STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395830	A. BLDG: __--_____ B. WING: _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MEADOW VIEW NURSING CENTER STATE LICENSE NUMBER: **191702**	**1404 HAY STREET BERLIN, PA 15530**

(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 Based on an Emergency Preparedness Survey completed on February 12, 2025, at Meadow View Nursing 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

MEADOW VIEW NURSING CENTER

STATE LICENSE NUMBER: 191702

SURVEY EXIT DATE: 02/12/2025

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

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K 0000	INITIAL COMMENT Facility ID # 191702 Component 01 Main Building Based on a Medicare/ Medicaid Recertification Survey completed on February 12, 2025, it was determined that Meadow View Nursing 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 non-combustible building, without a basement, that is fully sprinklered.	K 0000		

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

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K 0353 SS=E	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	Preparation and/or execution of this plan of correction does not constitute 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. A storage in the therapy room will be moved to a lower shelf to maintain the horizontal sprinkler plane. Therapy staff will be educated on the importance of following the 18-inch rule. Random audits will be completed monthly X3. Results will be reported at the monthly Quality Assurance and Improvement meeting Ceiling will be sealed with an approved sealant. random audits will be completed monthly X3 maintenance staff will be educated on the importance of maintaining a smoke / heat resistive ceiling Results will be reported at the monthly Quality Assurance and Improvement meeting	Completion Date: **03/07/2025** Status: **APPROVED** Date: **03/03/2025**

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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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 two instances, affecting two of sixteen smoke compartments. Findings include: 1. Observation on February 12, 2025, revealed the following automatic sprinkler system deficiencies: a) 11:04 a.m., the facility failed to maintain storage below the 18-inch horizontal sprinkler plane in the Therapy Storage room. b) 12:50 p.m., there was a gap in a ceiling tile greater than 1/8 inch, in the Nourishment Room on the third floor. Interview with the Facility Administrator and Maintenance Director on February 12, 2025, at 2:45 p.m., confirmed the listed automatic sprinkler system deficiencies.	K 0353		

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K 0353 SS=E	Continued from page 3	K 0353		
K 0363 SS=E	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	K 0363	Adjustments and repairs will be made to the following doors 127 and level 2 staff lounge. Random audits will be completed monthly X3 maintenance staff will be educated on the importance of the latching of the doors. Results will be reported at the monthly Quality Assurance and Performance Improvement meeting.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **03/03/2025**

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K 0363 SS=E	Continued from page 4 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. 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 sixteen smoke compartments. Findings include: 1. Observation on February 12, 2025, revealed the following corridor doors would not latch in their frame when tested: a) 12:45 p.m., the door to resident room 127 would not close and latch in its frame; b) 1:35 p.m., the door to the Staff Lounge on Level 2 would not close and latch in its frame. Interview with the Facility Administrator and Maintenance Director on February 12, 2025, at 2:45 p.m., confirmed the listed corridor door deficiencies.	K 0363		

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K 0363 SS=E	Continued from page 6	K 0363		

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