| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395651 | A. BLDG: __--_____ B. WING: _____ | 04/21/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **BIRCHWOOD REHABILITATION & HEALTHCARE CENTER** STATE LICENSE NUMBER: **026402** | **395 EAST MIDDLE ROAD NANTICOKE, PA 18634** |

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|---|---|---|---|---|
| E 0000 | INITIAL COMMENT<br><br>Based on an Emergency Preparedness Survey completed on April 21, 2025, at Birchwood Rehabilitation and Healthcare 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

**BIRCHWOOD REHABILITATION & HEALTHCARE CENTER**

**STATE LICENSE NUMBER: 026402**

**SURVEY EXIT DATE: 04/21/2025**

**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
*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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| | 395651 | A. BLDG: 01<br>B. WING: | 04/21/2025 |

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| K 0000 | INITIAL COMMENT<br><br>Facility ID# 026402<br>Component 01<br>Building 01<br><br>Based on a Medicare/Medicaid Recertification Survey completed on April 21, 2025, it was determined that Birchwood Rehabilitation and Healthcare 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).<br><br>This is a two story, Type II (000), unprotected, noncombustible building, that is fully sprinklered. | K 0000 | | |
| K 0291<br><br>SS=E | | K 0291 | | |

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

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| K 0291<br><br>SS=E | Continued from page 1<br><br>NFPA 101 Emergency Lighting<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1<br><br>This REQUIREMENT is not met as evidenced by: | K 0291 | 1) Bulb was replaced and light works as designed.<br>2) To identify other areas of potential concern, NHA/ designee quality monitored emergency lights. No issues noted.<br>3) To prevent this from recurring, NHA/designee re-educated Maintenance on scheduled emergency lighting testing.<br>4) To monitor and maintain compliance, NHA/designee to quality monitor emergency lighting function 1x weekly x 4 weeks then 2x monthly x 1 month. Findings will be forwarded to QA Committee for review and recommendation. | Completion Date: **05/20/2025** Status: **APPROVED** Date: **04/25/2025** |

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| K 0291<br><br>SS=E | Continued from page 2<br><br>Based on observation and interview, the facility failed to maintain functional battery-powered emergency lighting in one location, on one of two floors.<br><br>Findings include:<br><br>1. Observation on April 21, 2025, at 11:15 am, 2nd floor, revealed emergency light #4 located outside the Administrators office, left bulb failed to light when tested.<br><br>Exit interview with the Facility Administrator and Maintenance Manager on April 21, 2025, at 12:30 pm, confirmed the bulb failed to illuminate. | K 0291 | | |
| K 0353<br><br>SS=E | | K 0353 | | |

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| K 0353<br><br>SS=E | Continued from page 3<br><br>NFPA 101 Sprinkler System - Maintenance and Testing<br><br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br><br>This REQUIREMENT is not met as evidenced by: | K 0353 | 1) Escutcheon in walk-in freezer was replaced.<br>2) To identify other areas for potential concern, Maintenance Director/ designee quality monitored sprinklers within facility for escutcheon plates. Negative findings addressed.<br>3) To prevent this from recurring, NHA/ designee re-educated Maintenance on sprinkler escutcheon plates.<br>4) To monitor and maintain compliance, Maintenance Director/ designee to quality monitor sprinkler escutcheon plates 1x weekly x 4 weeks then 2x monthly x 1 month. Findings will be forwarded to QA Committee for review and recommendation. | Completion Date: **05/20/2025**<br>Status: **APPROVED**<br>Date: **04/25/2025** |

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| K 0353<br><br>SS=E | Continued from page 4<br><br>Based on document review observations and interview, it was determined the facility failed to maintain the sprinkler system in one location, one on of two floors.<br><br>Findings include:<br><br>1. Observation on April 21, 2025, at 11:19 am, revealed the Dietary walk-in freezer was missing an escutcheon.<br><br>Exit interview with the Facility Administrator and Maintenance Manager on April 21, 2025, at 12:30 pm, confirmed the missing escutcheon. | K 0353 | | |
| K 0363<br><br>SS=E | | K 0363 | | |

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| K 0363<br><br>SS=E | Continued from page 5<br><br>NFPA 101 Corridor - Doors<br><br>Corridor - Doors<br>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.<br>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) 2nd floor Activities Door and Room 223 were fixed by Maintenance.<br>2) To identify other areas for potential concern, Maintenance Director/ designee quality monitored facility doors to ensure doors latched appropriately. Negative findings addressed.<br>3) To prevent this from recurring, NHA/designee re-educated Maintenance on corridor opening deficiencies.<br>4) To monitor and maintain compliance, Maintenance Director/ designee to quality monitor facility doors for opening deficiencies 1x weekly x 4 weeks then 2x monthly x 1 month. Findings will be forwarded to QA Committee for review and recommendation. | Completion Date: **05/20/2025** Status: **APPROVED** Date: **04/25/2025** |

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| K 0363<br><br>SS=E | Continued from page 6<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br><br>This REQUIREMENT is not met as evidenced by: | K 0363 | | |

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| K 0363<br><br>SS=E | Continued from page 7<br><br>Based on observation and interview, it was determined the facility failed to maintain corridor openings in two locations, affecting one of two floors.<br><br>Findings include:<br><br>1. Observation on April 21, 2025, between 11:33 am, and 11:53 am, revealed the following:<br><br>a. 11:33 am, 2nd floor, Activities room, first door failed to latch into frame when tested.<br>b. 10:47 am, 2nd floor, Resident room 223, door failed to latch into frame when tested.<br><br>Exit interview with the Facility Administrator and Maintenance Manager on April 21, 2025, at 12:30 pm, confirmed the corridor opening deficiencies. | K 0363 | | |

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