

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
STATE LICENSE NUMBER: 130102				
(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 Based on an Emergency Preparedness Survey completed on December 9, 2024, at McMurray Hills Manor, 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

MCMURRAY HILLS MANOR

STATE LICENSE NUMBER: 130102

SURVEY EXIT DATE: 12/09/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
STATE LICENSE NUMBER: 130102				
(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
K 0000	INITIAL COMMENT Facility ID# 130102 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 9, 2024, it was determined that McMurray Hills Manor 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 (000), unprotected non-combustible building, with a basement, that is fully sprinklered.	K 0000		
K 0321 SS=E		K 0321		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR STATE LICENSE NUMBER: 130102	STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317
---	--

(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
K 0321 SS=E	Continued from page 2 This REQUIREMENT is not met as evidenced by:	K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR STATE LICENSE NUMBER: 130102		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
(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
K 0321 SS=E	Continued from page 3 Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in two instances, affecting two of nine smoke compartments. Findings include: 1. Observation on December 9, 2024, revealed the following hazardous area enclosure deficiencies: a) 10:54 a.m., the door to the oxygen storage room on the C-2 wing did not contain a self closing device; b) 11:30 a.m., the door to the transfer switch room failed to latch when tested. Interview with the Facility Administrator and Maintenance Director on December 9, 2024, at 1:30 p.m., confirmed the listed hazardous area enclosure deficiencies.	K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
STATE LICENSE NUMBER: 130102				
(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
K 0321	Continued from page 4	K 0321		
SS=E				
K 0324	NFPA 101 Cooking Facilities	K 0324		
SS=E	<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>	<p>F-0324</p> <p>1. Facility maintenance director 12/9/2024 properly tethered cooking appliance so it could not be moved and educated dietary staff after cleaning to properly tether cooking appliance.</p> <p>2. Audit will be completed by maintenance director /designee daily x 4weeks, then weekly x 2 months</p>	<p>Completion Date: 01/10/2025</p> <p>Status: APPROVED</p> <p>Date: 12/19/2024</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR STATE LICENSE NUMBER: 130102		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
(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
K 0324 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to properly install and maintain equipment protected by the kitchen hood extinguishing system in one instance, affecting one of nine smoke compartments. Findings Include: 1. Observation on December 9, 2024, at 10:30 a.m., revealed a gas-fired oven on wheels, in the main kitchen, was not provided with an approved method that would ensure the appliance was returned to an approved design location after it had been moved for maintenance and cleaning, as required by section 12.1.2.3 and 12.1.2.3.1 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Interview with the Facility Administrator and Maintenance Director on December 9, 2024, at 1:30 p.m., confirmed the gas-fired cooking appliance was not tethered in a way so it could not be moved from the ventilation hood and gas	K 0324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
STATE LICENSE NUMBER: 130102				
(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
K 0324 SS=E	Continued from page 6 connection.	K 0324		
K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	f-0353 1. Maintenance Director on 12/9/2024 removed wire from sprinkler line. 2. Maintenance Director on 12/09/2024 replaced missing ceiling tile and tile with 1/8 inch or greater gap 3. Maintenance Director on 12/12/2024 placed missing escutcheon Maintenance Director/ designee will audit ceiling tile weekly x 4weeks, then biweekly x 2 months. findigs will be reported at monthly QA meeting	Completion Date: 01/10/2025 Status: APPROVED Date: 12/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR STATE LICENSE NUMBER: 130102		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
(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
K 0353 SS=E	Continued from page 7 Based on documentation review, observation, and interview, it was determined the facility failed to maintain the automatic sprinkler system in five instances, affecting four of nine smoke compartments. Findings include: 1. Observation on December 9, 2024, revealed the following automatic sprinkler system deficiencies which may affect the operation of the sprinkler system: a) 10:00 a.m., there was a missing ceiling tile in the sprinkler room; b) 10:09 a.m., there was MC wire laying on top of a sprinkler line, above the smoke doors to the C2 wing; c) 10:15 a.m., there was a gap, greater than 1/8 inch, in the ceiling tile in the electrical room behind the Laundry room; d) 10:22 a.m., there was a gap, greater than 1/8	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR STATE LICENSE NUMBER: 130102		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
(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
K 0353 SS=E	Continued from page 8 inch, in the ceiling tile in the Dietary Manager's office; e) 10:45 a.m., a sprinkler head, in the first floor storage room, was missing an escutcheon. Interview with the Facility Administrator and Maintenance Director on December 9, 2024, at 1:30 p.m., confirmed the listed automatic sprinkler system deficiencies.	K 0353		
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.	K 0372	F-0372 1.Maintenance Director on 12/9/2024 sealed opening with 3M Fireblock caulking.	Completion Date: 01/10/2025 Status: APPROVED Date: 12/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
STATE LICENSE NUMBER: 130102				
(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
K 0372 SS=E	Continued from page 9 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395032	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: MCMURRAY HILLS MANOR STATE LICENSE NUMBER: 130102		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 WEST MCMURRAY ROAD MCMURRAY, PA 15317		
(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
K 0372 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls in one instance, affecting two of nine smoke compartments. Findings include: 1. Observation on December 9, 2024, at 11:05 a.m., revealed a penetration in the first floor smoke barrier wall, next to a steel beam, above the smoke doors to enter the C2 Wing. Interview with the Facility Administrator and Maintenance Director on December 9, 2024, at 1:30 p.m., confirmed the smoke barrier penetration.	K 0372		



Certified End Page

MCMURRAY HILLS MANOR

STATE LICENSE NUMBER: 130102

SURVEY EXIT DATE: 12/09/2024

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