





# Certified End Page

**ST. BARNABAS NURSING HOME**

**STATE LICENSE NUMBER: 710302**

**SURVEY EXIT DATE: 01/23/2025**

**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**

Handwritten signature of Jeanne Parisi in black ink.

*Jeanne Parisi*  
Deputy Secretary for Quality Assurance

Handwritten signature of Debra L. Bogen MD in black ink.

*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:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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	<p>INITIAL COMMENT</p> <p>Facility ID# 710302 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on January 23, 2025, it was determined that St. Barnabas Nursing Home was not in compliance with the following requirements of the Life Safety Code for existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a three-story, Type II (222), fire resistive building, with a basement, that is fully sprinklered.</p>	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>  STATE LICENSE NUMBER: <b>710302</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>
--	--

(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 0311  SS=D		K 0311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>  STATE LICENSE NUMBER: <b>710302</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
(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 0311  SS=D	Continued from page 2  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	Assuming for the sake of this discussion, the validity of the deficiencies noted in the Department of Health's Statement of Deficiencies Report to St. Barnabas Nursing Home, Inc for the survey ending January 23, 2025, which St. Barnabas does not admit, we offer the following Plan of Correction. Nothing contained in the Plan of Correction shall/ should be deemed an admission either expressed or implied, on the part of St. Barnabas Nursing Home, Inc. as to the validity of the deficiencies noted in the report.  1. Facility maintenance will Purchase and install the proper electrical tray and fire blocking material around cables, data lines and electrical wires in U115 on or before March 14, 2025  2. Director of maintenance or designee will perform a one time audit of building ensuring all date, cable and electrical wires	Completion Date: <b>03/14/2025</b> Status: <b>APPROVED</b> Date: <b>02/10/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 0311  SS=D	Continued from page 3	K 0311	<p>passing through vertical openings are properly sealed.</p> <p>3.Results of audit will be reviewed in QA</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 0311  SS=D	Continued from page 4  Based on observation and interview, it was determined the facility failed to maintain the vertical opening enclosures in one instance, affecting one of 15 smoke compartments.  Findings include:  1. Observation on January 23, 2025, at 11:25 a.m., revealed multiple data, cable, and electrical wires passing through a large open hole in the back corner of Room U 115.  Interview with the Facility Administrator and Maintenance Director on January 23, 2025, at 1:30 p.m., confirmed the listed vertical opening enclosure deficiency.	K 0311		
K 0353  SS=E		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 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	A. 1. Facility maintenance will repair gaps in ceiling tile in HR copy room and dietary storage greater than 1/8" with , but not limited to tighter fitting ceiling tile and /or caulking. On or before March 14, 2025.  2. Director of maintenance or designee will Perform quarterly audits of facility To ensure no penetrations or gaps in ceiling 3. Results of audit will be reviewed in QA  B. 1. Facility maintenance will install escutcheon On chemical room sprinkler head and ensure all facility sprinkler heads have the proper escutcheon plates in place on or before March 14, 2025.	Completion Date: <b>03/14/2025</b> Status: <b>APPROVED</b> Date: <b>02/10/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 6	K 0353	<p>2. Director of maintenance or designee will Perform quarterly audits of facility to Ensure escutcheon plates are in place around sprinkler heads</p> <p>3. Results of audit will be reviewed in QA</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 7  Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in three instances, affecting three of 15 smoke compartments.  Findings include:  1. Observation on January 23, 2025, revealed the following automatic sprinkler system deficiencies:  a) 10:00 a.m., a ceiling tile in the HR Copy Room was missing a portion of the tile, larger than 1/8 inch; b) 10:20 a.m., a ceiling tile in Dietary Storage was broken and missing a corner piece; c) 10:55 a.m., a sprinkler head, in Chemical Storage room North stairwell, was missing an escutcheon plate.  Interview with the Facility Administrator and Maintenance Director on January 23, 2025, at 1:30 p.m., confirmed the automatic sprinkler system	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 8  deficiencies.	K 0353		
