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GLEN BROOK REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 281102

SURVEY EXIT DATE: 03/31/2025

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: 395421	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/31/2025
NAME OF PROVIDER OR SUPPLIER: GLEN BROOK REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 801 E 16TH STREET BERWICK, PA 18603		
STATE LICENSE NUMBER: 281102				
(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# 281102 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on March 31, 2025, it was determined that Glen Brook Rehabilitation and Healthcare 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 483.70(a). This is a one story, Type II (000), unprotected, noncombustible structure, which is fully sprinklered.	K 0000		
K 0211 SS=E		K 0211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

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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 0211 SS=E	Continued from page 1 NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	K 0211 1. A wooden pallet and vacuum cleaner were being stored near resident room 53, in the exit corridor. 2. The wooden pallet and vacuum cleaner were immediately removed from the exit corridor near resident room 53. 3. The Maintenance manager/Designee will audit the affected area and other potential areas to ensure the facility maintains a proper means of egress. 4. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

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K 0211 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to ensure that exit access was being maintained readily accessible at all times in one location, affecting one of ten smoke compartments, within this component. . Findings include: 1. Observation on March 31, 2025, at 12:11 pm, revealed that a wooden pallet and vacuum cleaner was being stored in the exit corridor near Resident Room 53. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm, confirmed the storage in the exit corridor.	K 0211		
K 0363 SS=D		K 0363		

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K 0363 SS=D	Continued from page 3 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	K 0363 1. The Main dining room, single door, in the main lobby failed to close and latch. 2. The Main dining room, single door, in the main lobby has been adjusted and closes appropriately. 3. The Maintenance manager/Designee will audit other areas of the facility to ensure doors are latching correctly. 4. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

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K 0363 SS=D	Continued from page 4 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		

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K 0363 SS=D	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain one corridor openings, affecting one of one floor, within this component. Findings include: 1. Observation on March 31, 2025, at 12:22 pm, revealed the Main dining room, single door in main lobby, failed to close and latch due to the door hitting the frame. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm., confirmed the door failed to close and latch into frame.	K 0363		
K 0372 SS=E		K 0372		

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K 0372 SS=E	Continued from page 6 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	K 0372 1. The North Hall, smoke barrier wall had an unsealed penetration above the ceiling around a black and blue wire. 2. The area above the ceiling in the North Hall has been sealed. Point to reference is that the facility is currently installing wires to upgrade the current phone system. 3. The Maintenance manager/Designee will audit other areas of the facility to ensure smoke barrier walls are sealed. 4. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

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K 0372 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain one smoke barrier separation wall, affecting two of ten smoke compartments, within this component. Findings include: 1. Observation on March 31, 2025, at 12:32 pm, revealed the North Hall, smoke barrier wall had an unsealed penetration above the ceiling around black and blue wires. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm, confirmed the unsealed penetration.	K 0372		
K 0374 SS=E		K 0374		

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K 0374 SS=E	Continued from page 8 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	K 0374 1. The North Wing, A hall smoke barrier separation doors failed to latch into frame. 2. The North Wing, A hall smoke barrier separation door has been adjusted to ensure the door latches to the frame. 3. The Maintenance manager/Designee will audit other facility doors to ensure the doors are properly adjusted. 4. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

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K 0374 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain one smoke barrier separation doors, affecting two of ten smoke compartments, within this component. Findings include: 1. Observation on March 31, 2025, at 12:37 pm, revealed the North Wing A-Hall, smoke barrier separation doors failed to latch into frame when released from hold open device. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm, confirmed the smoke barrier separation door deficiency.	K 0374		
K 0521 SS=E		K 0521		

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K 0521 SS=E	Continued from page 10 NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	K 0521 1. The fire/smoke damper report from March 12, 2025, stated 14 of 59 fire/smoke dampers failed because of deficient parts. 2. A contract was signed with a vendor and scheduled to be completed the week of 04-28-2025. 3. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

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K 0521 SS=E	Continued from page 11 Review on documentation and interview, the facility failed to maintain Heating, Ventilating, and Air Conditioning (HVAC) system ductwork through fire-rated walls through-out the facility. Findings include: 1. Observation on March 31, 2025, at 10:50 am, revealed the fire/smoke damper report from March 12, 2025, stated 14 of 59 fire/smoke dampers failed to due deficient parts. At the time of the survey this deficiency remains. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm, confirmed the above condition remains.	K 0521		



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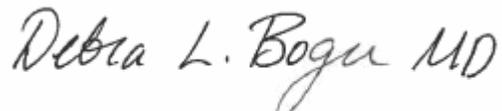
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K 0000	INITIAL COMMENT Facility ID# 281102 Component 02 Building 02 Based on a Medicare/Medicaid Recertification Survey completed on March 31, 2025, it was determined that Glen Brook Rehabilitation and Healthcare Center was not in compliance with the 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 483.70(a). This is a one story, Type II (000), unprotected, noncombustible structure, which is fully sprinklered.	K 0000		
K 0353 SS=E		K 0353		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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K 0353 SS=E	Continued from page 1 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	K 0353 1. The facility failed to maintain the automatic sprinkler system in the following areas: a. unsealed penetration of a ceiling tile in the soiled utility hall of Willow unit. b. missing ceiling tiles within storage room of Spruce Hall. c. missing escutcheon within room 233, of Spruce Hall. d. missing escutcheon within 200 hall lounge area. e. missing escutcheon within Dietary Walk-in freezer 2. Areas listed in the pre-ceding statement have all been resolved. 3. The Maintenance manager/Designee will audit the affected areas and other potential areas to ensure the automatic sprinkler system is monitored appropriately. 4. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

