

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395767	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
NAME OF PROVIDER OR SUPPLIER: ROSE VIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1201 RURAL AVENUE WILLIAMSPORT, PA 17701		
STATE LICENSE NUMBER: 185502				
(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 December 30, 2024, at Rose View Nursing and Rehabilitation 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

ROSE VIEW NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 185502

SURVEY EXIT DATE: 12/30/2024

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, 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	INITIAL COMMENT Facility ID# 185502 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 30, 2024, 2023, it was determined that Rose View Nursing and Rehabilitation 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 483.90(a). This is a three story, Type II (111), protected, noncombustible building, with an unused attic space, that is fully sprinklered.	K 0000		
K 0161 SS=E		K 0161		

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TITLE:

(X6) DATE:

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K 0161 SS=E	Continued from page 1 NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small	K 0161	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. The plan of correction represents the facility's credible allegation of compliance. 1. Both ceiling tiles were replaced with a rated ceiling tile. 2. Other ceiling tiles will be checked to ensure they are in place. 3. Maintenance will be re-educated on ensuring that ceiling tiles are in place. 4. Maintenance Director/ designee will conduct random audits to verify that ceiling tiles are in place weekly for 4 weeks and then monthly for 2 months thereafter. Audit results will be presented at QAPI meeting for review and recommendations.	Completion Date: 02/05/2025 Status: APPROVED Date: 01/08/2025

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K 0161 SS=E	Continued from page 2 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain building construction requirements in one location, affecting one of nine smoke compartments. Findings include: 1. Observation on December 30, 2024, at 10:55 a.m., revealed the ceiling tiles lacking in two locations within the first floor, Maintenance Storage Room. Exit interview with the Facility Administrator on December 30, 2024, between 11:35 a.m., and 11:40 a.m., confirmed the building construction deficiency.	K 0161		
K 0225 SS=E		K 0225		

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K 0225 SS=E	Continued from page 3 NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	1. Missing end cap on the first floor west stair tower door was replaced. 2. Other stair tower door enclosures will be checked for missing end caps. 3. Maintenance will be re-educated on ensuring that door enclosures have end caps installed. 4. Maintenance Director/ designee will conduct random audits to verify that exit hardware end caps are in place weekly for 4 weeks and then monthly for 2 months thereafter. Audit results will be presented at QAPI meeting for review and recommendations.	Completion Date: 02/05/2025 Status: APPROVED Date: 01/08/2025

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K 0225 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain one exit stair tower enclosure, affecting three of three floors. Findings include: 1. Observation on December 30, 2024, at 10:40 a.m., revealed the first floor, west stair tower enclosure exit discharge door, fire exit hardware, was missing an end cap. Exit interview with the Facility Administrator on December 30, 2024, between 11:35 a.m., and 11:40 a.m., confirmed the stair tower enclosure deficiency.	K 0225		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 6 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 nine smoke compartments. Findings include: 1. Observation on December 30, 2024, at 10:12 a.m., revealed the second floor, Soiled Utility Room door was not smoke-tight. Exit interview with the Facility Administrator on December 30, 2024, between 11:35 a.m., and 11:40 a.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 7 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	<ol style="list-style-type: none"> 1. Door will be replaced so it will close and latch properly. 2. Other doors enclosures will be checked to verify closing and latching. 3. Maintenance will be re-educated on ensuring that all door enclosures are closing and latching. 4. Maintenance Director/ designee will conduct random audits to verify that door enclosures are closing and latching weekly for 4 weeks and then monthly for 2 months thereafter. Audits results will be presented at the QAPI meeting for review and recommendations. 	Completion Date: 02/05/2025 Status: APPROVED Date: 01/08/2025

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K 0363 SS=E	<p>Continued from page 8</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to maintain one corridor opening, affecting one of nine smoke compartments.</p> <p>Findings include:</p> <p>1. Observation on December 30, 2024, at 11:01 a.m., revealed the first floor, Dietary door failed to close and latch, due to door drag.</p> <p>Exit interview with the Facility Administrator on December 30, 2024, between 11:35 a.m., and 11:40 a.m., confirmed the corridor opening deficiency.</p>	K 0363		



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