STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396048	A. BLDG: __--_____ B. WING: _____	03/17/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HARMAR VILLAGE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **077802**	**715 FREEPORT ROAD CHESWICK, PA 15024**

(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 March 17, 2025, it was determined that Harmar Village Health and Rehab Center had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0039 SS=C	483.73(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 0039	The Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0039 Testing Requirements. The facility had previously conducted a community based full scale exercise on March 11, 2025. The facility completed a tabletop exercise on March 25, 2025. The NHA/Designee will ensure the facility completes a community based full scale exercise and tabletop exercise per the regulation.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

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

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E 0039 SS=C	Continued from page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the	E 0039		

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E 0039 SS=C	Continued from page 2 following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 0039		

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E 0039 SS=C	Continued from page 3 (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is	E 0039		

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E 0039 SS=C	Continued from page 4 community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is	E 0039		

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E 0039 SS=C	Continued from page 5 community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including	E 0039		

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E 0039 SS=C	Continued from page 6 unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the	E 0039		

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E 0039 SS=C	Continued from page 7 emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the	E 0039		

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E 0039 SS=C	Continued from page 8 emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 0039		

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E 0039 SS=C	Continued from page 9 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency	E 0039		

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E 0039 SS=C	Continued from page 10 events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined the facility failed to meet emergency preparation testing requirements in the emergency preparedness plan. Findings include: 1. Documentation review on March 17, 2025, at 8:40 a.m., revealed the facility failed to meet the annual requirements for a community-based, full-scale exercise. Interview with the Facility Administrator and Maintenance Director on March 17, 2025, at 1:30 p.m., confirmed the above deficiency.	E 0039		

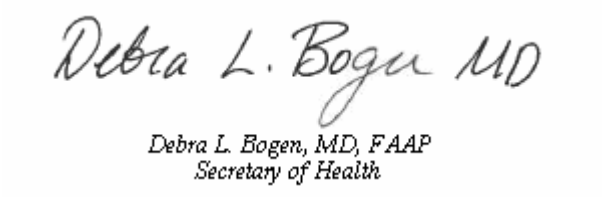
Certified End Page

HARMAR VILLAGE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 077802

SURVEY EXIT DATE: 03/17/2025

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



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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K 0000	INITIAL COMMENT Facility ID#077802 Component 01 Main building Based on a Medicare/Medicaid Recertification Survey completed on March 17, 2025, it was determined that Harmar Village Health and Rehab 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 (222), fire resistive building, with a basement, that is fully sprinklered.	K 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.

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K 0291 SS=C	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	The Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0291 Emergency Lightening. The facility is unable to correct the lack of previous month's documentation. The facility's emergency lighting, is a hard wired system. The Maintenance Director is currently performing monthly emergency lighting inspections per regulation. The NHA/designee will randomly audit the Maintenance Director emergency lighting inspection log monthly.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

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K 0291 SS=C	Continued from page 2 Based on document review and interview, it was determined the facility failed to perform the monthly test of the emergency lighting for three of twelve months, affecting the entire facility. Findings include: 1. Documentation review on March 17, 2025, at 9:10 a.m., revealed the facility lacked documentation for the monthly test of battery back-up emergency lighting, for three of the last twelve months (October, November, December 2024). Interview with the Facility Administrator and Maintenance Director on March 17, 2025, at 1:30 p.m. confirmed the facility lacked documentation for the three monthly tests of the emergency lights at the time of survey.	K 0291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396048	A. BLDG: __01_____ B. WING: _____	03/17/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0291 SS=C	Continued from page 3	K 0291		
K 0293 SS=C	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	The Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0293 Exit Signage. The facility is unable to correct the lack of previous month's documentation. The maintenance Director is currently performing monthly exit sign inspections per regulation. The NHA/designee will randomly audit the Maintenance Director exit signage inspection log monthly.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

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K 0293 SS=C	Continued from page 4	K 0293		

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K 0293 SS=C	Continued from page 5 Based on document review and interview, it was determined the facility failed to perform monthly exit sign inspections for three of 12 months, affecting the entire facility. Findings Include: 1. Document review on March 17, 2025, at 8:50 a.m., revealed the facility lacked documentation for the monthly exit sign inspections for three of the last 12 months (October, November, December 2024). Interview with the Facility Administrator and Maintenance Director on March 17, 2025, at 1:30 p.m., confirmed the lack of documentation at the time of the survey.	K 0293		

