





# Certified End Page

**GREEN HOME INC**

**STATE LICENSE NUMBER: 072202**

**SURVEY EXIT DATE: 12/30/2024**

**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**

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:  <b>395318</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/30/2024</b>
NAME OF PROVIDER OR SUPPLIER: <b>GREEN HOME INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>37 CENTRAL AVENUE WELLSBORO, PA 16901</b>		
STATE LICENSE NUMBER: <b>072202</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	INITIAL COMMENT  Facility ID #072202 Component 01 Main Building 01  Based on a Medicare/Medicaid Recertification Survey completed on December 30, 2024, it was determined that Green Home, Inc., 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 483.70(a).  This is a two story, Type II (000), unprotected, noncombustible building, that is fully sprinklered.	K 0000		
K 0225		K 0225		
SS=E				

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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K 0225  SS=E	Continued from page 1  NFPA 101 Stairways and Smokeproof Enclosures  Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2  This REQUIREMENT is not met as evidenced by:	K 0225	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. The plastic storage tote, located under the stairs in the of the first-floor north exit, was removed and the work was documented in work order # 20321918. The Facilities Manager or his designee will maintain compliance through monthly safety rounding to identify and correct issues related to stairways and exits. 2. This corrective action was completed on the day of the survey. The Facilities Manager is	Completion Date: <b>02/04/2025</b> Status: <b>APPROVED</b> Date: <b>01/10/2025</b>

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K 0225  SS=E	Continued from page 2  Based on observation and interview, it was determined the facility failed to maintain one stair tower enclosures, affecting two of two floors.  Findings include:  1. Observation on December 30, 2024, at 11:36 am, 1st floor, North Exit, revealed a plastic storage tote, being stored under the stairs.  Exit interview with the Facility Administrator, Facility Assistant Administrator, and Facility Representative #1, on December 30, 2024, at 12:30 pm, confirmed the tote storage.	K 0225	responsible to ensure that corrections are completed and documented in the maintenance work order program.	
K 0321  SS=E		K 0321		



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K 0321  SS=E	Continued from page 4  This REQUIREMENT is not met as evidenced by:	K 0321	responsible to ensure that corrections are completed and documented in the maintenance work order program.		

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K 0321  SS=E	Continued from page 5  Based on observation and interview, it was determined the facility failed to maintain one hazardous area enclosure, affecting one of two floors.  Findings include:  1. Observation on December 30, 2024, at 11:01 am, 2nd floor, revealed the Mechanical Room, had 2 unsealed penetrations in the concrete ceiling.  Exit interview with the Facility Administrator, Facility Assistant Administrator, and Facility Representative #1, on December 30, 2024, at 12:30 pm, confirmed the hazardous area enclosure deficiency.	K 0321		

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K 0353  SS=E		K 0353		
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K 0353  SS=E	Continued from page 7  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	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. a. The penetration in the ceiling tile in the second-floor janitor's closet, near resident room B-24 was repaired and the work was documented in work order #20321912. b. The escutcheon in the ceiling of the first-floor transportation garage will be replaced and the work will be documented in work order #20321923. c. The ceiling tile in the first-floor janitor's closet was replaced and the work was documented in work order	Completion Date: <b>02/04/2025</b> Status: <b>APPROVED</b> Date: <b>01/10/2025</b>

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K 0353  SS=E	Continued from page 8	K 0353	#20321924. The Facilities Manager or his designee will maintain compliance through monthly safety rounding to identify and correct issues related to automatic sprinkler systems. All four of the corrective actions will be completed by February 4, 2025. The Facilities Manager is responsible to ensure that corrections are completed and documented in the maintenance work order program.	

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K 0353  SS=E	Continued from page 9  Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in three locations, affecting two of two floors.  Findings include:  1. Observation on December 30, 2024, between 10:50 am, and 11:46 am, revealed the following:  a. At 10:50 am, 2nd floor, Janitors closet near Resident Room B-24, had an unsealed penetration in a ceiling tile. b. At 11:39 am, 1st floor, Transportation Garage, was missing an escutcheon in the ceiling. c. At 11:46 am, 1st floor, Janitors closet near East Exit, was missing a ceiling tile.  Exit interview with the Facility Administrator, Facility Assistant Administrator, and Facility Representative #1, on December 30, 2024, at 12:30 pm, confirmed the automatic sprinkler system deficiencies.	K 0353		

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K 0353  SS=E	Continued from page 10	K 0353		
K 0363  SS=E		K 0363		

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K 0363  SS=E	Continued from page 11  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.	K 0363	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. a. The closer of the second floor living room doors was adjusted to ensure latching and the work was documented in work order # 20321910. b. The door to resident room B-17 was adjusted to ensure latching and the work was documented in work order # 20321911. c. The door to the Doctor's office on the first floor was repaired and adjusted to ensure that it latched and was smoke-tight. The work was	Completion Date: <b>02/04/2025</b> Status: <b>APPROVED</b> Date: <b>01/10/2025</b>

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K 0363  SS=E	Continued from page 12  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.  This REQUIREMENT is not met as evidenced by:	K 0363	documented in work order # 20321916. d. The door to the first-floor shower room was adjusted to ensure latching and the work was documented in work order # 20321917. The Facilities Manager or his designee will maintain compliance through monthly safety rounding to identify and correct issues related to door closure and integrity. All four of the corrective actions were completed by January 2, 2025. The Facilities Manager is responsible to ensure that corrections are completed and documented in the maintenance work order program.	

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K 0363  SS=E	Continued from page 13  Based on observation and interview, it was determined the facility failed to maintain corridor openings in four locations, affecting two of two floors.  Findings include:  1. Observation on December 30, 2024, between 10:35 am, and 11:34 am, revealed the following:  a. 10:35 am, 2nd floor, Living Room doors, failed to latch into frame b. 10:48 am, 2nd floor, Resident Room B-17 door, failed to latch into frame c. 11:26 am, 1st floor, Dr's Office door, failed to latch into frame and was not smoke-tight d. 11:34 am, 1st floor, Shower Room door, failed to latch into frame.  Exit interview with the Facility Administrator, Facility Assistant Administrator, and Facility Representative #1, on December 30, 2024, at 12:30 pm, confirmed the corridor opening	K 0363		

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K 0363  SS=E	Continued from page 14  deficiencies.	K 0363			



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Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



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