STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395560	A. BLDG: __--_____ B. WING: _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022**

(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 17, 2024, at Masonic Village at Elizabethtown, 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

MASONIC VILLAGE AT ELIZABETHTOWN

STATE LICENSE NUMBER: 131502

SURVEY EXIT DATE: 12/17/2024

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

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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395560	A. BLDG: 01 B. WING:	12/17/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE** **ELIZABETHTOWN, PA 17022**

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K 0000	INITIAL COMMENT Facility ID #131502 Component 01 Washington/Roosevelt/Clinic/Ben Franklin/Lafayette Buildings Based on a Medicare/Medicaid Recertification Survey completed on December 17, 2024, it was determined that Masonic Village at Elizabethtown 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 four-story, Type II (222), fire resistive structure, with a basement, which is fully sprinklered.	K 0000		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022**

(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
K 0225 SS=D	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	1. The door to the 4th floor door to the Clinics and Clinic's 2nd floor was repaired on 12/18/2024 to ensure positive latching within the door frame. 2. Maintenance staff will be educated that stair tower doors will be maintained to ensure positive latching within the door frame. General education to staff to report doors not latching for appropriate work orders. 3. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building monthly to ensure that stair tower doors will positively latch within the door frame. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: 131502	ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022

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K 0225 SS=D	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain the rating of exit stairtower enclosures, affecting two of 43 smoke compartments within the component. Findings include: 1. Observation on December 16, 2024, at 12:31 PM, revealed the Roosevelt Building 4th floor door to the Clinics South Stairtower failed to positively latch within the door frame. Interview with the Assistant Director of Facilities and Grounds on December 16, 2024, at 12:31 PM, confirmed the compromised fire resistance rating of the stairtower. 2. Observation on December 17, 2024, at 11:30 AM, revealed the Clinics 2nd floor door to the West Stairtower failed to positively latch within the door frame.	K 0225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022**

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K 0225 SS=D	Continued from page 3 Interview with the Assistant Director of Facilities and Grounds on December 17, 2024, at 11:30 AM, confirmed the compromised fire resistance rating of the stairtower.	K 0225		
K 0345 SS=D		K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022**

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K 0345 SS=D	Continued from page 4 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	1. The smoke detectors were functionally inspected in the previous twelve months, in the following rooms on 07/03/2024 and placed in the Life Safety book: a) 2981; b) 2998; c) 3918; d) 4917; e) 4965; f) 4966; 2. Maintenance staff will be educated that smoke detectors will be functionally inspected every twelve months. 3. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building to ensure that smoke detectors are functionally inspected every twelve months as well as the Life Safety book is reviewed semi-annually. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0345 SS=D	Continued from page 5 Based on document review and interview, it was determined the facility failed to functionally test smoke detectors within the previous twelve months, affecting three of 43 smoke compartments within the component. Findings include: 1. Review of documentation on December 16, 2024, at 10:09 AM, revealed smoke detectors had not been functionally inspected within the previous twelve months, in the following rooms: a) 2981; b) 2998; c) 3918; d) 4917; e) 4965; f) 4966. Interview with the Assistant Director of Facilities and Grounds on December 16, 2024, at 10:09 AM, confirmed the smoke detectors had not been	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0345 SS=D	Continued from page 6 functionally tested within the previous twelve months.	K 0345		
K 0353 SS=D	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. The electrical cable zip-tied to the sprinkler piping within Clinic's 4th floor IT Mechanical Room was corrected on 12/19/2024. 2. Maintenance staff will be educated that the automatic sprinkler protection system will be free of extraneous weight. 3. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building monthly to ensure that the automatic sprinkler protection system will be free of extraneous weight. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0353 SS=D	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler protection system to be free from extraneous weight, affecting one of 43 smoke compartments within the component. Findings include: 1. Observation on December 17, 2024, at 10:47 AM, revealed an electrical cable zip-tied to sprinkler piping within the Clinics 4th floor IT Mechanical Room. Interview with the Assistant Director of Facilities and Grounds on December 17, 2024, at 10:47 AM, confirmed the electrical cable was supported by the automatic sprinkler protection system.	K 0353		
K 0355 SS=D		K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0355 SS=D	Continued from page 8 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	1. The Washington 3rd floor portable fire extinguisher, located next to the East Mini Care Base, obstructed by a wheelchair and a chair was corrected on 12/17/2024. 2. Staff will be educated in maintaining unobstructed portable fire extinguishers. 3. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building monthly to ensure that portable fire extinguishers are unobstructed. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/10/2025**