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 0293 SS=C	Continued from page 6	K 0293		
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 0321	The Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0321 Hazardous Area Enclosures. The door to the transfer switch room was repaired and now latches as appropriate. The Maintenance Director completed an audit of hazardous area enclosures and no other noncompliant areas were identified. The Maintenance Director will complete a random audit of hazardous area enclosures weekly times two weeks then monthly times 2 months.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

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K 0321 SS=E	Continued from page 7 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in one instance, affecting one of eight smoke compartments. Findings include: 1. Observation on March 17, 2025, at 10:50 a.m., revealed the door to the transfer switch room, across from the boiler room, failed to latch when tested. Interview with the Facility Administrator and Maintenance Director on March 17, 2025 at 1:30 p.m., confirmed the listed hazardous area enclosure deficiency.	K 0321		
K 0324 SS=E		K 0324		

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K 0324 SS=E	Continued from page 9 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * 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. 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. 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 This REQUIREMENT is not met as evidenced by:	K 0324	The Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0324 Cooking Facilities. Observation #1 – wheeled gas-fired deep fryer was appropriately secured to ensure that the appliance is returned to the designated location after any maintenance or cleaning. Observation #2 is unable to be corrected. The Kitchen Fire Suppression Testing/Maintenance has been completed and is current. The Maintenance Director will continue to ensure that Kitchen Fire Suppression system is tested and maintenance completed per regulation. The Maintenance Director/designee will perform random audits of the securement of the deep fryer weekly x 2 weeks then monthly x 2 months.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

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K 0324 SS=E	Continued from page 10 Based on document review, observation, and interview, it was determined the facility failed to properly install and maintain equipment protected by the kitchen hood fire suppression system in two instances, affecting one of eight smoke compartments. The findings include: 1. Observation on March 17, 2025, at 11:00 a.m., revealed the wheeled gas-fired deep fryer, located on the cooking line in the kitchen, was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Interview with the Facility Administrator and Maintenance Director on March 17, 2025, at 1:30 p.m., confirmed the equipment deficiency. 2. Document review on March 17, 2025, at 8:45 a.m., revealed the facility failed to provide	K 0324		

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K 0324 SS=E	Continued from page 11 documentation that kitchen fire suppression Testing/Maintenance was completed in the first six months of 2024. Interview with the Facility Administrator and Maintenance Director on March 17, 2025 at 1:30 p.m., confirmed the lack of documentation for one of two semi-annual inspections of the kitchen hood.	K 0324		
K 0353 SS=E		K 0353		

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K 0353 SS=E	Continued from page 12 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 Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0353 Sprinkler System. The observation 1a. The stored items within 18 inches of a sprinkler head was removed. The observation 1b. Observed gap in ceiling tile in basement classroom/storage room was repaired. The observation 1c. Observed gap in ceiling tile teledata room was repaired. 1d. Observed gap in ceiling tile electric room was repaired. The observation 1e. The stored items within 18 inches of a sprinkler head was removed. The Maintenance Director/designee will perform random audits of ceiling tile to ensure no gaps greater than 1/8 inch and storage areas to ensure there are no items within 18 inches of a sprinkler head weekly times 2 weeks then monthly times 2 months.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

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K 0353 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in five instances, affecting four of eight smoke compartments. Findings include: 1. Observation and document review on March 17, 2025, revealed the following automatic sprinkler system deficiencies: a) 9:35 a.m., there were stored items with 18 inches of a sprinkler head located in the Storage Room, on the third floor; b) 10:15 a.m., there was a gap, greater than 1/8 inch in a ceiling tile in the Classroom/Storage Room in the basement; c) 10:18 a.m., there was a gap in the ceiling tile, greater than 1/8 inch, in the Tele-data closet, in the rear of the Classroom/Storage room in the basement; d) 10:30 a.m., there was a gap, greater than 1/8	K 0353		

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K 0353 SS=E	Continued from page 14 inch, in the ceiling tile, in the Electric room, across from the Laundry room. e) 11:15 a.m., there was storage, within 18 inches of a sprinkler head, in a storage closet, in the Physical therapy room. Interview with the Facility Administrator and Maintenance Director on March 17, 2025, at 1:30 p.m., confirmed the above listed automatic sprinkler system deficiencies.	K 0353		
K 0355 SS=E		K 0355		