K 0374  SS=E	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. Facility maintenance contacted Vender that installed 1st floor south Fire doors, the Vender made repairs to doors on January 31st 2025, eliminating the excessive gap between meeting edges of the doors  2. Maintenance director or designee will Perform a onetime inspection of facility To ensure fire doors do not have Excessive gaps between meeting edges of the doors on or before March 14, 2025  3. Results of audit will be reviewed in QA	Completion Date: <b>03/14/2025</b> Status: <b>APPROVED</b> Date: <b>02/10/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 0374  SS=E	Continued from page 9  Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors in one instance, affecting two of 15 smoke compartments.  Findings include:  1. Observation on January 23, 2025, at 10:40 a.m., revealed the smoke barrier doors to the South Wing hallway had an excessive gap between the meeting edges of the doors, which would not resist the passage of smoke.  Interview with the Facility Administrator and Maintenance Director on January 23, 2025, at 1:30 p.m., confirmed the smoke barrier doors had an excessive gap that would not resist the passage of smoke.	K 0374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 0912  SS=D	<p>NFPA 101 Electrical Systems - Receptacles</p> <p>Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0912	<ol style="list-style-type: none"> <li>Facility maintenance will replace broken Electrical receptacle in hallway of HR On or before March 14, 2025</li> <li>Director of maintenance or designee will Perform a onetime inspection of Electrical receptacles throughout Facility to ensure all electrical receptacles are properly maintained.</li> <li>Results of audit will be reviewed in QA</li> </ol>	<p>Completion Date: <b>03/14/2025</b> Status: <b>APPROVED</b> Date: <b>02/10/2025</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 0912  SS=D	Continued from page 11  Based on observation and interview, it was determined the facility failed to maintain electrical receptacles in one instance, affecting one of 15 smoke compartments.  Findings include:  1. Observation on January 23, 2025, at 10:35 a.m., revealed there was a broken electrical receptacle in the HR Hallway, near the entrance doors.  Interview with the Facility Administrator and Maintenance Director, on January 23, 2025, at 1:30 p.m., confirmed the listed electrical receptacle deficiency.	K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 0919  SS=D	NFPA 101 Electrical Equipment - Other  Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)  This REQUIREMENT is not met as evidenced by:	K 0919	A. 1. Facility maintenance will ensure a Cover plate is installed on electrical junction box in the North stairwell by exit doors on or before March 14, 2025  2. Director of maintenance or designee Will perform a onetime inspection of Facility to ensure all electrical junction Boxes have the proper cover plate  3. Results of audit will be reviewed in QA	Completion Date: <b>03/14/2025</b> Status: <b>APPROVED</b> Date: <b>02/10/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395605</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/23/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. BARNABAS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>5827 MERIDIAN ROAD GIBSONIA, PA 15044</b>		
STATE LICENSE NUMBER: <b>710302</b>				
(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 0919  SS=D	Continued from page 13  Based on observation and interview, it was determined the facility failed to maintain electrical junction boxes to be covered, affecting one of 15 floors smoke compartments.  Findings include:  1. Observation on January 23, 2025, at 11:40 a.m., revealed an electrical junction box lacked a cover plate, next to the Exit doors in the North Stairwell.  Interview with the Facility Administrator and Maintenance Director on January 23, 2025, at 1:30 p.m., confirmed the missing electrical junction box cover.	K 0919		



# Certified End Page

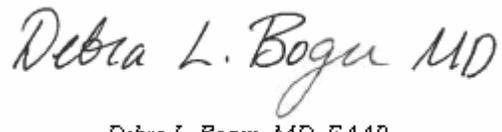
**ST. BARNABAS NURSING HOME**

**STATE LICENSE NUMBER: 710302**

**SURVEY EXIT DATE: 01/23/2025**

**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