

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395325	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/09/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: MORAVIAN MANOR STATE LICENSE NUMBER: 135202	STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WEST LEMON STREET LITITZ, PA 17543
---	---

(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
F 0000	<p>INITIAL COMMENT</p> <p>Findings of an Abbreviated survey completed on April 9, 2025 at Moravian Manor, identified no deficient practice related to the reported complaint allegations, under the requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.</p>	F 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: 395325	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/09/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: MORAVIAN MANOR STATE LICENSE NUMBER: 135202	STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WEST LEMON STREET LITITZ, PA 17543
---	---

(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
--------------------	--	---------------	--	--------------------

F 0689 SS=E		F 0689		
--------------------	--	--------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395325	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/09/2025	
NAME OF PROVIDER OR SUPPLIER: MORAVIAN MANOR STATE LICENSE NUMBER: 135202		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WEST LEMON STREET LITITZ, PA 17543		
(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
F 0689 SS=E	Continued from page 2 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices 483/25(d) Accidents The facility must ensure that 483.25(d)(1) the resident environment remains as free of accident hazards as is possible; and 483.25(d)(2) Each resident received adequate supervision and assistance devices to prevent accidents. The facility failed to provide an environment free of accident hazards for one of the two dining area per National Fire Protection Agency (NFPA) 96. Upon knowledge of the open flames, the flames were turned off. The Dining Leadership team and Maintenance was called. The steam table that was not working was fixed and working by 2pm on 4/9/25. The emergency plan will be if the steam tables are not working, portable steam wells will be in place with electricity. A policy was created on 4/10/25 to use the portable steam tables. Audits will only need to be done when Steam tables would not be	Completion Date: 04/22/2025 Status: APPROVED Date: 04/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395325	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/09/2025
NAME OF PROVIDER OR SUPPLIER: MORAVIAN MANOR STATE LICENSE NUMBER: 135202		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WEST LEMON STREET LITITZ, PA 17543		
(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
F 0689 SS=E	Continued from page 3	F 0689	working, and Portable Steam Wells are in use. Audits would be completed for each meal period the Portable Steam Wells are in use. Staff were educated on 4/9/25 not to use sternos and on 4/22/25 of the new process with the steam wells.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395325	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/09/2025	
NAME OF PROVIDER OR SUPPLIER: MORAVIAN MANOR STATE LICENSE NUMBER: 135202	STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WEST LEMON STREET LITITZ, PA 17543			
(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
F 0689 SS=E	Continued from page 4 Based on review of the National Fire Protection Agency's (NFPA) 96, observation and interview with staff, it was determined the facility failed to provide an environment free of accident hazards for one of two dining areas. (2nd floor dining room). Findings include: Review of NFPA 96: Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations states that open flames are not permitted in health care settings. Observation in the second floor dining room on April 9, 2025 at 11:15 a.m. revealed four hotel pans containing food being warmed by 8 sterno burners (fuel made from denatured and jellied alcohol). Interview with Dietary Employees E3 and E4 on April 9, 2025 at 11:35 a.m. revealed the steam table had broken, and they had been using the sterno to keep the food warm until the steam table was able to be replaced. Further interview revealed the	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395325	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/09/2025
NAME OF PROVIDER OR SUPPLIER: MORAVIAN MANOR STATE LICENSE NUMBER: 135202			STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WEST LEMON STREET LITITZ, PA 17543		
(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	
F 0689 SS=E	Continued from page 5 sterno had been used for about a month. Interview with the Nursing Home Administrator on April 9, 2025 at 11:30 confirmed there should not be open flame in the nursing home and instructed the dietary staff to extinguish the sterno flames. 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.14 (a) Responsibility of Licensee	F 0689			



Certified End Page

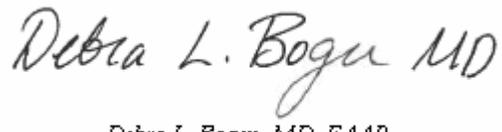
MORAVIAN MANOR

STATE LICENSE NUMBER: 135202

SURVEY EXIT DATE: 04/09/2025

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