STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395390	A. BLDG: __--_____ B. WING: _____	12/16/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
NOTTINGHAM VILLAGE STATE LICENSE NUMBER: **401002**	**58 NEITZ ROAD PO BOX 32 NORTHUMBERLAND, PA 17857**

(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 December 16, 2024, at Nottingham Village, 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.

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Certified End Page

NOTTINGHAM VILLAGE

STATE LICENSE NUMBER: 401002

SURVEY EXIT DATE: 12/16/2024

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
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

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K 0000	INITIAL COMMENT Facility ID# 401002 Component 01 Building 01 Based on a Medicare/Medicaid Recertification Survey completed on December 16, 2024, it was determined that Nottingham Village 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 V (000), unprotected, wood frame 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 0241 SS=C	NFPA 101 Number of Exits - Story and Compartment Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by:	K 0241	1. Life Safety Inspector Jason Long completed the FSES for the issue in March of 2024 as requested by Nottingham Village.	Completion Date: **02/13/2025** Status: **APPROVED** Date: **12/24/2024**

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K 0241 SS=C	Continued from page 2 Based on observation and interview, it was determined the facility failed to provide required exiting means of egress, affecting one of ten smoke compartments. Findings include: 1. Observation on December 16, 2024, at 10:00 a.m., revealed the basement level lacked two acceptable means of egress. Exit interview with the Facility Administrator on December 16, 2024, at 12:00 p.m., confirmed the exiting deficiency.	K 0241		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 3 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	1. The penetration areas around the copper pipes were resolved with the application of a silicone caulk-filler. 2. Corrective action occurred on 12/16/24 3. Administrator / Designee will educate maintenance staff on K321 and regarding hazardous area wall penetration issues. 4. Maintenance staff will conduct random inspections of other potential hazardous areas to determine that no other penetration issues are identified. Inspections to be done weekly x4 weeks and results submitted to the QA Committee.	Completion Date: **02/13/2025** Status: **APPROVED** Date: **12/24/2024**

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K 0321 SS=E	Continued from page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in one location, affecting one of two floors. Findings include: 1. Observation on December 16, 2024, at 10:05 a.m., Unit 3, Soiled Utility, revealed unsealed penetrations of the wall around 3 copper pipes. Exit interview with the Facility Administrator on December 16, 2024, at 12:00 p.m., confirmed the wall penetrations.	K 0321		
K 0353 SS=E		K 0353		

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K 0353 SS=E	Continued from page 5 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. Unsealed penetration in the ceiling of Environmental Service Room was adjusted and corrected. Sprinkler Escutcheon at station 3 nurses station causing the gap was adjusted and is back into place. Missing escutcheon for walk-in freezer has been ordered. 2. Issue in the Environmental Service Room and Nursing station 3 noted above were corrected on 12/16/24. The missing escutcheon for sprinkler head in walk-in freezer is scheduled to be replaced on 12/27/24. 3. Administrator / Designee will educate maintenance staff regarding K353 maintenance of required sprinkler systems. 4. Maintenance Staff will conduct random inspections of other smoke compartments containing sprinkler heads to identify other similar issues. Inspections will be done weekly x 4 weeks and results reported to QA committee.	Completion Date: **02/13/2025** Status: **APPROVED** Date: **12/24/2024**

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K 0353 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain required sprinkler systems in three locations, affecting four of ten smoke compartments. Findings include: 1. Observation on December 16, 2024, between 10:14 a.m., and 11:16 a.m., revealed the following: a. At 10:14 a.m., Unit 3, Environmental Service Room, had an unsealed penetration of the ceiling. b. At 10:18 a.m., Unit 3, Nurse's Station, had an unsealed gap around a sprinkler escutcheon. c. At 11:16 a.m., Dietary, Walk-In freezer, was missing an escutcheon. Exit interview with the Facility Administrator on December 16, 2024, at 12:00 p.m., confirmed the sprinkler system deficiencies.	K 0353		

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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	1. Resident Room Doors 125 & 120 had adjustments made to the frames to eliminate the gap and ensure smoke tight closure. 2. Corrective action was completed on 12/16/24. 3. Administrator / Designee will educate maintenance staff on K363 regarding corridor doors and maintaining sufficient smoke tight closure. 4. Maintenance Staff will conduct random inspections of resident room doors to identify other potential closure issues. Inspections will be conducted weekly x 4 weeks and results will be submitted to the QA committee.	Completion Date: **02/13/2025** Status: **APPROVED** Date: **12/24/2024**

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K 0363 SS=E	Continued from page 8 This REQUIREMENT is not met as evidenced by:	K 0363		

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K 0363 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain two corridor openings, affecting one of two floors. Findings include: 1. Observation on December 16, 2024, between 10:55 a.m., and 11:04 a.m., revealed the following: a. At 10:55 a.m., Unit 1, Resident Room 125, door was not smoke tight when latched into frame. b. At 11:04 a.m., Unit 1, Resident Room 120, door failed to latch into frame when tested. Exit interview with the Facility Administrator on December 16, 2024, at 12:00 p.m., confirmed the corridor opening deficiencies.	K 0363		

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K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	1. A door latch mechanism will be installed on the attic door to correct the gap and wall separation. 2. The door latch will be installed on 12/27/24. 3. Administrator / Designee will educate maintenance staff on K374 regarding smoke barrier wall separation deficiencies. 4. Maintenance staff will conduct random inspections of other similar areas to identify other potential issues. Inspections will be conducted weekly x4 weeks and results will be reported to the QA committee.	Completion Date: **02/13/2025** Status: **APPROVED** Date: **12/24/2024**

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K 0374 SS=E	Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain one smoke barrier separation wall, affecting two of ten smoke compartments. Findings include: 1. Observation on December 16, 2024, at 11:12 a.m., revealed the attic level smoke barrier separation wall door was not smoke tight when closed into frame, inside Dietary storage. Exit interview with the Facility Administrator on December 16, 2024, at 12:00 p.m., confirmed the smoke barrier separation wall deficiency.	K 0374		

Certified End Page

NOTTINGHAM VILLAGE

STATE LICENSE NUMBER: 401002

SURVEY EXIT DATE: 12/16/2024

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
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

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K 0000	INITIAL COMMENT	K 0000		

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

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K 0000	Continued from page 1 Facility ID# 401002 Component 03 Therapy Building Based on a Medicare/Medicaid Recertification Survey completed on December 16, 2024, at Nottingham Village, 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 483.70(a). This is a one story, Type V (111), protected wood frame building, that is fully sprinklered.	K 0000		

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K 0000	Continued from page 2	K 0000		

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