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K 0355 SS=D	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain unobstructed access to portable fire extinguishers, affecting one of 43 smoke compartments within the component. Findings include: 1. Observation on December 17, 2024, at 10:33 AM, revealed the Washington 3rd floor portable fire extinguisher, located next to the East Mini Care Base, was obstructed by a wheelchair and a chair. Interview with the Assistant Director of Facilities and Grounds on December 17, 2024, at 10:33 AM, confirmed the obstructed portable fire extinguisher.	K 0355		
K 0363 SS=D		K 0363		

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K 0363 SS=D	Continued from page 10 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	1. The Washington 3rd Supply Room door, next to Resident Room 3911, was corrected on 12/18/2024 to ensure that it positively latched within the door frame. 2. Maintenance staff will be educated that corridor doors protecting corridor openings in other than required enclosures of vertical openings, exits, hazardous areas will be maintained to ensure positive latching within the door frame. General staff education to initiate Work orders when doors are not latching appropriately. 3. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building monthly to ensure that corridor doors protecting corridor openings in other than required enclosures of vertical openings, exits, hazardous areas will be maintained to ensure positive latching within the door frame. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/10/2025**

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K 0363 SS=D	Continued from page 11 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 corridor doors to positively latch, affecting one of 43 smoke compartments within the component. Findings include: 1. Observation on December 17, 2024, at 9:49 AM, revealed the Washington 3rd floor Supply Room door, next to Resident Room 3911, failed to positively latch within the door frame. Interview with the Assistant Director of Facilities and Grounds on December 17, 2024, at 9:49 AM, confirmed the corridor door did not latch within the door frame.	K 0363		

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K 0374 SS=D	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. The Roosevelt 2nd floor smoke barrier door, by Resident Room 2648, obstructed from closing by a patient lift was corrected on 12/16/2024. 2. Staff will be educated in maintaining the unobstructed closing of smoke barrier doors. 3. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building monthly to ensure that smoke barrier doors are unobstructed. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/10/2025**

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K 0374 SS=D	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain the unobstructed closing of smoke barrier doors, affecting two of 43 smoke compartments within the component. Findings include: 1. Observation on December 16, 2024, at 1:30 PM, revealed the Roosevelt 2nd floor smoke barrier door, by Resident Room 2648, was obstructed from closing by a patient lift. Interview with the Assistant Director of Facilities and Grounds on December 16, 2024, at 1:30 PM, confirmed the obstructed smoke barrier door.	K 0374		
K 0511 SS=D		K 0511		

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MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022**

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K 0511 SS=D	Continued from page 14 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	1. The Roosevelt 3rd floor outlet, located within the corridor, between Resident Room 3801 and the Laundry, was replaced on 12/18/2024. 2. Maintenance staff will be educated in maintaining the physical integrity of electrical receptacles. Staff education will include initiating work orders when receptables are physically broken. 3. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building monthly to ensure the physical integrity of electrical receptacles. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395560	A. BLDG: __01_____ B. WING: _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022**

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K 0511 SS=D	Continued from page 15 Based on observation and interview, it was determined the facility failed to maintain the physical integrity of electrical receptacles, affecting one of 43 smoke compartments within the component. Findings include: 1. Observation on December 16, 2024, at 1:06 PM, revealed the Roosevelt 3rd floor electrical outlet, located within the corridor, between Resident Room 3801 and the Laundromat, was physically broken. Interview with the Assistant Director of Facilities and Grounds on December 16, 2024, at 1:06 PM, confirmed the compromised physical integrity of the electrical receptacle.	K 0511		
K 0541 SS=D		K 0541		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022**

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K 0541 SS=D	Continued from page 16 NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by:	K 0541	1. (Observation 1) -- The Roosevelt 4th floor Linen Chute door that failed to positively latch was corrected on 12/18/2024. (Observation 2) -- The Roosevelt 2nd floor Linen Chute door that failed to positively latch was corrected on 12/18/2024. 2. Maintenance staff will be educated in maintaining the fire resistance rating for Linen Chute doors. Staff has been educated to initiate a work order when a linen chute door is not latching appropriately. 3. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building monthly to ensure the fire resistance rating for Linen Chute doors. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/10/2025**

