



Certified End Page

SHERWOOD OAKS

STATE LICENSE NUMBER: 197002

SURVEY EXIT DATE: 03/11/2025

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: 395549	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/11/2025
NAME OF PROVIDER OR SUPPLIER: SHERWOOD OAKS STATE LICENSE NUMBER: 197002		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 NORMAN DRIVE CRANBERRY TOWNSHIP, PA 16066		
(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 #197002 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on March 11, 2025, it was determined that Sherwood Oaks 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 (222), fire resistive building, that is fully sprinklered.	K 0000		
K 0223 SS=D		K 0223		

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 0223 SS=D	Continued from page 1 NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:	K 0223	K 0223 Work order #192926 added to our computerized work order system to replace door closer for Medical Suite Entrance to one which complies with Life Safety Code 7.2.1.8.2. The device has been replaced and will be monitored every week for 4 weeks and reported in quarterly QAPI meeting.	Completion Date: 04/10/2025 Status: APPROVED Date: 03/24/2025

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K 0223 SS=D	Continued from page 2 Based on observation and interview, the facility failed to meet requirements for doors with self-closing devices on one of three building levels. Findings include: Observation on March 11, 2025, at 10:01 a.m., revealed the basement library door had a closure arm missing. Interview with the maintenance supervisor on March 11, 2025, at 10:01 a.m., confirmed the arm was missing from the door closure device.	K 0223		
K 0325 SS=B		K 0325		

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K 0325 SS=B	Continued from page 3 NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by:	K 0325	K 0325 Work order #192927 added to our computerized work order system to address and relocate any/all alcohol-based hand rubbing stations which may be located above any electrical devices throughout the Skilled Nursing Unit. All sanitizing stations have been relocated and will be monitored weekly for 4 weeks and reported at our quarterly QAPI meeting.	Completion Date: 04/10/2025 Status: APPROVED Date: 03/24/2025

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K 0325 SS=B	Continued from page 4 Based on observation and interview, the facility failed to meet alcohol-based hand rub dispenser requirements in one of over twenty resident rooms. Findings include: Observation on March 11, 2025, at 10:40 a.m., revealed resident room 440 had an alcohol-based hand rub dispenser mounted above an ignition source. Interview with the maintenance supervisor on March 11, 2025, at 10:40 a.m., confirmed the deficiency at the time of the survey.	K 0325		
K 0374 SS=D		K 0374		

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K 0374 SS=D	Continued from page 5 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 Work order # 192928 added to our computerized work order system to replace the astragals of smoke barrier doors between West and Lake halls on our Skilled Nursing Unit limiting the gap of the doors to 1/8 of an inch or less. The astragal have been replaced and will be monitored monthly for 4 months and reported at our quarterly QAPI meeting.	Completion Date: 04/10/2025 Status: APPROVED Date: 03/24/2025

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K 0374 SS=D	Continued from page 6 Based on observation and interview, the facility failed to meet smoke barrier requirements on one of three building levels. Findings include: Observation on March 11, 2025, between 11:00 a.m. and 11:24 a.m., revealed the following smoke barrier doors had large gaps that would allow air flow: A.(11:00 a.m.) Smoke barrier doors next to administration office; B.(11:24 a.m.) Smoke barrier doors next to room 430. Interview with the maintenance supervisor on March 11, 2025, at 11:24 a.m., confirmed the deficiency at the time of the survey.	K 0374		



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