STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395047	A. BLDG: __--_____ B. WING: _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HERITAGE POINTE REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **070102**	**400 SOUTH MAIN STREET DOYLESTOWN, PA 18901**

(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 December 11, 2024, at Heritage Pointe Rehabilitation And Healthcare Center, 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.

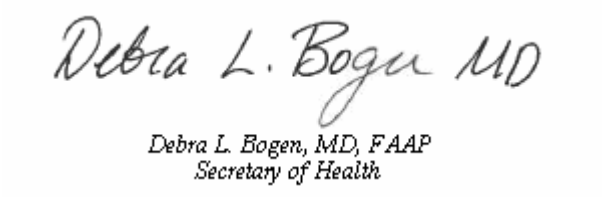
Certified End Page

HERITAGE POINTE REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 070102

SURVEY EXIT DATE: 12/11/2024

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



Pennsylvania
Department of Health

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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# 070102 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 11, 2024, it was determined that Heritage Pointe Rehabilitation and Healthcare Center 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 one-story, Type III (200), unprotected ordinary building, with an unused attic, that is fully sprinklered.	K 0000		

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

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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	The facility submitted a request for a waiver to lock all doors to Plan review Department prior to survey. Department of health approved the waiver that allows All Exit Doors to be secured at all times. Facility will verify the status. Stickers were removed from the doors noted.	Completion Date: **01/21/2025** Status: **APPROVED** Date: **01/02/2025**

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K 0222 SS=E	Continued from page 2 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 3 Based on observation and interview, it was determined facility failed to maintain emergency exit doors affecting, 4 of 6 emergency exit doors. Findings Include: 1. Observations on December 11, 2024, between 8:00 a.m. and 10:15 a.m., revealed the following deficiencies: a. 9:17 a.m.,West wing hallway emergency exit door next to resident room 46 failed to release after 15 seconds as indicated on sign posted; b. 9:18 a.m., West wing hallway emergency exit door next to resident room 37 failed to release after 15 seconds as indicated on sign posted; c. 9:43 a.m., North wing hallway emergency exit door next to resident room 18 failed to release after 15 seconds as indicated on sign posted; d. 9:46 a.m., North wing hallway emergency exit door next to resident room 8 failed to release after 15 seconds as indicated on sign posted.	K 0222		

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K 0222 SS=E	Continued from page 4 Exit Interview with the Administrator and the Maintenance Director on December 11, 2024, at 10:15 a.m., confirmed failure to maintain emergency exit doors.	K 0222		
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	K 0321	Trash room on West Wing has a self-closure device. Facility ensured that the self-closure device is functioning properly. Maintenance & housekeeping will be educated on proper closure of self-closure doors & proper reporting issues. An Audit will be conducted to ensure all doors have the proper closure weekly x 4. Audit results will be reported to QAPI committee.	Completion Date: **01/21/2025** Status: **APPROVED** Date: **12/31/2024**

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K 0321 SS=E	Continued from page 5 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (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 6 Based on observation and interview, it was determined the facility failed to maintain hazardous areas, affecting one of two smoke compartments in the facility Findings include Observation on December 11, 2024, at 9:12 a.m., revealed the door to the trash room in the west wing lacked a self-closure device. Exit interview with the Administrator and the Maintenance Director on December 11, 2024, at 10:15 a.m., confirmed the lack of self- closure device.	K 0321		
K 0355 SS=F		K 0355		

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K 0355 SS=F	Continued from page 7 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	Facility had received the inspector's certificate by the end of day of the survey. Maintenance Director/Designee will ensure that we will receive any inspector's certificate at time of the inspection.	Completion Date: **01/21/2025** Status: **APPROVED** Date: **01/02/2025**

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K 0355 SS=F	Continued from page 8 Based on document review and interview, it was determined the facility failed to maintain and inspect portable fire extinguishers, affecting the entire facility. Findings include: Document review on December 11, 2024, at 8:30 a.m., revealed the facility could not provide the certification for the inspector who conducted the annual maintenance/inspection of the portable fire extinguishers. Exit interview with the Administrator and the Maintenance Director on December 11, 2024, at 10:15 a.m., confirmed the lack of documentation.	K 0355		
K 0511 SS=F		K 0511		

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K 0511 SS=F	Continued from page 9 NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by:	K 0511	All cited electrical panels have been cleared and are no longer blocked. Maintenance and Nursing will be educated regarding the regulation for blocking electrical panels. An Audit will be conducted to ensure the electrical panels are not blocked weekly x 4. Audit results will be reported to QAPI committee.	Completion Date: **01/21/2025** Status: **APPROVED** Date: **12/31/2024**

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K 0511 SS=F	Continued from page 10 Based on observation and interview, it was determined the facility failed to comply with NFPA 70, National Electric Code, for electrical wiring and equipment, affecting two of two smoke zones in the facility Findings include Observation on December 11, 2024, between 8:00 a.m. and 10:15 a.m., revealed the following deficiencies: a. 9:14 a.m., West wing, in the medication room, there was a blocked electrical panel; b 9:21 a.m., West wing, in the central supply room, there was a blocked electrical panel; c. 9:42 a.m., North wing, in the nurse station medication room, there was a blocked electrical panel; d. 9:44 a.m., West wing, in the boiler room room, there was a blocked electrical panel Exit interview with the Administrator and the Maintenance Director on December 11, 2024, at 10:15 a.m., confirmed the blocked electrical panels	K 0511		

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K 0511 SS=F	Continued from page 11	K 0511		
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the	K 0918	The Battery testing is being completed weekly as required. The Generator Load test was ran for the 30 minute month load test and will continue to be ran monthly as required. An Audit will be conducted to ensure the testing is completed monthly. Audit results will be reported to QAPI committee	Completion Date: **01/21/2025** Status: **APPROVED** Date: **12/31/2024**

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K 0918 SS=F	Continued from page 12 emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

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K 0918 SS=F	Continued from page 13 Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator, affecting the entire facility. Findings include: Document review on December 11, 2024, at 8:30 a.m., revealed the following deficiencies: a. Weekly inspection of battery electrolyte levels or voltage not completed; b. Monthly testing under load for 30 minutes not completed. Exit interview with the Administrator and the Maintenance Director on December 11, 2024, at 10:15 a.m., confirmed the above deficiencies.	K 0918		

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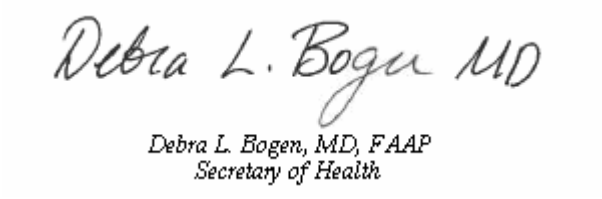

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