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: 131502	ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022

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K 0541 SS=D	Continued from page 17 Based on observation and interview, it was determined the facility failed to maintain Linen Chute enclosure doors to positively latch, affecting two of 43 smoke compartments within the component. Findings include: 1. Observation on December 16, 2024, at 12:34 PM, revealed the Roosevelt 4th floor Linen Chute door failed to positively latch within the frame. Interview with the Assistant Director of Facilities and Grounds on December 16, 2024, at 12:34 PM, confirmed the compromised fire resistance rating of the Linen Chute enclosure. 2. Observation on December 16, 2024, at 1:40 PM, revealed the Roosevelt 2nd floor Linen Chute door failed to positively latch within the frame. Interview with the Assistant Director of Facilities and Grounds on December 16, 2024, at 1:40 PM,	K 0541		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022**

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K 0541 SS=D	Continued from page 18 confirmed the compromised fire resistance rating of the Linen Chute enclosure.	K 0541		
K 0920 SS=D		K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: **131502**	**ONE MASONIC DRIVE** **ELIZABETHTOWN, PA 17022**

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K 0920 SS=D	Continued from page 19 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) assembles 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	1. (Observation 1) The surge suppressor supplying electrical power to two refrigerators and a coffee machine, within the Roosevelt 2nd floor West Conference Room, was corrected on 12/26/2024 Staff will be educated on not having high draw appliances plugged in to surge suppressors. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building monthly to ensure that high draw appliances are not plugged in to surge suppressors. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment. (Observation 2) The surge suppressor supplying power to another surge suppressor, at the Washington Care Base was corrected on 12/16/2024.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/10/2025**

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K 0920 SS=D	Continued from page 20	K 0920	Staff will be educated on not using a surge suppressor to supply electrical power to another surge suppressor. The Director of Security and/or Maintenance Assistant Director or designee will monitor the building monthly to ensure that a surge suppressor is not used to supply electrical power to another surge suppressors. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment. (Observation 3) The extension cord supplying electrical power to a surge suppressor, within the Clinic's 3rd floor office was corrected on 12/17/2024. Staff will be educated on not using extension cords to supply electrical power to a surge suppressor. The Director of Security and/or Maintenance Assistant Director or	

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K 0920 SS=D	Continued from page 21	K 0920	designee will monitor the building monthly to ensure that an extension cord is not used to supply electrical power to a surge suppressor. The results of the audit will be forwarded to the Quality Assurance Committee for review and comment.	

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K 0920 SS=D	Continued from page 22 Based on observation and interview, it was determined the facility failed to monitor the use of surge suppressors and extension cords, affecting three of 43 smoke compartments within the component. Findings include: 1. Observation on December 16, 2024, at 2:02 PM, revealed a surge suppressor supplying electrical power to two refrigerators and a coffee machine, within the Roosevelt 2nd floor West Conference Room. Interview with the Assistant Director of Facilities and Grounds on December 16, 2024, at 2:02 PM, confirmed the high draw appliances were plugged into a surge suppressor. 2. Observation on December 17, 2024, at 10:30 AM, revealed a surge suppressor supplying electrical power to another surge suppressor, at the	K 0920		

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K 0920 SS=D	Continued from page 23 Washington 3 Care Base. Interview with the Assistant Director of Facilities and Grounds on December 17, 2024, at 10:30 AM, confirmed the daisy-chained surge suppressors. 3. Observation on December 17, 2024, at 11:01 AM, revealed an extension cord supplying electrical power to a surge suppressor, within the Clinics 3rd floor LGH Providers Room. Interview with the Assistant Director of Facilities and Grounds on December 17, 2024, at 11:01 AM, confirmed the surge suppressor was plugged into an extension cord.	K 0920		

Certified End Page

MASONIC VILLAGE AT ELIZABETHTOWN

STATE LICENSE NUMBER: 131502

SURVEY EXIT DATE: 12/17/2024

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

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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0000	INITIAL COMMENT Facility ID #131502 Component 02 Assembly Building Based on a Medicare/Medicaid Recertification Survey completed on December 17, 2024, at Masonic Village at Elizabethtown, 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 483.90(a). This is a one-story, Type II (000), unprotected noncombustible structure, without a basement, which is fully sprinklered.	K 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

MASONIC VILLAGE AT ELIZABETHTOWN

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Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
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Secretary of Health

Pennsylvania
Department of Health

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