

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
STATE LICENSE NUMBER: 081302				
(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	E 0000		
E 0007	Based on a Revisit to an Emergency Preparedness Survey completed on November 20, 2024, it was determined that Westgate Hills Rehabilitation and Nursing Center had deficiencies that have potential for minimal harm as related to the requirements of 42 CFR 483.73	E 0007		
SS=C				

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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E 0007 SS=C	Continued from page 1 483.73(a)(3) EP Program Patient Population §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD]	E 0007	Plan of Correction for TAG E0007: Emergency Preparedness Plan - Patient Population and Continuity of Operations 1. Deficiency: Based on document review and interview, the facility failed to ensure policies and procedures were in place addressing patient population, including but not limited to persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegation of authority and succession plans, affecting the entire facility. Document review on November 20, 2024, at 8:00 a.m., revealed the Facility's Emergency Preparedness Plan did not include policies and procedures addressing persons at-risk. Exit interview with the Administrator and the Maintenance Director on	Completion Date: 01/28/2025 Status: APPROVED Date: 01/27/2025

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E 0007 SS=C	Continued from page 2 facilities.] This REQUIREMENT is not met as evidenced by:	E 0007	November 20, 2024, at 11:00 a.m., confirmed the missing documentation. No current residents were directly affected by this deficiency; however, all residents have the potential to be affected in the event of an emergency where these provisions are required 2. Corrective Action: The facility will update its Emergency Preparedness Plan to include: Policies and procedures addressing persons at-risk within the patient population. A clear description of the types of services the facility is able to provide in the event of an emergency. Continuity of operations, including	

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E 0007 SS=C	Continued from page 3	E 0007	<p>delegation of authority and succession plans for key personnel to ensure continued operation during an emergency.</p> <p>3. Monitoring:</p> <p>The Emergency Preparedness Plan will be reviewed annually to ensure it includes all necessary policies and procedures for the patient population, including those at risk, and for continuity of operations.</p> <p>Any updates or changes will be presented to the Quality Assessment and Assurance Committee for review and approval.</p> <p>4. Timeline:</p> <p>The Emergency Preparedness Plan will be updated by 01/28/25, with an annual review thereafter.</p>	

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E 0007 SS=C	Continued from page 4 Based on document review and interview, it was determined the facility failed to ensure policies and procedures were in place addressing patient population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans, affecting the entire facility. Findings include: Document review on November 20, 2024, at 8:00 a.m., revealed the Facility's Emergency Preparedness Plan did not include policies and procedures that addressed persons at-risk, affecting the entire facility. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the missing documentation. *****	E 0007		

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E 0007 SS=C	Continued from page 5 Not Completed - Document review during an onsite Revisit conducted on January 8, 2025, between 12:00 p.m. and 12:30 p.m., revealed the Facility's Emergency Preparedness Plan did not include policies and procedures that addressed persons at-risk, affecting the entire facility. Exit interview with the Administrator and Regional Maintenance Director on January 8, 2025, at 12:45 p.m., confirmed the missing documentation.	E 0007		
E 0026 SS=C		E 0026		

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E 0026 SS=C	Continued from page 6 483.73(b)(8) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by:	E 0026	Plan of Correction for TAG E0026 - Scope C: Emergency Preparedness Plan 1. Deficiency: A document review on November 20, 2024, at 8:00 a.m. revealed that the facility could not provide Emergency Preparedness Plan policy and procedure documentation concerning the roles under a waiver declared by the Secretary. No current residents were directly affected by this deficiency; however, all residents have the potential to be affected in the event of an emergency situation where the waiver provisions need to be implemented. 2. Corrective Action: The facility will review and update its Emergency Preparedness Plan to include: Roles and responsibilities of the	Completion Date: 01/28/2025 Status: APPROVED Date: 01/27/2025

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E 0026 SS=C	Continued from page 7	E 0026	<p>facility under a waiver declared by the Secretary, in accordance with Section 1135 of the Act.</p> <p>Procedures for the provision of care and treatment at an alternate care site identified by emergency management officials, if necessary.</p> <p>3. Monitoring:</p> <p>The Emergency Preparedness Plan will be reviewed annually to ensure continued compliance with updated policies and procedures.</p> <p>Any necessary updates will be presented to the Quality Assessment and Assurance Committee for review and approval.</p> <p>4. Timeline:</p> <p>The Emergency Preparedness Plan will be reviewed and updated by 1/28/25, with an annual review thereafter.</p>	

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E 0026 SS=C	<p>Continued from page 8</p> <p>Based on document review and interview, it was determined the facility failed to provide policy and procedure documentation concerning the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials, affecting the entire facility.</p> <p>Findings include:</p> <p>Document review on November 20, 2024, at 8:00 a.m., revealed the facility could not provide Emergency Preparedness Plan policy and procedure documentation concerning the Roles under a Waiver Declared by Secretary.</p> <p>Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the lack of documentation.</p> <p>*****</p>	E 0026		

