| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395684 | A. BLDG: __--_____ B. WING: _____ | 07/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **CONCORDIA LUTHERAN HEALTH AND HUMAN CARE** STATE LICENSE NUMBER: **900202** | **134 MARWOOD ROAD CABOT, PA 16023** |

| (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<br><br>Based on an Emergency Preparedness Survey completed on July 30, 2025, at Concordia Lutheran Health and Human Care, 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

**CONCORDIA LUTHERAN HEALTH AND HUMAN CARE**

**STATE LICENSE NUMBER: 900202**

**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
*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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| | 395684 | A. BLDG: 06<br>B. WING: | 07/30/2025 |

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|---|---|---|---|---|
| K 0000 | INITIAL COMMENT<br><br>Facility ID #900202<br>Component 06<br>Main Building<br><br>Based on a Medicare/Medicaid Recertification Survey completed on July 30, 2025, it was determined that Concordia Lutheran Health and Human Care 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).<br><br>This is a three-story, Type II (111), protected, non-combustible building, that is fully sprinklered. | K 0000 | | |
| K 0311<br><br>SS=B | | K 0311 | | |

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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.

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| K 0311<br><br>SS=B | Continued from page 1<br><br>NFPA 101 Vertical Openings - Enclosure<br><br>Vertical Openings - Enclosure<br>2012 EXISTING<br>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.<br>19.3.1.1 through 19.3.1.6<br>If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.<br><br>This REQUIREMENT is not met as evidenced by: | K 0311 | Fusible link replaced immediately at time of survey. Weekly audits to ensure fusible link is installed will be completed by Maintenance or designee weekly for four weeks. After four weeks, audits will continue monthly. The results of these audits will be reviewed quarterly by the Quality Assurance and Quality Improvement committee for further analysis and recommendation. | Completion Date: **08/25/2025**<br>Status: **APPROVED**<br>Date: **08/08/2025** |

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| K 0311<br><br>SS=B | Continued from page 2<br><br>Based on observation and interview, the facility failed to maintain self-closing vertical opening doors for one of over five doors.<br><br>Findings include:<br><br>Observation on July 30, 2025, at 11:53 a.m., revealed the basement laundry chute door failed to have adequate fusible links applied to the hold-open springs, preventing the chute door from closing (only one of the two required fusible links was installed on one of the two springs). The missing link was corrected during the survey with the application of the second fusible link.<br><br>Interview with the administrator and maintenance supervisor on July 30, 2025, at 11:53 a.m., confirmed the chute door deficiency. | K 0311 | | |

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| K 0324<br><br>SS=C | NFPA 101 Cooking Facilities<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by: | K 0324 | Education will be provided to dietary employees for ansul system. Dietary manager or designee will audit knowledge of location and operation of ansul system weekly x 3 weeks then monthly until substantial compliance achieved. The results of these audits will be reviewed quarterly by the Quality Assurance and Quality Improvement committee for further analysis and recommendation. | Completion Date: **08/25/2025**<br>Status: **APPROVED**<br>Date: **08/08/2025** |

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| K 0324<br><br>SS=C | Continued from page 4<br><br>Based on document review and interview, the facility failed to maintain cooking equipment for one of one kitchen hood suppression system.<br><br>Findings include:<br><br>Document review on July 30, 2025, at 11:53 a.m., revealed the kitchen staff members interviewed were uncertain of the location and operation of the hood fire suppression system's manual activation.<br><br>Interview with the administrator on July 30, 2025, at 11:53 a.m., confirmed the kitchen suppression system deficiency. | K 0324 | | |
| K 0353<br><br>SS=E | | K 0353 | | |

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| K 0353<br><br>SS=E | Continued from page 5<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 | Education will be provided to maintenance staff for schedule of annual trip test and semi-annual supervisory switch inspection. Annual inspection will be completed 8/14/25 and full flow trip dry system will be completed 8/15/25. Maintenance director or designee will audit compliance with dry system annual trip test and semi annual supervisory switch inspection quarterly until substantial compliance is achieved. The results of these audits will be reviewed quarterly by the Quality Assurance and Quality Improvement committee for further analysis and recommendation. | Completion Date: **08/25/2025**<br>Status: **APPROVED**<br>Date: **08/13/2025** |

