





# Certified End Page

**QUAKERTOWN CENTER**

**STATE LICENSE NUMBER: 691102**

**SURVEY EXIT DATE: 02/10/2025**

**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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>395405</b>                          | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>01</u><br>B. WING: _____                                  | (X3) DATE SURVEY COMPLETED:<br><br><b>02/10/2025</b> |
|---|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER:<br><b>QUAKERTOWN CENTER</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br><b>1020 SOUTH MAIN STREET<br/>QUAKERTOWN, PA 18951</b> |  |  |
| STATE LICENSE NUMBER: <b>691102</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<br><br>Facility ID# 691102<br>Component 01<br>Main Building<br><br>Based on a Medicare/Medicaid Recertification Survey completed on February 11, 2025, it was determined that Quakertown Center was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).<br><br>This is a one-story, Type II (000), unprotected non-combustible building, that is fully sprinklered. | K 0000   |  |  |
| K 0291<br>SS=E  |   | K 0291   |  |  |

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 0291<br><br>SS=E   | Continued from page 1<br><br>NFPA 101 Emergency Lighting<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1<br><br>This REQUIREMENT is not met as evidenced by: | K 0291   | 1) Maintenance was able to find paperwork after the audit was completed.<br>2) Maintenance was educated on how to find Emergency Lighting documentation.<br>3) Maintenance will audit the online monitoring system weekly to monitor regulatory tasks three times a week for 8 weeks, then monthly x2. Results of the audit will be presented at the monthly QAPI meetings for review and or recommendations. | Completion Date:<br><b>03/18/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>02/28/2025</b> |
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| K 0291<br><br>SS=E   | Continued from page 2<br><br>Based on document review and interview, it was determined the facility failed to ensure emergency lighting was tested annually for one of one emergency light.<br><br>Findings include:<br><br>Document review on February 10, 2025, at 10:45 a.m., revealed the facility could not produce documentation showing a 90-minute annual test was performed over the past 12 months for their emergency lighting.<br><br>Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:15 p.m., confirmed the above deficiencies existed. | K 0291   |  |  |
| K 0321<br><br>SS=E   |  | K 0321   |  |  |



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| K 0321<br><br>SS=E   | Continued from page 4<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, it was determined the facility failed to maintain a hazardous area enclosure, affecting one of five smoke compartments in the facility.<br><br>Findings include:<br><br>Observation on February 10, 2025, at 11:00 a.m., inside the Laundry room, revealed both doors were propped open with door wedges, prohibiting the doors from closing and latching.<br><br>Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:15 p.m., confirmed the laundry room doors were propped open. | K 0321   |  |                    |

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| K 0345<br><br>SS=F   | NFPA 101 Fire Alarm System - Testing and Maintenance<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br><br>This REQUIREMENT is not met as evidenced by: | K 0345   | 1) The facility will contact vendors for quotes on repairs to the panel.<br>2) A time limited waiver was submitted for repairs to the panel<br>3) The facility will make repairs to the panel. | Completion Date:<br><b>03/18/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>02/28/2025</b> |
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| K 0345<br><br>SS=F   | Continued from page 6<br><br>Based on observation, document review, and interview, it was determined the facility failed to maintain fire alarm system components in operable condition, affecting the entire facility.<br>Findings Include:<br>Documentation reviewed on February 10, 2025, at 10:50 a.m., revealed the fire alarm report dated January 15, 2025, listed Inspector's comment "FACP- Panel acknowledge, silence and reset buttons are broken on the panel, recommended new panel".<br>Exit Interview with the Administrator and the Maintenance Director on February 10, 2025, at 1:15 p.m., confirmed verification of repair was not available at the time of survey. | K 0345   |  |  |
| K 0363<br><br>SS=E   |  | K 0363   |  |  |

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| K 0363<br><br>SS=E   | Continued from page 7<br><br>NFPA 101 Corridor - Doors<br><br>Corridor - Doors<br>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.<br>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   | 1) Parts were ordered for door latch in Ice Machine Room<br>2) Maintenance will replace latch when part is received<br>3) The maintenance director or designee will perform random weekly audits for 8 weeks, then monthly for two months, as part of a preventive maintenance plan to ensure corridor doors do not have problems closing. Results of the audit will be presented at the monthly QAPI meetings for review and or recommendations. | Completion Date:<br><b>03/18/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>02/28/2025</b> |

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| K 0363<br><br>SS=E   | Continued from page 8<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, it was determined the facility failed to ensure corridor doors were maintained to resist the passage of smoke and positively latch, affecting one of five smoke compartments in the facility.<br><br>Findings include:<br><br>Observation on February 10, 2025, at 11:45 a.m., revealed the Ice Machine Room door failed to latch.<br><br>Interview at the exit conference with Administrator and Maintenance Director on February 10, 2025 at 1:15 p.m., confirmed the door's inability to latch. | K 0363   |  |                    |
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| K 0374<br><br>SS=E   | NFPA 101 Subdivision of Building Spaces - Smoke Barrie<br><br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>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.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br><br>This REQUIREMENT is not met as evidenced by: | K 0374   | 1) The facility contacted an outside vendor for repair quotes on fire doors.<br>2) The facility will have outside vendor make repairs and a timed limited waiver was submitted for repairs to the panel.<br>3) The maintenance director or designee will perform weekly audits for 8 weeks, then monthly for two months, as part of a preventive maintenance plan to ensure corridor doors do not have problems closing. Results of the audit will be presented at the monthly QAPI meetings for review and or recommendations. | Completion Date:<br><b>03/18/2025</b><br>Status:<br><b>APPROVED</b><br>Date:<br><b>02/28/2025</b> |
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| K 0374<br><br>SS=E   | Continued from page 10<br><br>Based on observation and interview, it was determined the facility failed to ensure doors in smoke barrier walls were maintained to resist the passage of smoke, two of five smoke compartments in the facility.<br><br>Findings include:<br><br>Observation on February 10, 2025, at the following times revealed:<br><br>a) 11:20 a.m., The smoke doors outside medical records failed to close smoke tight when tested;<br>b) 12:30 p.m., The smoke doors outside resident room 147 failed to close smoke tight when tested.<br><br>Exit Interview with the Administrator and Maintenance Director on February 10, 2025, at 1:15 p.m., confirmed the doors failed to close smoke tight. | K 0374   |  |                    |



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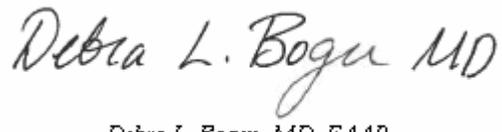
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