STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395840	A. BLDG: __--_____ B. WING: _____	01/07/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PATRIOT VILLAGE STATE LICENSE NUMBER: **167902**	**495 WEST PATRIOT STREET SOMERSET, PA 15501**

(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 January 7, 2025, at Patriot Village, 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

PATRIOT VILLAGE

STATE LICENSE NUMBER: 167902

SURVEY EXIT DATE: 01/07/2025

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# 167902 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on January 7, 2025, it was determined that Patriot Village 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		
K 0293 SS=F		K 0293		

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

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K 0293 SS=F	Continued from page 1 NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Patriot Village OPCO LLC agrees with the allegations and citations listed on the statement of deficiencies. Patriot Village OPCO LLC maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Patriot Village OPCO LLC's written credible allegation of compliance. By submitting this plan of correction, Patriot Village OPCO LLC does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Patriot Village OPCO LLC all rights to raise all possible contentions and defenses in any civil or criminal	Completion Date: **02/14/2025** Status: **APPROVED** Date: **01/22/2025**

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K 0293 SS=F	Continued from page 2	K 0293	claim, action or proceeding. The exit sign inspections were completed, but not documented appropriately. A new exit sign inspection form was developed and includes all exit signs throughout the facility. The Maintenance Director was educated on K 0293 and how it applies to Patriot Village. The Executive Director will review the exit sign inspections monthly for two months to ensure compliance. Results will be reviewed at the Quality Assurance Performance Improvement meeting.	

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K 0293 SS=F	Continued from page 3 Based on document review and interview, it was determined the facility failed to perform monthly exit sign inspections for the last 12 months, affecting the entire facility. Findings Include: 1. Document review on January 7, 2025, at 8:35 a.m., revealed the facility lacked documentation for the monthly exit sign inspections for the year of 2024. Interview with the Facility Administrator, Maintenance Director, and Staff on Janaury 7, 2025, at 8:35 a.m., confirmed the facility lacked documentation for exit sign inspections for the last twelve months.	K 0293		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 4 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	The five-year internal pipe inspection, gauge replacement, and sprinkler inspection are scheduled to be completed on 01/24/2025. The Maintenance Director was educated on K 0353 and how it applies to Patriot Village. The schedule maintenance items were added to the annual calendar. Any issues that arise from the inspection will be corrected. Results will be reviewed at the Quality Assurance Performance Improvement meeting.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **01/22/2025**

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K 0353 SS=F	Continued from page 5 Based on document review, observation, and interview, it was determined the facility failed to maintain the automatic sprinkler system in three instances, affecting the entire facility. Findings include: 1. Documentation review on January 7, 2025, revealed the following deficiencies: a) 9:00 a.m., the facility was not able to provide documentation for automatic sprinkler system inspections performed after 2-7-24; b) 9:10 a.m., the facility failed to change or recalibrate the sprinkler system gages which expired in 2024; c) 9:20 a.m., the facility failed to perform a five-year internal pipe inspection, within the last 5 years. Interview with the Facility Administrator and the Maintenance Director on January 7, 2025, at 9:20 a.m., confirmed the automatic sprinkler system deficiencies.	K 0353		

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K 0353 SS=F	Continued from page 6	K 0353		
K 0363 SS=D	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	The door on room 347 was adjusted and now latches properly. Other doors in the facility were inspected and all have been verified to latch correctly. Maintenance staff are aware of K 0363 and how it is applicable to Patriot Village. Maintenance staff will conduct an audit of 15 doors monthly for two months. Results will be reviewed at the Quality Assurance Performance Improvement meeting.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **01/22/2025**

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K 0363 SS=D	Continued from page 7 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: Based on observation and interview, it was determined the facility failed to maintain corridor doors in one instance, affecting one of fifteen smoke compartments. Findings include: 1. Observation on January 7, 2025, at 10:30 a.m., revealed the door to room 347 on the third floor failed to latch when tested. Interview with the Facility Administrator and Maintenance Director on January 7, 2025, at 1:00 p.m., confirmed the corridor door deficiency.	K 0363		

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K 0712 SS=C	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	The facility is unable to make up the missed drill. No other discrepancies was noted for other drills conducted during 2024. A schedule for 2025 fire drills was developed and meets the requirements of K 0761. Maintenance staff were educated on K 0761. The Executive Director will audit fire drills monthly for one quarter. Results will be reviewed at the Quality Assurance Performance Improvement meeting.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **01/22/2025**

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K 0712 SS=C	Continued from page 9 Based on documentation review and interview, it was determined the facility failed to perform 1 of 12 required fire drills, affecting the entire facility. Findings include: 1. Review of documentation on January 7, 2025, at 8:30 a.m., revealed the facility lacked documentation for a third shift fire drill in the first quarter. Interview with the Facility Administrator and Maintenance Director on January 7, 2025, at 8:30 a.m., confirmed the facility lacked documentation for a drill between January and March in 2024.	K 0712		
K 0761 SS=F		K 0761		

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K 0761 SS=F	Continued from page 10 NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 0761	The facility is unable to determine what happened to the door rating on the third floor soiled utility room door. Other doors were inspected and documented on the newly created fire door inspection sheet. No discrepancies were noted. The door will be inspected and appropriately rated or replaced with an approved door. Maintenance staff were re-educated on K 0761. The Executive Director will audit fire door assembly inspections monthly for two months. Results will be reviewed at the Quality Assurance Performance Improvement meeting.	Completion Date: 02/14/2025 Status: APPROVED Date: 01/22/2025

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K 0761 SS=F	Continued from page 11 Based on documentation review and interview, it was determined the facility failed to perform the required annual fire door assembly inspection, affecting the entire facility. Findings include: 1. Review of documentation on January 7, 2025, at 9:30 a.m., revealed the facility lacked documentation for an annual fire door assembly inspection. Interview with the Facility Administrator and Director of Maintenance on January 7, 2025, at 9:30 a.m., confirmed the facility lacked documentation, at the time of the survey, showing that an annual fire door assembly inspection had been completed.	K 0761		

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