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K 0355 SS=E	Continued from page 15 NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	The Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0355 Fire Extinguishers. The fire extinguisher in the physical therapy department was replaced. The Maintenance Director will perform a house audit of fire extinguishers to ensure that they are maintained and ready for use per regulation. The Maintenance Director/designee will perform random audits on the fire extinguishers weekly times 2 weeks then monthly.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

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K 0355 SS=E	Continued from page 16 Based on observation and interview, it was determined the facility failed to maintain fire extinguishers in one instance, affecting one of eight smoke compartments. Findings include: 1. Observation on March 17, 2025, at 10:20 a.m., revealed the pressure gauge on the fire extinguisher in Physical Therapy, near the kitchen area, indicated it would have to be recharged before use. Interview with the Facility Administrator and Maintenance Director on March 17, 2025, at 1:30 p.m., confirmed the portable fire extinguisher was not ready for use.	K 0355		
K 0374 SS=E		K 0374		

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K 0374 SS=E	Continued from page 17 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	The Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0374 Smoke Barriers. The observed smoke barrier door excessive gap was repaired. The maintenance Director observed the facilities smoke barrier doors and found no other issues identified. The Maintenance Director/designee will randomly audit the smoke barrier doors weekly x 2 weeks then monthly to ensure there are no excessive gaps to allow passage of smoke.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

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K 0374 SS=E	Continued from page 18 Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors in one instance, affecting two of eight smoke compartments. Findings include: 1. Observation on March 17, 2025, at 10:45 a.m., revealed the smoke barrier doors next to the Receiving Room on the first floor, had an excessive gap between the meeting edges of the doors, which would not resist the passage of smoke. Interview with the Facility Administrator and Maintenance Director on March 17, 2025, at 1:30 p.m., confirmed the smoke barrier doors had an excessive gap that would not resist the passage of smoke.	K 0374		

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HARMAR VILLAGE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **077802**	**715 FREEPORT ROAD CHESWICK, PA 15024**

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K 0712 SS=E	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 Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0712 Fire Drills. The previous month's fire drills are unable to be corrected. Current fire drills are up to date. The Maintenance Director will ensure fire drills are held per regulation and policy. The NHA/designee will perform random audit monthly to ensure the fire drills are held per regulation and policy	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396048	A. BLDG: __01_____ B. WING: _____	03/17/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0712 SS=E	Continued from page 20 Based on documentation review and interview, it was determined the facility failed to perform 6 of 12 required fire drills. Findings include: 1. Review of documentation on March 17, 2025, at 8:40 a.m., revealed the facility lacked documentation for the second and third shift fire drills in the second quarter. Third shift in the third quarter. Also, the first, second, and third shifts in the fourth quarter. Interview with the Facility Administrator and Maintenance Director on March 17, 2025, at 1:30 p.m., confirmed the facility lacked documentation for the required fire drills in the last twelve months.	K 0712		
K 0761 SS=F		K 0761		

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 0761 SS=F	Continued from page 21 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 Nursing Home Administrator (NHA) provided re-education to the Maintenance Director on 0761 Maintenance, Inspection & Testing – Doors. The Maintenance Director is performing an annual fire door assembly inspection. The Maintenance Director will ensure an annual fire door assembly inspection is completed per regulation.	Completion Date: **04/14/2025** Status: **APPROVED** Date: **04/04/2025**

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 0761 SS=F	Continued from page 22 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 March 17, 2025, at 9:15 a.m., revealed the facility lacked documentation for an annual fire door assembly inspection. Interview with the Facility Administrator and Maintenance Director on March 17, 2025, at 1:30 p.m., confirmed the facility lacked documentation showing that an annual fire door assembly inspection had been completed.	K 0761		

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 0761 SS=F	Continued from page 23	K 0761		

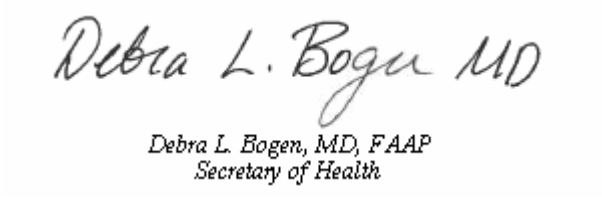
Certified End Page

HARMAR VILLAGE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 077802

SURVEY EXIT DATE: 03/17/2025

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY