

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/24/2025
NAME OF PROVIDER OR SUPPLIER: SCHUYLKILL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 SCHUYLKILL MANOR ROAD POTTSVILLE, PA 17901		
STATE LICENSE NUMBER: 453002				
(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	E 0000		
E 0006 SS=F	Based on an Emergency Preparedness Survey completed on June 24, 2025, it was determined that Schuylkill Center was not in compliance with the requirements of 42 CFR 483.73.	E 0006		

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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E 0006 SS=F	Continued from page 1 483.73(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events	E 0006	The facility will continue to provide an updated all hazards risk assessment for the facility. 1. The facility utilizes the Kaiser Permanente Hazard Vulnerability Assessment Tool, which was last updated at time of annual manual approvals on 1/17/2025. This tool will be updated at least quarterly, or as needed, and used to identify and update the facility's Emergency Preparedness plan. The Hazards Risk Assessment will be filed in all copies of the Emergency Preparedness plan. 2. The Maintenance Director or designee will audit the Hazard Vulnerability Assessment tool at least semi-annually to confirm that updates are filed in all copies of the Emergency Preparedness plan. Results of the audits will be reviewed at least semi-annually with the QAPI Committee, including any revisions required to the Facility Emergency Preparedness plan as a result of the assessment. Date of Correction is 7/30/2025.	Completion Date: 07/30/2025 Status: APPROVED Date: 07/11/2025

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E 0006 SS=F	Continued from page 2 identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by:	E 0006		

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E 0006 SS=F	Continued from page 3 Based on document review and interview, it was determined the facility failed to provide an updated all hazards risk assessment for the facility, affecting the entire component. Findings include: 1. Review of documentation on June 24, 2025, at 1:30 PM, revealed the facility failed to provide an updated all hazards risk assessment for the facility. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the facility could not provide an updated all hazards risk assessment for the facility.	E 0006		



Certified End Page

SCHUYLKILL CENTER

STATE LICENSE NUMBER: 453002

SURVEY EXIT DATE: 06/24/2025

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	INITIAL COMMENT Facility ID #453002 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on June 24, 2025, it was determined that Schuylkill 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 two-story, Type II (222), fire resistive structure, without a basement, which is fully sprinklered.	K 0000		
K 0100 SS=C		K 0100		

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K 0100 SS=C	Continued from page 1 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	1. The facility Life Safety drawings will be revised to include the items noted lacking in the survey process. Documentation of annual testing and inspection of installed Carbon Monoxide alarms, per manufacturer's instructions, will also be maintained. The Carbon Monoxide alarms will be modified to insure they can be heard by on-duty staff as required. Evacuation and alarm protocols will be updated and reviewed at least annually, with annual in-service education for facility staff. 2. The Life safety drawings will be reviewed for compliance with the required components by the Maintenance Director and NHA. The documentation of annual testing and inspection of Carbon Monoxide alarms will also be reviewed monthly by the Maintenance Director, and documentation of the the carbon monoxide alarms being able to be heard by on duty staff will occur monthly. Evacuation and alarm protocols will be reviewed and updated as required, and staff	Completion Date: 07/30/2025 Status: APPROVED Date: 07/10/2025

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K 0100 SS=C	Continued from page 2	K 0100	in-services will be held with facility staff to educate on same. Each of these items will be reported monthly to the QAPI Committee for three months, and at least quarterly thereafter until compliance is achieved. Date of correction is 7/30/2025.	

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K 0100 SS=C	Continued from page 3 28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met. 35 P.S. § 448.808. Issuance of license. (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met: (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered. Based on document review, observation and	K 0100		

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K 0100 SS=C	Continued from page 4 interview, it was determined the following items did not meet the minimum standards for the operation of a facility, as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents within the component. Findings include: 1. Review of documentation and interview on June 24, 2025, between 9:30 AM and 11:30 AM, revealed the facility life safety drawings lacked resident room capacities, door swings, fire wall boundaries, smoke wall boundaries, hazardous areas and compartment designation. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the life safety drawings of the facility lacked required information. 2. Review of documentation and interview, on June	K 0100		

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K 0100 SS=C	Continued from page 5 24, 2025, between 9:30 AM and 11:30 AM, revealed the facility lacked documentation of annual testing and inspection of installed Carbon Monoxide Alarms, per manufacturer's instructions, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the lack of documentation confirming annual inspections were not done, per manufacturer's instructions. 3. Review of documentation and interview, on June 24, 2025, between 9:30 AM and 11:30 AM, revealed the facility lacked documentation confirming installed carbon monoxide alarms could be heard by on duty staff, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview at the time of the exit conference with the	K 0100		

