STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395567	A. BLDG: __--_____ B. WING: _____	12/23/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
DUNMORE HEALTH CARE CENTER STATE LICENSE NUMBER: **120902**	**1000 MILL STREET DUNMORE, PA 18512**

(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 23, 2024, at Dunmore Health Care 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

DUNMORE HEALTH CARE CENTER

STATE LICENSE NUMBER: 120902

SURVEY EXIT DATE: 12/23/2024

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# 120902 Component 02 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 23, 2024, it was determined that Dunmore Health Care 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 two story, Type II (111), protected, noncombustible building, that is fully sprinklered	K 0000		
K 0311 SS=E		K 0311		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

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K 0311 SS=E	Continued from page 1 NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by:	K 0311	Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. The plan of correction is prepared and executed as a means to continually improve quality of care and to comply with all applicable state and federal regulatory requirements. Door closer has been installed on the Private Dining Room door. Door closers throughout the facility have been audited and are working properly. NHA/Designee educated the Maintenance Director on NFPA 101 Hazardous Areas-Enclosures. Maintenance Director will randomly audit door closures 1x week for 4 weeks then monthly x2.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **01/02/2025**

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K 0311 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain one vertical opening, affecting one of two floors. Findings include: 1. Observation on December 23, 2024, at 10:33 a.m., revealed the self-closing devices had been removed from the Private Dining Room, double doors (note: the doors are part of a one-hour, two story, vertical opening). Exit interview with the Facility Administrator and the Facilities Manager on December 23, 2024, between 1:25 p.m., and 1:30 p.m., confirmed the vertical opening deficiency.	K 0311		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 3 NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 0321	The first floor Trash Room door was corrected and made smoke tight. Hazardous area doors were audited and are all smoke tight. NHA/Designee educated the Maintenance Director on NFPA 101 Hazardous Area-Enclosures. Maintenance Director will randomly audit Hazardous area doors 1x week for 4 weeks then monthly x2.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **01/02/2025**

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K 0321 SS=E	Continued from page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain one hazardous area enclosure, affecting one of two floors. Findings include: 1. Observation on December 23, 2024, at 10:53 a.m., revealed the first floor, Trash Room door was not smoke-tight. Exit interview with the Facility Administrator and the Facilities Manager on December 23, 2024, between 1:25 p.m., and 1:30 p.m., confirmed the hazardous area enclosure deficiency.	K 0321		
K 0363 SS=E		K 0363		

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K 0363 SS=E	Continued from page 5 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	Resident # 122 Room Door was corrected and made smoke tight. Corridor doors were audited and are all smoke tight. NHA/Designee educated the Maintenance Director on NFPA 101-Corridor Doors. Maintenance Director will randomly audit Corridor doors 1x week for 4 weeks then monthly x2.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **01/02/2025**

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K 0363 SS=E	Continued from page 6 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 one corridor opening, affecting one of two floors. Findings include: 1. Observation on December 23, 2024, at 11:23 a.m., revealed the first floor, resident Room 122, door was not smoke-tight. Exit interview with the Facility Administrator and the Facilities Manager on December 23, 2024, between 1:25 p.m., and 1:30 p.m., confirmed the corridor opening deficiency.	K 0363		
K 0374 SS=E		K 0374		

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K 0374 SS=E	Continued from page 7 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	First floor, smoke barrier separation doors, were adjusted and fully latch. Smoke barrier separation doors throughout the facility were audited and fully latch. NHA/Designee educated the Maintenance Director on NFPA 101 Subdivision of Building Spaces-Smoke Barrier. Maintenance Director will randomly audit Smoke barrier separation doors 1x week for 4 weeks then monthly x2.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **01/02/2025**

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K 0374 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain one set of smoke barrier separation doors, affecting one of two floors. Findings include: 1. Observation on December 23, 2024, at 10:50 a.m., revealed the first floor, smoke barrier separation doors, located closest to the Nurse's Station, required adjustment to fully latch. Exit interview with the Facility Administrator and the Facilities Manager on December 23, 2024, between 1:25 p.m., and 1:30 p.m., confirmed the smoke barrier separation door deficiency.	K 0374		

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