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| K 0353<br><br>SS=E | Continued from page 6<br><br>Based on document review and interview, the facility failed to maintain sprinkler system regulations for two of four systems.<br><br>Findings include:<br><br>Document review on July 30, 2025, at 9:57 a.m., revealed the following inspections were not completed at the time of the survey:<br><br>A. (9:57 a.m.) One of two semi-annual supervisory switch inspections;<br>B. (9:57 a.m.) Dry system, annual trip test.<br><br>Interview with the maintenance director on July 30, 2025, at 9:57 a.m., confirmed the inspections were not completed at the time of the survey. | K 0353 | | |
| K 0912<br><br>SS=B | | K 0912 | | |

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| K 0912<br><br>SS=B | Continued from page 7<br><br>NFPA 101 Electrical Systems - Receptacles<br><br>Electrical Systems - Receptacles<br>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.<br>If used in patient care room, ground-fault circuit interrupters (GFCI) are listed.<br>6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by: | K 0912 | Education will be provided to maintenance all outlets within 6 feet of water source are GFCI. Outlet by hand sink replaced to be GFCI on 7/30/25. Dietary manager or designee will audit outlet by hand sink is GFCI weekly x 4 weeks. The results of these audits will be reviewed quarterly by the Quality Assurance and Quality Improvement committee for further analysis and recommendation. | Completion Date: **08/25/2025**<br>Status: **APPROVED**<br>Date: **08/13/2025** |

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| K 0912<br><br>SS=B | Continued from page 8<br><br>Based on observation and interview, the facility failed to maintain electrical receptacles in one of over twenty rooms.<br><br>Findings include:<br><br>Observation on July 30, 2025, at 11:36 a.m., revealed the kitchen, near the hand sink, had a receptacle that failed to have ground fault circuit interrupter (GFCI) protection.<br><br>Interview with the administrator and maintenance supervisor on July 30, 2025, at 11:36 a.m., confirmed the electrical outlet deficiency. | K 0912 | | |
| K 0923<br><br>SS=F | | K 0923 | | |

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| K 0923<br><br>SS=F | Continued from page 9<br><br>NFPA 101 Gas Equipment - Cylinder and Container Storag<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders | K 0923 | Oxygen cylinders immediately placed into oxygen holders. Empty/used bottles moved to storage in used oxygen cylinder rack. Education will be provided to staff to not place used oxygen cylinders in full oxygen cylinder rack. NHA or designee will audit oxygen cylinders for appropriately placed into oxygen holders and only full oxygen cylinders placed into full oxygen cylinder rack weekly x 4 then monthly until substantial compliance achieved. The results of these audits will be reviewed quarterly by the Quality Assurance and Quality Improvement committee for further analysis and recommendation. | Completion Date: **08/25/2025**<br>Status: **APPROVED**<br>Date: **08/08/2025** |

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| K 0923<br><br>SS=F | Continued from page 10<br><br>are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by: | K 0923 | | |

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| K 0923<br><br>SS=F | Continued from page 11<br><br>Based on observation and interview, the facility failed to maintain gas equipment storage requirements in three of three storage areas.<br><br>Findings include:<br><br>Observation on July 30, 2025, between 9:16 a.m. and 10:47 a.m., revealed the following oxygen cylinder storage deficiencies:<br><br>A. (9:16 a.m.) Second floor RNAC office had four oxygen cylinders that were not properly stored. The cylinders were not in a rack or similar protected storage device to prevent the cylinders from being tipped over;<br>B. (9:51 a.m.) Second floor, Siegert hall O2 storage room had empty/used bottles stored in the full bottle rack;<br>C. (10:47 a.m.) First floor, Buchman Hall O2 storage room had empty/used bottles stored in the full bottle rack.<br><br>Interview with the administrator and maintenance | K 0923 | | |

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| K 0923<br><br>SS=F | Continued from page 12<br><br>supervisor on July 30, 2025, at 10:47 a.m., confirmed that the oxygen cylinder deficiencies at the time of the survey. | K 0923 | | |

# Certified End Page

**CONCORDIA LUTHERAN HEALTH AND HUMAN CARE**

**STATE LICENSE NUMBER: 900202**

**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
*Debra L. Bogen, MD, FAAP*
*Secretary of Health*

Pennsylvania
Department of Health

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