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K 0100 SS=C	Continued from page 6 Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the lack of documentation, verifying the carbon monoxide detectors could be heard by on duty staff. 4. Review of documentation on June 24, 2025, between 9:30 AM and 11:30 AM, revealed the facility lacked documentation verifying evacuation and alarm protocols, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the lack of documentation of evacuation and alarm protocols.	K 0100		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the smoke resistance of hazardous area enclosure, affecting one of seven smoke compartments within the component. Findings include: 1. Observation on June 24, 2025, at 11:35 AM, revealed the door to the Service Hall Food Storage Room door failed to self-close and latch within the door frame. Door was dragging on the floor. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the door failed to self-close and positively latch.	K 0321		

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K 0324 SS=C	<p>NFPA 101 Cooking Facilities</p> <p>Cooking Facilities</p> <p>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> * 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 * 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 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. <p>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.</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0324	<ol style="list-style-type: none"> 1. Kitchen suppression system inspections and hood cleaning certificates will be placed in the facility's life safety book. The owner's quick checks of the fixed chemical fire suppression system will continue to be displayed in the kitchen. The semi-annual hood cleaning has been scheduled for July, 2025, and documentation will be maintained when completed. 2. The Maintenance Director will audit, at least semi-annually, the facility's life safety book to verify existence of the required kitchen suppression inspections and hood cleaning certificates, and report to the QAPI Committee with results of these audits. Date of correction is 7/30/2025. 	<p>Completion Date: 07/30/2025</p> <p>Status: APPROVED</p> <p>Date: 07/11/2025</p>

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K 0324 SS=C	Continued from page 10 Based on document review and interview, it was determined the facility failed to provide owner's quick checks of the fixed chemical fire suppression system, and semi-annual hood cleaning documentation, in one of seven smoke compartments within the component. Findings include: 1. Review of documentation on June 24, 2025, between 9:30 AM and 11:30 AM, revealed the facility failed to provide documentation of owner's quick check for the fixed chemical fire suppression system, installed in the Kitchen. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the lack of documentation of quick checks on the Kitchen's fixed chemical fire suppression system. 2. Review of documentation on June 24, 2025,	K 0324		

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K 0324 SS=C	Continued from page 11 between 9:30 AM and 11:30 AM, revealed the facility could not provide documentation verifying the Kitchen exhaust ductwork had been cleaned on a semi-annual basis. Documentation verified last cycle was completed on 9/11/2023. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the facility could not provide Kitchen ductwork had been cleaned semi-annually.	K 0324		
K 0345 SS=F		K 0345		