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K 0353 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in fives locations, affecting one of one floor, within this component. Findings include: 1. Observation on March 31, 2025, between 11:19 am, and 11:50 am, revealed the following: a. At 11:19 am, Unsealed penetration of a ceiling tile within soiled utility, Willow Hall. b. At 11:30 am, 2 missing ceiling tiles within storage room, Spruce Hall. c. At 11:40 am, Missing escutcheon within Resident Room 233, Spruce Hall. d. At 11:44 am, Missing escutcheon within 200 Hall lounge. e. At 11:50 am, Missing escutcheon within Dietary walk-in freezer. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm,	K 0353		

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(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 0353 SS=E	Continued from page 3 confirmed the automatic sprinkler system deficiencies.	K 0353		
K 0355 SS=E	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	K 0355 1. The Kitchen "K" fire extinguisher lacked a current annual inspection tag. 2. The Kitchen "K" fire extinguisher has been inspected with appropriate tag attached. 3. The Maintenance manager/Designee will audit other areas with portable fire extinguishers to ensure the devices are properly inspected. 4. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/31/2025	
NAME OF PROVIDER OR SUPPLIER: GLEN BROOK REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: 281102		STREET ADDRESS, CITY, STATE, ZIP CODE: 801 E 16TH STREET BERWICK, PA 18603		
(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 0355 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain one portable fire extinguisher, on one of one floors, within this component. Findings include: 1. Observation on March 31, 2025, at 11:51 am, revealed the kitchen "K" fire extinguisher lacked a current annual inspection tag, the tag attached was from 2022. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm, confirmed the lack of a current inspection tag.	K 0355		
K 0372 SS=E		K 0372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/31/2025	
NAME OF PROVIDER OR SUPPLIER: GLEN BROOK REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: 281102		STREET ADDRESS, CITY, STATE, ZIP CODE: 801 E 16TH STREET BERWICK, PA 18603		
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K 0372 SS=E	Continued from page 5 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	K 0372 1. The smoke barrier wall near the generator room had an unsealed penetration above the ceiling. 2. The area above the ceiling near the generator room has been sealed. 3. The Maintenance manager/Designee will audit other areas of the facility to ensure smoke barrier walls are sealed. 4. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/31/2025	
NAME OF PROVIDER OR SUPPLIER: GLEN BROOK REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: 281102		STREET ADDRESS, CITY, STATE, ZIP CODE: 801 E 16TH STREET BERWICK, PA 18603		
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K 0372 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain one smoke barrier separation wall, affecting two of six smoke compartments, within this component. Findings include: 1. Observation on March 31, 2025, at 12:32 pm, revealed the smoke barrier wall near the Generator room, had an unsealed penetration above the ceiling. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm, confirmed the unsealed penetration.	K 0372		
K 0521 SS=E		K 0521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/31/2025	
NAME OF PROVIDER OR SUPPLIER: GLEN BROOK REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: 281102		STREET ADDRESS, CITY, STATE, ZIP CODE: 801 E 16TH STREET BERWICK, PA 18603		
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K 0521 SS=E	Continued from page 7 NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	K 0521 1. The fire/smoke damper report from March 12, 2025, stated 14 of 59 fire/smoke dampers failed because of deficient parts. 2. A contract was signed with a vendor and scheduled to be completed the week of 04-28-2025. 3. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/31/2025
NAME OF PROVIDER OR SUPPLIER: GLEN BROOK REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 801 E 16TH STREET BERWICK, PA 18603		
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K 0521 SS=E	Continued from page 8 Review on documentation and interview, the facility failed to maintain Heating, Ventilating, and Air Conditioning (HVAC) system ductwork through fire-rated walls through-out the facility. Findings include: 1. Observation on March 31, 2025, at 10:50 am, revealed the fire/smoke damper report from March 12, 2025, stated 14 of 59 fire/smoke dampers failed to due deficient parts. At the time of the survey this deficiency remains. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm, confirmed the above condition remains.	K 0521		
K 0923 SS=E		K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/31/2025
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NAME OF PROVIDER OR SUPPLIER: GLEN BROOK REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: 281102	STREET ADDRESS, CITY, STATE, ZIP CODE: 801 E 16TH STREET BERWICK, PA 18603
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K 0923 SS=E	Continued from page 9 NFPA 101 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	K 0923 1. One oxygen "E" cylinder in the outdoor oxygen storage cabinet was stored on the ground. 2. The oxygen "E" cylinder in the outdoor oxygen storage cabinet was immediately removed and stored appropriately. 3. The Maintenance Manager/Designee will audit oxygen storage areas to ensure oxygen "E" tanks are stored correctly. 4. Corrective Action Date: April 17, 2025	Completion Date: 04/17/2025 Status: APPROVED Date: 04/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395421	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/31/2025	
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K 0923 SS=E	Continued from page 10 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly secure and separate oxygen cylinders in one location, on one of one floors, within this component. Findings include: 1. Observation on March 31, 2025, at 11:05 am, revealed that one oxygen "E" cylinder, stored on the ground inside of the outdoor oxygen empty storage cabinet. Exit interview with the Facility Administrator and the Facilities Manager on March 31, 2025, at 1:15 pm, confirmed the cylinders was not secured.	K 0923		



Certified End Page

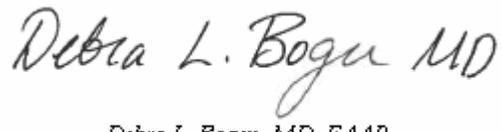
GLEN BROOK REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 281102

SURVEY EXIT DATE: 03/31/2025

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