STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: __--_____ B. WING: _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET OXFORD, PA 19363**

(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 January 28, 2025, at Oxford Health 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

OXFORD HEALTH CENTER

STATE LICENSE NUMBER: 410302

SURVEY EXIT DATE: 01/28/2025

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:
	395367	A. BLDG: 01 B. WING:	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0000	INITIAL COMMENT Facility ID #410302 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on January 28, 2025, it was determined that Oxford Health 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 two-story, Type II (000), unprotected noncombustible structure, which is fully sprinklered.	K 0000		
K 0133 SS=D		K 0133		

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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: 01 B. WING:	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0133 SS=D	Continued from page 1 NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by:	K 0133	The four penetrations of the common wall, separating the 01 and 02 components above the suspended ceiling above the double doors will be corrected by the Maintenance Manager using an approved through penetration fire stop system. The Maintenance Manager or designee will conduct an audit of corridor walls weekly for one month. Monthly fire walls inspections will be added to PM schedule to check for penetrations and caulking in place to ensure the facility maintains the rating of the common wall. Deficient findings will be reported to DES and QAPI meeting.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: __01_____ B. WING: _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: 410302	7 EAST LOCUST STREET OXFORD, PA 19363

(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
K 0133 SS=D	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain the fire resistance of building separating common walls, affecting one of 14 smoke compartments within the component. Findings include: 1. Observation on January 28, 2025, at 11:35 AM, revealed four unprotected penetrations of the common wall, separating the 01 and 02 Components, located above the suspended ceiling, above the double doors, on the 01 Component side, with three penetrations located around groups of wires, and one empty penetration. Interview with the Maintenance Manager on January 28, 2025, at 11:35 AM, confirmed the unprotected penetrations of the fire wall.	K 0133		
K 0225 SS=D		K 0225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: __01_____ B. WING: _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET OXFORD, PA 19363**

(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
K 0225 SS=D	Continued from page 3 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	1.The end cap on the fire exit hardware for Rosewood east stairwell door will be replaced. 2. The Maintenance Manager or designee will conduct an audit the fire exit hardware weekly for one month. 3.Fire door hardware inspection will be added to PM checklist to ensure all parts are on the fire doors. 4. Deficient findings will be reported to DES and QAPI meeting.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: 01 B. WING:	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0225 SS=D	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain the fire resistance of exit stairtower enclosures, affecting one of 14 smoke compartments within the component. Findings include: 1. Observation on January 28, 2025, at 1:30 PM, revealed the fire exit hardware, installed on the 1st floor Rosewood East Stairwell door, was missing an end cap. Interview with the Maintenance Manager on January 28, 2025, at 1:30 PM, confirmed the compromised fire resistance of the fire exit hardware.	K 0225		
K 0321 SS=D		K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: 01 B. WING:	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0321 SS=D	Continued from page 5 NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 0321	A door closure will be installed on the basement maintenance storage The Maintenance Manager or designee will conduct a facility wide audit on hazardous doors, and then random doors on a quarterly basis. Education will be provided to all staff on when to report doors missing hardware. Deficient findings will be reported to DES and QAPI meeting.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/11/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: __01_____ B. WING: _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET OXFORD, PA 19363**