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K 0345 SS=F	Continued from page 12 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	1. The facility will provide testing and maintenance to the fire alarm system on a semi-annual basis as required. A copy of the January 2025 inspection report was acquired and placed in the facility life safety book. Documentation of repairs will also be placed in the life safety book. 2. At least semi-annually, the Maintenance Director or NHA will audit the life safety book to confirm that all reports have been filed in the book. Results of the audits will be reported to the QAPI Committee. Date of correction is 7/30/2025.	Completion Date: 07/30/2025 Status: APPROVED Date: 07/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/24/2025	
NAME OF PROVIDER OR SUPPLIER: SCHUYLKILL CENTER STATE LICENSE NUMBER: 453002		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 SCHUYLKILL MANOR ROAD POTTSVILLE, PA 17901		
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K 0345 SS=F	Continued from page 13 Based on observation and interview, it was determined the facility failed to provide testing and maintenance to their fire alarm system on a semi-annual basis, which serves the entire component. Findings include: 1. Review of documentation on June 24, 2025, between 9:30 AM and 11:30 AM, revealed the facility failed to provide documentation verifying semi-annual visual inspections/testing of the fire alarm system had occurred within the previous twelve months. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the facility lacked one full year of documentation for fire alarm system. 2. Review of documentation on June 24, 2025, between 10:00 AM and 10:03 AM, revealed the	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/24/2025	
NAME OF PROVIDER OR SUPPLIER: SCHUYLKILL CENTER STATE LICENSE NUMBER: 453002		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 SCHUYLKILL MANOR ROAD POTTSVILLE, PA 17901		
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K 0345 SS=F	Continued from page 14 facility lacked documentation, for the following: a. 10:00 AM, wet system, semi-annual, Valve Supervisory Switches and Pressure Switch Waterflow Alarm; b. 10:03 AM, dry system, semi-annual, Valve Supervisory Switches and Pressure Switch Waterflow Alarm. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the facility lacked documentation the wet/dry sprinkler systems Supervisory/Pressure Switches, which are performed during fire alarm inspections. 3. Review of documentation on June 24, 2025, at 10:05 AM, revealed the 3/20/2025 service call report indicated the 1 and 2 wet system Supervisory Flow Switches and Tamper Flow Switches failed to register as a priority fire alarm, but no documentation was provided to indicate the issue	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/24/2025
NAME OF PROVIDER OR SUPPLIER: SCHUYLKILL CENTER STATE LICENSE NUMBER: 453002		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 SCHUYLKILL MANOR ROAD POTTSVILLE, PA 17901		
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K 0345 SS=F	Continued from page 15 was resolved. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the facility lacked documentation, verifying the wet sprinkler systems Supervisory Switches and Tamper Switches alarm deficiency was resolved.	K 0345		
K 0353 SS=F		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/24/2025
NAME OF PROVIDER OR SUPPLIER: SCHUYLKILL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 SCHUYLKILL MANOR ROAD POTTSVILLE, PA 17901		
STATE LICENSE NUMBER: 453002				
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K 0353 SS=F	Continued from page 16 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	1. The facility will insure the wet/dry sprinkler systems are subject to inspection and/or testing at least quarterly. The two sprinkler heads noted during the survey behind the dryers in Laundry will be modified for correct orientation. The 1 and 2 Wet System Supervisory Flow Switches will be repaired to resolve the issue. The sprinkler head identified as covered with debris will be cleaned. The sprinkler inspection reports will be maintained in the facility Life Safety book, including repair reports. 2. The Maintenance Director of designee will perform at least quarterly audits of the facility Life Safety book to confirm that the sprinkler system has been inspected and tested, and that deficiencies have been repaired. Audit results will be reported to the QAPI Committee. Date of compliance is 7/30/2025.	Completion Date: 07/30/2025 Status: APPROVED Date: 07/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/24/2025
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K 0353 SS=F	Continued from page 17 Based on document review, observation and interview, it was determined the facility failed to provide documentation verifying quarterly inspections of the automatic sprinkler protection system, maintain the system in a continuously reliable operating condition, and failed maintain the automatic sprinkler system to be free of obstructions, affecting the entire component. Findings include: 1. Review of documentation on June 24, 2025, between 10:15 AM and 10:20 AM, revealed the facility lacked documentation confirming the wet/dry sprinkler systems were subject to inspection and/or testing, for the following: a. 10:15 AM, wet system, quarterly inspections 2nd and 3rd of 2024; b. 10:20 AM, dry system, quarterly inspections 2nd and 3rd of 2024. Interview at the time of the exit conference with the	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/24/2025	
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K 0353 SS=F	Continued from page 18 Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the lack of documentation for quarterly inspection and testing of sprinkler systems. 2. Review of documentation and observation on June 24, 2025, between 9:30 AM and 11:30 AM, revealed two sprinkler heads, protecting the area behind the dryers, within the Laundry, were incorrectly oriented above the ceiling tile. This was listed on the June 21, 2024, quarterly report by Commonwealth Fire Protection, and verified visually that it was not performed. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the sprinkler heads were incorrectly oriented and repairs were not performed. 3. Review of documentation on June 24, 2025, at	K 0353		

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K 0353 SS=F	Continued from page 19 10:25 AM, revealed the quarterly inspection on 3/20/2025, the deficiency report indicated the 1 and 2 Wet System Supervisory Flow Switches and Tamper Flow Switches failed to register as a priority on the fire alarm panel, and no documentation was provided to indicate the issue was resolved. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed the facility lacked documentation the wet sprinkler systems Supervisory Switches and Tamper Switches alarm deficiency was resolved. 4. Observation on June 24, 2025, between 11:45 AM and 11:50 AM, revealed sprinkler heads covered with debris, at the following locations: a. 11:45 AM, Laundry Room, Clean Area, 4 heads; b. 11:47 AM, Laundry Room, Soiled Area, 2 heads;	K 0353		

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K 0353 SS=F	Continued from page 20 c. 11:50 AM, Laundry Room, Personal, 2 heads. Interview at the time of the exit conference with the Administrator and Maintenance Director on June 24, 2025, at 1:30 PM, confirmed debris on sprinkler heads.	K 0353		



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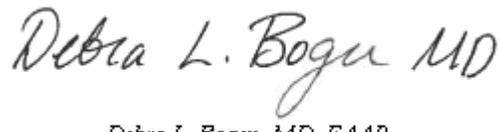
SCHUYLKILL CENTER

STATE LICENSE NUMBER: 453002

SURVEY EXIT DATE: 06/24/2025

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**

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