STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395298	A. BLDG: __--_____ B. WING: _____	06/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LAKEWOOD REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **191502**	**147 OLD NEWPORT ST NANTICOKE, PA 18634**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on June 30, 2025, at Lakewood Rehabilitation and Healthcare Center, 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

LAKEWOOD REHABILITATION & HEALTHCARE CENTER

STATE LICENSE NUMBER: 191502

SURVEY EXIT DATE: 06/30/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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LAKEWOOD REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **191502**	**147 OLD NEWPORT ST** **NANTICOKE, PA 18634**

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K 0000	INITIAL COMMENT Facility ID# 191502 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on June 30, 2025, it was determined that Lakewood Rehabilitation and Healthcare Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one story, Type II (000), unprotected, noncombustible building, with a partial basement, that is fully sprinklered.	K 0000		

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

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K 0363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 0363	Maintenance has repaired the doors to rooms 217 and 223 to ensure that they latch appropriately. NHA to re-educate facility Maintenance Director on proper latching of corridor doors. A full house audit completed by maintenance to ensure that corridor doors were not getting stuck in their corresponding frames to prevent them from fully latching. Maintenance will conduct weekly audits x 4 weeks and monthly audits x 2 months to ensure doors latch appropriately. Audits to be submitted to QAPI for review and recommendations.	Completion Date: **07/09/2025** Status: **APPROVED** Date: **07/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0363 SS=E	Continued from page 2 This REQUIREMENT is not met as evidenced by:	K 0363		

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K 0363 SS=E	Continued from page 3 Based on observation and interview, it was determined the facility failed to maintain two corridor doors in one of six smoke compartments. Findings include: 1. Observation on June 30, 2025, between 10:56 am and 10:57 am, revealed the following doors were getting stuck in their corresponding frames preventing them from fully latching. a. At 10:56 am, Resident Room 217. b. At 10:57 am, Resident Room 223. Interview at the time of the exit conference on June 30, 2025, at 11:30 am, with the Administrator and Director of Maintenance, confirmed the doors failed to positive latch into frame.	K 0363		

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K 0712 SS=C	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	A fire drill has been conducted, for the first shift, at 11:15AM. Administrator to re-educate Maintenance Director on fire drills being held at random. Maintenance Director will continue to perform monthly fire drills at random basis. NHA/designee will conduct audits weekly x 4 weeks and monthly x 2 months to ensure fire drills are being held randomly monthly. Audits to be submitted to QAPI for review and recommendations.	Completion Date: **07/09/2025** Status: **APPROVED** Date: **07/08/2025**

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K 0712 SS=C	Continued from page 5 Based on documentation review and interview, it was determined the facility failed to perform four of twelve fire drills on a random basis. Findings include: 1. Observation on June 30, 2025, at 10:20 am, revealed that the facility performed the 1st shift fire drills for the last 12 months, within the same hour. (9:59 am, 10:03 am, 9:18 am, 9:08 am). Interview at the time of the exit conference on June 30, 2025, at 11:30 am, with the Administrator and Director of Maintenance, confirmed the fire drills were not performed on a random basis.	K 0712		

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