(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
K 0321 SS=D	Continued from page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the smoke resistance of hazardous area enclosures, affecting one of 14 smoke compartments within the component. Findings include: 1. Observation on January 28, 2025, at 12:30 PM, revealed the basement door, to the Maintenance Storage Room (over 100 square feet), lacked an automatic closure. Interview with the Maintenance Manager on January 28, 2025, at 12:30 PM, confirmed the door did not automatically close.	K 0321		
K 0355 SS=D		K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: 01 B. WING:	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0355 SS=D	Continued from page 7 NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	Fire extinguisher located within the elevator Machine Room was reinstalled onto the wall bracket. The Maintenance Manager, or designee will audit fire extinguisher placement for one month. Add to our monthly Fire Extinguishers checklist to ensure extinguisher is in mounting bracket. Education will be provided to all staff on the proper mounting of fire extinguishers, and the reporting when a bracket or cabinet is damaged. Deficient findings will be reported to DES and QAPI meeting.	Completion Date: **01/28/2025** Status: **APPROVED** Date: **02/11/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: __01_____ B. WING: _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0355 SS=D	Continued from page 8 Based on observation and interview, it was determined the facility failed to secure portable fire extinguishers, affecting one of 14 smoke compartments within the component. Findings include: 1. Observation on January 28, 2025, at 12:20 PM, revealed the portable fire extinguisher, located within the basement Elevator Machine Room, by the vending machines, was removed from a wall bracket and placed, unsecured, on the floor. Interview with the Maintenance Manager on January 28, 2025, at 12:20 PM, confirmed the portable fire extinguisher was unsecured.	K 0355		
K 0372 SS=E		K 0372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: 01 B. WING:	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0372 SS=E	Continued from page 9 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	The two penetrations of the basement Linen Storage Room will be corrected by the Maintenance Manager using an approved through penetration fore stop system. The Maintenance Manager or designee will conduct an audit of corridor walls weekly for one month, then bi-weekly for one month. Monthly fire walls inspections will be added to PM schedule to check for penetrations and caulking in place and ensure that the facility is maintaining the rating of the smoke barrier wall. Deficient findings will be reported to DES and QAPI meeting.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/11/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: __01_____ B. WING: _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: 410302	7 EAST LOCUST STREET OXFORD, PA 19363

(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
K 0372 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain the smoke resistance of smoke barrier walls, affecting two of 14 smoke compartments within the component. Findings include: 1. Observation on January 28, 2025, at 12:41 PM, revealed two unprotected penetrations of the basement Linen Storage Room wall, where two pipes had been removed. Interview with the Maintenance Manager on January 28, 2025, at 12:41 PM, confirmed the unprotected penetrations of the smoke barrier wall.	K 0372		
K 0920 SS=D		K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: 01 B. WING:	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0920 SS=D	Continued from page 11 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	An additional electrical outlet will be installed to supply electricity to the communication equipment. The multiplying power tap in the Chaplewood Communication closet has been removed. The Maintenance Manager or designee will conduct an audit for unauthorized electrical equipment not less than quarterly, and more frequently during high decoration holidays such as Christmas and Easter. Deficient findings will be reported to DES and QAPI meeting.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/11/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: 01 B. WING:	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0920 SS=D	Continued from page 12 Based on observation and interview, it was determined the facility failed to monitor the use of surge suppressors and extension cords, affecting one of 14 smoke compartments within the component. Findings include: 1. Observation on January 28, 2025, at 12:45 PM, revealed a surge suppressor, supplying electrical power to an extension cord, which in turn, supplied electrical power to communications equipment, within the basement Communications Room. Interview with the Maintenance Manager on January 28, 2025, at 12:45 PM, confirmed a surge suppressor was used to supply electrical power to an extension cord. 2. Observation on January 28, 2025, at 1:09 PM, revealed a receptacle multiplying power tap supplying electrical power to a surge suppressor, within the Chapelwood Communications Closet.	K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395367	A. BLDG: __01_____ B. WING: _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: 410302	7 EAST LOCUST STREET OXFORD, PA 19363

(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
K 0920 SS=D	Continued from page 13 Interview with the Maintenance Manager on January 28, 2025, at 1:09 PM, confirmed the use of a receptacle multiplying power tap.	K 0920		

Certified End Page

OXFORD HEALTH CENTER

STATE LICENSE NUMBER: 410302

SURVEY EXIT DATE: 01/28/2025

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:
	395367	A. BLDG: 02 B. WING:	01/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
OXFORD HEALTH CENTER STATE LICENSE NUMBER: **410302**	**7 EAST LOCUST STREET** **OXFORD, PA 19363**

(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
K 0000	INITIAL COMMENT Facility ID #410302 Component 02 Chapel Building Based on a Medicare/Medicaid Recertification Survey completed on January 28, 2025, at Oxford Health Center, it was determined there were no deficiencies identified under the 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 (111), protected noncombustible structure, with a basement, which is fully sprinklered.	K 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

OXFORD HEALTH CENTER

STATE LICENSE NUMBER: 410302

SURVEY EXIT DATE: 01/28/2025

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