

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 |
| E 0000 | INITIAL COMMENT Based on an Emergency Preparedness Survey completed on July 28, 2025, at Laureldale Skilled Nursing and Rehabilitation 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

LAURELDALE SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 903502

SURVEY EXIT DATE: 07/28/2025

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, 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: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 #903502 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on July 28, 2025, it was determined that Laureldale Skilled Nursing and Rehabilitation 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 three-story, Type II (000), unprotected noncombustible structure, with a basement, which is fully sprinklered. | K 0000 | | |
| K 0161 SS=C | | K 0161 | | |

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: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|--|--|--|---|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 0161 SS=C | Continued from page 1 NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small | K 0161 | The facility has requested the K161 TLW and also requests a FSES Survey be conducted | Completion Date: 09/05/2025 Status: APPROVED Date: 08/18/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 0161 SS=C | Continued from page 2 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain building construction requirements, affecting the entire component. Findings include: 1. Observation on July 28, 2025, at 10:00 AM, revealed the facility is a three-story, Type II (000), unprotected noncombustible structure, with a basement. The building exceeds the maximum allowable story height for this type of construction. Interview with the Director of Maintenance on July 28, 2025, at 10:00 AM, confirmed the construction type and height was not permitted. | K 0161 | | |
| K 0293 SS=E | | K 0293 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|---|--|--|---|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 0293 SS=E | Continued from page 3 NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: | K 0293 | The light bulb for the Exit Signage in Zone 11 by Resident room 319 has been replaced Maintenance staff will be educated on ensuring all exit signage is illuminated moving forward Maintenance Director/ Designee to perform random quarterly audits on exit signage to ensure all exit signage is illuminated. Results of audits will be forwarded to the QAPI Committee | Completion Date: 09/05/2025 Status: APPROVED Date: 08/15/2025 |
| | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 0293 SS=E | Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain the illumination of exit signage, affecting one of twelve smoke compartments within the component. Findings include: 1. Observation on July 28, 2025, at 11:50 AM, revealed the Zone 11 exit sign, by Resident Room 319, was not illuminated. Interview with the Director of Maintenance on July 28, 2025, at 11:50 AM, confirmed the exit sign was not illuminated. | K 0293 | | |
| K 0353 SS=C | | K 0353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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=C | 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 | Quarterly Sprinkler inspections were conducted at Laureldale Skilled Nursing and Rehabilitation Center throughout the previous 12 months Maintenance staff will be educated on ensuring all sprinkler inspection documentation is maintained moving forward Maintenance Director/ Designee to perform quarterly audits on sprinkler inspection documentation for 1 year to ensure compliance. Results of audits will be forwarded to the QAPI Committee | Completion Date: 09/05/2025 Status: APPROVED Date: 08/13/2025 |
| | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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=C | Continued from page 6 Based on document review and interview, it was determined the facility failed to provide documentation verifying quarterly sprinkler inspections were conducted during the previous twelve months, affecting the entire component. Findings include: 1. Review of documentation on July 28, 2025, at 11:30 AM, revealed the facility failed to provide documentation verifying the automatic sprinkler system was inspected between 1/23/25 and 7/3/25. Interview with the Director of Maintenance on July 28, 2025, at 11:30 AM, confirmed the lack of documentation verifying the automatic sprinkler system was inspected between 1/23/25 and 7/3/25. | K 0353 | | |
| K 0363 SS=E | | K 0363 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 | |
|---|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 903502 | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| (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 0363 SS=E | Continued from page 7 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 | The Zone 8 patio lounge door has been adjusted to latch positively Maintenance staff will be educated on ensuring all doors latch positively moving forward Maintenance Director/Designee to perform an audit on doors latching positively weekly for 4 weeks and monthly for 2 months to ensure doors in the facility are latching properly. Results of audits will be forwarded to the QAPI Committee | Completion Date: 09/05/2025 Status: APPROVED Date: 08/13/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 0363 SS=E | Continued from page 8 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: Based on observation and interview, it was determined the facility failed to maintain the positive latching of corridor doors, affecting one of twelve smoke compartments within the component. Findings include: 1. Observation on July 28, 2025, at 12:30 PM, revealed the Zone 8 door to the Patio Lounge failed to positively latch within the door frame. Interview with the Director of Maintenance on July 28, 2025, at 12:30 PM, confirmed the corridor door failed to positively latch within the frame. | K 0363 | | |
| | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|--|--|--|---|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 0372 SS=E | 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 smoke barrier wall was repaired using an approved through penetration fire stop system. The facility will maintain the rating of the smoke barrier walls moving forward Maintenance Staff will be educated on ensuring penetrations are protected and maintaining the rating within smoke barrier walls Maintenance Director/ Designee to perform random quarterly audits for 1 year on smoke barrier walls. Results of audits will be forwarded to the QAPI Committee | Completion Date: 09/05/2025 Status: APPROVED Date: 08/15/2025 |
| | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 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 twelve smoke compartments within the component. Findings include: 1. Observation on July 28, 2025, at 12:10 PM, revealed an unprotected penetration of the Zone 11 smoke barrier wall, above the double doors, by the ADON/Medical Records Office, around blue and red wires. Interview with the Director of Maintenance on July 28, 2025, at 12:10 PM, confirmed the unprotected penetration of the smoke barrier wall. | K 0372 | | |
| K 0511 SS=E | | K 0511 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 | |
|---|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 903502 | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| (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 0511 SS=E | Continued from page 11 NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: | K 0511 | The electrical junction box cover plate was replaced above the suspended ceiling in Zone 8 Maintenance Staff will be educated on ensuring cover plates are in place for junction boxes moving forward Maintenance Director/Designee to perform an audit on junction box cover plates when work is completed above the ceiling to ensure the junction boxes have a cover plate in place. Results of audits will be forwarded to the QAPI Committee | Completion Date: 09/05/2025 Status: APPROVED Date: 08/15/2025 |
| | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 0511 SS=E | Continued from page 12 Based on observation and interview, it was determined the facility failed to maintain electrical hardware components, affecting one of twelve smoke compartments within the component. Findings include: 1. Observation on July 28, 2025, at 12:40 PM, revealed an electrical junction box lacking a cover plate, located above the Zone 8 suspended ceiling, by the smoke barrier doors by the Unit Scheduler's Office. Interview with the Director of Maintenance on July 28, 2025, at 12:40 PM, confirmed the exposed electrical wiring. | K 0511 | | |
| K 0920 SS=E | | K 0920 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|--|--|--|---|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 | | |
| STATE LICENSE NUMBER: 903502 | | | | |
| (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 0920 SS=E | Continued from page 13 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) assemblies 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 | The surge suppressor containing the toaster, coffee machine and microwave has been removed from the Medical Records Office Staff will be educated on the forbidden use of surge suppressors/mini appliances moving forward Maintenance Director/Designee to perform a quarterly random audit for 1 year to determine if surge protectors are in use within the facility. Results of audits will be forwarded to the QAPI Committee | Completion Date: 09/05/2025 Status: APPROVED Date: 08/15/2025 |
| | | | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 07/28/2025 |
|--|---|---|--|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER: LAURELDALE SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 903502 | STREET ADDRESS, CITY, STATE, ZIP CODE: 2125 ELIZABETH AVE LAURELDALE, PA 19605 |
|---|--|

| (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 0920 SS=E | <p>Continued from page 14</p> <p>Based on observation and interview, it was determined the facility failed to monitor the use of surge suppressors, affecting one of twelve smoke compartments within the component.</p> <p>Findings include:</p> <p>1. Observation on July 28, 2025, at 12:00 PM, revealed a surge suppressor supplying electrical power to a toaster, coffee machine and microwave, located within the Zone 11 Medical Records Room.</p> <p>Interview with the Director of Maintenance on July 28, 2025, at 12:00 PM, confirmed the high draw appliances were plugged into a surge suppressor.</p> | K 0920 | | |



Certified End Page

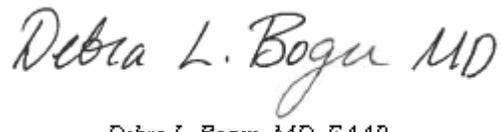
LAURELDALE SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 903502

SURVEY EXIT DATE: 07/28/2025

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, 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