 1976 Building Based on a revisit to a Medicare/Medicaid Recertification Survey conducted on October 7 & 8, 2024, it was determined that the Lutheran Home at Topton 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 two-story, Type III (200), unprotected ordinary structure, without a basement, which is fully sprinklered.	K 0000		
K 0761 SS=C		K 0761		

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K 0761 SS=C	Continued from page 1 NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 0761	1. Doors are scheduled to be inspected 12/31/24. 2. Documentation of inspection will be maintained by the Maintenance Director. 3. Doors will be inspected monthly by a member of the maintenance team. 4. Inspection results will be reported to the Safety Committee and QAPI Committee meetings.	Completion Date: 12/31/2024 Status: APPROVED Date: 01/02/2025

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K 0761 SS=C	Continued from page 2 Based on document review and interview, it was determined the facility failed to provide documentation verifying fire doors within the facility had been subjected to an inspection within the previous twelve months, affecting the entire component. Findings include: 1. Review of documentation on October 8, 2024, at 11:00 AM, revealed the facility lacked documentation verifying fire doors within the facility had been inspected within the previous twelve months. Interview with the Maintenance Lead on October 8, 2024, at 11:00 AM, confirmed the lack of documentation verifying fire doors within the facility had been inspected within the previous twelve months. *** ** Based on document review and interview, it was	K 0761		

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K 0761 SS=C	Continued from page 3 determined Item 1 was not corrected. Interview with the Manager of Plant Operations on December 6, 2024, at 12:00 PM, confirmed Item 1 was not corrected.	K 0761			



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K 0000	INITIAL COMMENT	K 0000		
K 0353	<p>Facility ID #643102 Component 02 1996 Building</p> <p>Based on a revisit to a Medicare/Medicaid Recertification Survey conducted on October 7 & 8, 2024, it was determined that the Lutheran Home at Topton 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 three-story, Type II (111), protected noncombustible structure, with a basement, which is fully sprinklered.</p>	K 0353		
SS=E				

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K 0353 SS=E	Continued from page 1 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	1. Escutcheons were installed on 12/12/24. 2. All sprinkler heads were checked to ensure escutcheons were in place 12/12/24. 3. Checks will be made by maintenance monthly to ensure that sprinkler escutcheons are in place. 4. Results of these checks will be made by the maintenance director to the monthly meeting of the Safety Committee and QAPI Committee.	Completion Date: 12/31/2024 Status: APPROVED Date: 01/02/2025

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K 0353 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain hardware components of the automatic sprinkler protection system, affecting two of four floors within the component. Findings include: 1. Observation on October 7, 2024, between 11:19 AM and 12:37 PM, revealed sprinkler heads missing an escutcheon, in the following locations: a) 11:19 AM, 3rd floor Pantry; b) 12:30 PM, 1st floor RNAC Office, within Nursing Administration, by electrical panels; c) 12:33 PM, 1st floor Resident Room 104; d) 12:36 PM, 1st floor Memory Care Unit, by the television; e) 12:37 PM, 1st floor Memory Care Unit, by the Bathing Area. Interview with the Maintenance Lead on October 7, 2024, at 12:37 PM, confirmed the sprinkler head	K 0353		

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K 0353 SS=E	Continued from page 3 assemblies were incomplete. *** ** Based on observation and interview on December 6, 2024, at 11:00 AM, it was determined Item 1 was not corrected. Interview with the Manager of Plant Operations on December 6, 2024, at 11:00 AM, confirmed Item 1 was not corrected.	K 0353		
K 0761 SS=C	NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC)	K 0761	1. Doors in D Building Component 02 are scheduled to be inspected 12/31/24. 2. Documentation of the inspection will be maintained by the Maintenance Director. 3. Doors will be inspected monthly by a member of the maintenance team. 4. Inspection results will be reported to the Safety Committee and QAPI Committee meetings.	Completion Date: 12/31/2024 Status: APPROVED Date: 01/02/2025

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K 0761 SS=C	Continued from page 4 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 0761		

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K 0761 SS=C	Continued from page 5 Based on document review and interview, it was determined the facility failed to provide documentation verifying fire doors within the facility had been subjected to an inspection within the previous twelve months, affecting the entire component. Findings include: 1. Review of documentation on October 8, 2024, at 11:00 AM, revealed the facility lacked documentation verifying fire doors within the facility had been inspected within the previous twelve months. Interview with the Maintenance Lead on October 8, 2024, at 11:00 AM, confirmed the lack of documentation verifying fire doors within the facility had been inspected within the previous twelve months. *** ** Based on document review and interview on December 6, 2024, at 12:00 PM, it was determined	K 0761		

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K 0761 SS=C	Continued from page 6 Item 1 was not corrected. Interview with the Manager of Plant Operations on December 6, 2024, at 12:00 PM, confirmed Item 1 was not corrected.	K 0761			

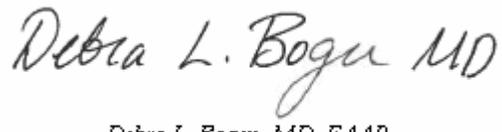


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