

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395661	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/30/2025
NAME OF PROVIDER OR SUPPLIER: CASSELMAN HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 HOSPITAL DRIVE MEYERSDALE, PA 15552		
STATE LICENSE NUMBER: 136802				
(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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on July 30, 2025, at Casselman Healthcare and Rehabilitation, 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.



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CASSELMAN HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 136802

SURVEY EXIT DATE: 07/30/2025

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

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID # 136802 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on July 30, 2025, it was determined that Casselman Healthcare and Rehabilitation was not in compliance with the following requirements of the Life Safety Code for an existing healthcare 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 two-story, Type II (000), unprotected, non-combustible building, with a basement, that is fully sprinklered.</p>	K 0000		

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K 0353 SS=E	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0353	<p>On July 30, 2025, the Maintenance Director repaired the excessive gap around the escutcheon.</p> <p>The Nursing Home Administrator re-educated the Maintenance Director and maintenance assistant to on the need to ensure no excessive gaps are present around the sprinkler heads.</p> <p>The Maintenance Director conducted a whole house audit to ensure no other sprinkler heads had an excessive gap.</p> <p>The Maintenance Director or designee will conduct a sprinkler head monthly audit. The audit findings will be submitted to the Safety Committee for review.</p>	<p>Completion Date: 08/21/2025</p> <p>Status: APPROVED</p> <p>Date: 08/12/2025</p>

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K 0353 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in one instance, affecting one of seven smoke compartments. Findings include: 1. Observation on July 30, 2025, at 11:00 a.m., revealed the sprinkler head near the dishwashing room on the third floor had an excessive gap around the escutcheon. Interview with the Facility Administrator and Maintenance Director on July 30, 2025, at 2:00 p.m., confirmed the automatic sprinkler system deficiency.	K 0353		
K 0363 SS=E		K 0363		

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K 0363 SS=E	Continued from page 3 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	On July 30, 2025, the Maintenance Director adjusted the Room 300 door and the Room 222 door and ensured the doors latched. The Nursing Home Administrator re-educated the Maintenance Director and maintenance assistant on the need to ensure all corridor doors latch properly. The maintenance staff will conduct a whole house audit to ensure all corridor doors in all smoke compartments latch properly. All corridor doors will be checked weekly during Interdisciplinary Team room rounds and work orders submitted for any doors not latching properly. Room rounds reports are reviewed during morning meeting and submitted to Safety Committee as appropriate for review.	Completion Date: 08/21/2025 Status: APPROVED Date: 08/12/2025

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K 0363 SS=E	Continued from page 4 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:	K 0363		

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K 0363 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain corridor doors in two instances, affecting two of seven smoke compartments. Findings include: 1. Observation on July 30, 2025, revealed the following: a) 9:45 a.m., the door to Room 300 on the third floor did not latch when tested; b) 10:00 a.m. the door to Room 222 on the second floor did not latch when tested. Interview with the Facility Administrator and Maintenance Director on July 30, 2025, at 2:00 p.m., confirmed the corridor door deficiencies	K 0363		

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K 0374 SS=E	<p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie</p> <p>Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0374	<p>On July 30, 2025 the Maintenance Director adjusted the smoke barrier doors near room 300 on the third floor to ensure the doors self-close and latch when tested.</p> <p>The Nursing Home Administrator re-educated the Maintenance Director and maintenance assistant on the need to ensure all smoke barrier doors self-close and latch when tested.</p> <p>The Maintenance Director re-tested all smoke barrier doors on all floors to ensure the smoke barrier doors self-close and latch when tested.</p> <p>The smoke barrier doors are already on a weekly testing schedule, but maintenance will increase frequency as needed during season weather changes that may increase/decrease swelling of doors. Results will be submitted to Safety Committee for review.</p>	<p>Completion Date: 08/21/2025</p> <p>Status: APPROVED</p> <p>Date: 08/12/2025</p>

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K 0374 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors in one instance, affecting two of seven smoke compartments. Findings include: 1. Observation on July 30, 2025, at 10:00 a.m., revealed the smoke barrier doors near Room 300 on the third floor failed to self-close and latch when tested. Interview with the Facility Administrator and Maintenance Director on July 30, 2025, at 2:00 p.m., confirmed the smoke barrier door deficiency.	K 0374		



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