STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395010	A. BLDG: __--_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
NESHAMINY MANOR HOME STATE LICENSE NUMBER: **140202**	**1660 EASTON ROAD WARRINGTON, PA 18976**

(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 30, 2025, at Neshaminy Manor Home, 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

NESHAMINY MANOR HOME

STATE LICENSE NUMBER: 140202

SURVEY EXIT DATE: 01/30/2025

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

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# 140202 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on January 30, 2025, it was determined that Neshaminy Manor Home was not in compliance with the following requirements of the Life Safety Code for an existing Nursing 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, that is fully sprinklered.	K 0000		

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

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K 0211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	The snow and ice were removed from the emergency exit egress paths for the A0 courtyard emergency exit and the D1 patio. Maintenance director or designee to conduct inspection of the emergency exit egress paths for the A0 courtyard and D1 patio to ensure they are not obstructed by snow and ice after winter storms. The Maintenance Director or designee will report monthly findings to Quality Assurance for a 90-day period.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **02/12/2025**

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K 0211 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain the means of egress free of impediments, affecting two of three levels. Findings include: Observation on January 30, 2025, at 11:20 a.m., revealed emergency exit egress paths to the public way were obstructed by snow and ice in the following locations: a. 10:10 a.m., AO courtyard emergency exit. b. 11:10 a.m., D1 patio. Exit Interview with the Administrator and Maintenance Director on January 30, 2025, at 12:45 p.m., confirmed the obstructions in the means of egress.	K 0211		

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K 0222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved,	K 0222	A delayed egress was installed in the exterior gate lock of the A0 Courtyard to ensure the gate will open after 15 seconds. Maintenance director or designee to conduct quarterly inspections on the exterior gates to ensure they will open after 15 seconds. The Maintenance Director or designee will report monthly findings to Quality Assurance for a 90-day period.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **02/13/2025**

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K 0222 SS=E	Continued from page 4 supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 0222		

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K 0222 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain exit egress doors on one of the three levels. Findings include: Observation on January, 30, 2025 at 10:10 a.m., revealed inside egress side of AO Courtyard, the egress exterior gate lock did not appear to be equipped with a delayed egress SLA, and failed to open. Exit interview with the Administrator and Maintenance Director on January 30, 2025, at 12:45 p.m., confirmed the exterior egress gate function at the time of survey.	K 0222		

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K 0372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	Maintenance to seal penetration above double doors from loading dock into laundry department with an approved UL listed fire stop barrier system. Maintenance director or designee to conduct monthly inspections of penetrations. The Maintenance Director or designee will report monthly findings to Quality Assurance for a 90-day period.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **02/12/2025**

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K 0372 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls, affecting one of three levels. Findings include: Observation on January 30, 2025, at 9:50 a.m., revealed an unsealed penetration, above double doors from loading dock into laundry department. Exit Interview with the Administrator and Maintenance Director on January 30, 2025, at 12:45 p.m., confirmed the penetration.	K 0372		
K 0521 SS=E		K 0521		

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K 0521 SS=E	Continued from page 8 NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	Portable air conditioning in the A0 staff room and the various locations in the administration department were removed or re-vented into the return system to ensure a plenum was not created. Maintenance director or designee will conduct monthly inspections of the portable air conditioning units to ensure they are not vented into the interstitial space or attic thus creating a plenum. The Maintenance Director or designee will report monthly findings to Quality Assurance for a 90-day period.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **02/13/2025**

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K 0521 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain the heating, ventilating and air conditioning (HVAC) system on one of three levels. Findings include: Observation on January 30, 2025, revealed, the following: a) 10:15 a.m., Inside AO- Staff Break Room, there was a portable air conditioner unit vented above the drop ceiling, into the interstitial space or attic, creating a plenum. b) 11:15 a.m., Inside Admin Department, there was several portable air conditioner units, in various office and conference locations, vented above the drop ceiling, into the interstitial space or attic, creating a plenum. Exit interview with the Administrator and Maintenance Director on January 30, 2025, at	K 0521		

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K 0521 SS=E	Continued from page 10 12:45 p.m., confirmed the portable air conditioner unit assemblies.	K 0521		
K 0920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 0920	The power strip in the D1 ADON office was removed. A new outlet was installed. The maintenance department will conduct quarterly electrical inspection in the D1 ADON office, checking for any power strips. The Maintenance Director or designee will report monthly findings to Quality Assurance for a 90-day period.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **02/13/2025**

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K 0920 SS=E	Continued from page 11 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prohibit the improper and unauthorized use of electrical devices, affecting one of three levels. Findings include: Observation on January 30, 2025, at 11:00 a.m., inside D1-ADON office, revealed a power strip utilized to power heat draw equipment, a refrigerator and a microwave. Exit Interview with the Administrator and Maintenance Director on January 30, 2025, at 12:45 p.m., confirmed the unauthorized use of electrical devices.	K 0920		
K 0923 SS=E		K 0923		

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K 0923 SS=E	Continued from page 12 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	The latch to the oxygen cabinet in the A0 clean utility room was replaced to ensure it would latch. The empty portable oxygen cylinders were separated from the full portable oxygen cylinders in the D1 oxygen storage room. D1 staff will be in-serviced on keeping full and empty oxygen cylinders separate. Maintenance will conduct quarterly inspections on the A0 clean utility room oxygen cabinet to ensure it latches properly. Maintenance will conduct monthly inspections on the D1 oxygen storage room to ensure the full and empty oxygen cylinders are separated. The Maintenance Director or designee will report monthly findings to Quality Assurance for a 90-day period.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **02/13/2025**

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K 0923 SS=E	Continued from page 13 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

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NESHAMINY MANOR HOME STATE LICENSE NUMBER: 140202	1660 EASTON ROAD WARRINGTON, PA 18976

(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
K 0923 SS=E	Continued from page 14 Based on observation and interview, it was determined the facility failed to maintain oxygen storage requirements, affecting two of three levels. Findings include: Observation on January 30, 2025, revealed the following oxygen storage deficiencies: a. 10:20 a.m., AO level clean utility room- oxygen cabinet failed to latch. b. 11:15 a.m., D1 level oxygen storage room - empty portable oxygen cylinders were not separated from full portable oxygen cylinders. Exit Interview with the Administrator and Maintenance Director on January 30, 2025, at 12:45 p.m., confirmed the oxygen storage deficiencies.	K 0923		

Certified End Page

NESHAMINY MANOR HOME

STATE LICENSE NUMBER: 140202

SURVEY EXIT DATE: 01/30/2025

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