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E 0026 SS=C	Continued from page 9 Not Completed - Document review during an onsite Revisit conducted on January 8, 2025, between 12:00 p.m. and 12:30 p.m., revealed the facility could not provide Emergency Preparedness Plan policy and procedure documentation concerning the Roles under a Waiver Declared by Secretary. Exit interview with the Administrator and the Regional Maintenance Director on January 8, 2025, at 12:45 p.m., confirmed the lack of documentation.	E 0026		
E 0036 SS=C		E 0036		

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E 0036 SS=C	Continued from page 10 483.73(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be	E 0036	Plan of Correction for TAG E0036: Emergency Preparedness Training and Testing 1. Deficiency: Based on documentation review and interview, it was determined that the facility failed to develop an emergency preparedness training program that is based on the facility's emergency preparedness plan. The training and testing program must be reviewed and updated at least annually, affecting the entire facility. Document review on November 20, 2024, at 8:00 a.m., revealed the facility failed to develop and maintain an emergency preparedness training and testing program that aligns with the emergency preparedness plan. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the lack of documentation.	Completion Date: 01/28/2025 Status: APPROVED Date: 01/27/2025

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E 0036 SS=C	Continued from page 11 reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by:	E 0036	No current residents were directly affected by this deficiency; however, all residents have the potential to be affected if the facility's staff is not properly trained in emergency preparedness protocols. 2. Corrective Action: The facility will develop and implement an emergency preparedness training program based on the facility's updated emergency preparedness plan. The training program will include testing procedures and will be reviewed and updated at least annually to ensure ongoing compliance. 3. Monitoring: The facility will track and document	

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E 0036 SS=C	Continued from page 12	E 0036	<p>all training sessions, including the participation of all relevant staff members.</p> <p>An annual review of the training program will be conducted to ensure that it remains aligned with the current emergency preparedness plan and includes all necessary updates.</p> <p>4. Timeline:</p> <p>The emergency preparedness training program will be developed and implemented by 01/28/25, with annual reviews thereafter.</p>	

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E 0036 SS=C	Continued from page 13 Based on documentation review and interview, it was determined the facility failed to develop an emergency preparedness training program that is based on the facility's emergency preparedness plan. The training and testing program must be reviewed and updated at least annually, affecting the entire facility. Findings include: Document review on November 20, 2024, at 8:00 a.m., revealed the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency preparedness plan. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the lack of documentation. ***** Not Completed - Document review during an onsite	E 0036		

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E 0036 SS=C	Continued from page 14 Revisit conducted on January 8, 2025, between 12:00 p.m. and 12:30 p.m., revealed the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency preparedness plan. Exit interview with the Administrator and the Regional Maintenance Director on January 8, 2025, at 12:45 p.m., confirmed the lack of documentation.	E 0036		
E 0039 SS=C		E 0039		

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NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
(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 0039 SS=C	Continued from page 15 483.73(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 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:	E 0039	Plan of Correction for TAG E0039: Emergency Preparedness Plan - Annual Exercises 1. Deficiency: Based on document review and interview, it was determined that the facility failed to conduct one of the two required annual exercises to test the facility's emergency preparedness plan, affecting the entire facility. Document review on November 20, 2024, at 8:00 a.m., revealed that within the previous 12 months, the facility performed only a full-scale exercise and did not perform the additional required exercise to test the emergency preparedness plan. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the lack of the additional exercise. No current residents were directly	Completion Date: 01/28/2025 Status: APPROVED Date: 01/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
STATE LICENSE NUMBER: 081302				
(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 0039 SS=C	Continued from page 16 (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 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	E 0039	affected by this deficiency; however, all residents have the potential to be affected if the facility's emergency preparedness plan is not properly tested through regular exercises. 2. Corrective Action: The facility will conduct the additional required annual exercise, ensuring that both a full-scale exercise and a tabletop exercise (or another approved exercise) are completed within the required time frame to properly test the emergency preparedness plan. A schedule will be developed to ensure that future exercises are performed on time and documented accordingly. 3. Monitoring: The facility will track the completion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
STATE LICENSE NUMBER: 081302				
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E 0039 SS=C	Continued from page 17 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 (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	E 0039	of required exercises and ensure they are conducted annually as per regulations. Documentation of each exercise, including participant involvement and outcomes, will be reviewed by the Quality Assessment and Assurance Committee. 4. Timeline: The additional required exercise will be completed by 01/28/25. Future exercises will be scheduled and conducted annually, with documentation reviewed for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
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E 0039 SS=C	Continued from page 18 (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 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	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u> -- </u> B. WING: <u> </u>	(X3) DATE SURVEY COMPLETED: 01/08/2025	
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
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E 0039 SS=C	Continued from page 19 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 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	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
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E 0039 SS=C	Continued from page 20 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 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.	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
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E 0039 SS=C	Continued from page 21 (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 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.	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __ B. WING: __	(X3) DATE SURVEY COMPLETED: 01/08/2025
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E 0039 SS=C	Continued from page 22 (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 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.	E 0039		

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E 0039 SS=C	Continued from page 23 (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. *[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	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
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E 0039 SS=C	Continued from page 24 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 events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by:	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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E 0039 SS=C	Continued from page 25 Based on document review and interview, it was determined the facility failed to conduct one of two required annual exercises to test the facility's emergency preparedness plan, affecting the entire facility. Findings include: Document review on November 20, 2024, at 8:00 a.m., revealed within the previous 12 months, the facility only preformed a full scale exercise and did not perform the additional required exercise to test the emergency preparedness plan. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the lack of additional exercise. ***** **** Not Completed - Document review during an onsite Revisit conducted on January 8, 2025, between	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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E 0039 SS=C	Continued from page 26 12:00 p.m. and 12:30 p.m., revealed within the previous 12 months, the facility only preformed a full scale exercise and did not perform the additional required exercise to test the emergency preparedness plan. Exit interview with the Administrator and the Regional Maintenance Director on January 8, 2025, at 12:45 p.m., confirmed the lack of of additional exercise.	E 0039		



Certified End Page

WESTGATE HILLS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 081302

SURVEY EXIT DATE: 01/08/2025

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, 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: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083
STATE LICENSE NUMBER: 081302	

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K 0000	INITIAL COMMENT	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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STATE LICENSE NUMBER: 081302				
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K 0000	Continued from page 1 Facility ID# 081302 Component 01 Based on a Revisit to a Medicare/Medicaid Recertification Survey completed on November 20, 2024, it was determined that Westgate Hills Rehabilitation And Nursing Center was not in substantial 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 two-story, Type II (222), fire resistive building, with a basement, that is fully sprinklered. Failure to correct the following deficiencies may negate the acceptance of certain earlier deficiencies by the approved FSES.	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302	STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083
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K 0321 SS=E		K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
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K 0321 SS=E	Continued from page 4 This REQUIREMENT is not met as evidenced by:	K 0321	are not fully met. 2. Corrective Action: The self-closing door was installed in the storage room near resident room 131 to maintain the required fire rating for the area. The Maintenance Director verified that all other storage areas are in compliance with fire safety regulations. 3. Monitoring: Weekly audits will be conducted for 4 weeks to ensure continuous compliance with fire safety regulations, including verification of the self-closing door installation and proper function. Findings will be documented, and any necessary corrective actions will	

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K 0321 SS=E	Continued from page 5	K 0321	<p>be taken.</p> <p>4. Timeline:</p> <p>The self-closing door was installed on 01/08/25.</p> <p>Weekly audits will be completed for 4 weeks starting from 01/28/25.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
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K 0321 SS=E	<p>Continued from page 6</p> <p>Based on observation and interview, it was determined the facility failed to maintain the fire rating of storage areas, affecting one of three levels within the facility.</p> <p>Findings include:</p> <p>Observation on November 20, 2024, at 10:44 a.m., revealed on the first floor, the Storage Room near resident room 131, lacked a self closer.</p> <p>Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the lack of self closer.</p> <p>*****</p> <p>Not Completed- Observation during an onsite Revisit conducted on January 8, 2025, between 12:00 p.m. and 12:30 p.m., revealed on the first floor, the Storage Room near resident room 131, lacked a self closer.</p> <p>Exit interview with the Administrator and the</p>	K 0321		

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K 0321 SS=E	Continued from page 7 Regional Maintenance Director on January 8, 2025, at 12:45 p.m., confirmed the lack of self closer.	K 0321		
K 0324 SS=E		K 0324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
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K 0324 SS=E	Continued from page 8 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	Plan of Correction for TAG K324: Kitchen Hood Suppression System 1. Deficiency: Based on observation and interview, it was determined that the facility failed to maintain and inspect the kitchen hood suppression system, affecting one of three levels in the facility. Observation on November 20, 2024, at 10:33 a.m., revealed that on the first floor, the kitchen hood suppression system lacked monthly inspections. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the missing monthly inspections. No current residents were directly affected by this deficiency; however, all residents have the potential to be affected if the kitchen hood suppression system is not properly	Completion Date: 01/28/2025 Status: APPROVED Date: 01/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
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K 0324 SS=E	Continued from page 9	K 0324	<p>maintained and inspected in case of a fire emergency.</p> <p>2. Corrective Action:</p> <p>The facility will conduct a thorough inspection of the kitchen hood suppression system immediately.</p> <p>Monthly inspections will be implemented going forward, and a log will be maintained to track the inspections.</p> <p>3. Monitoring:</p> <p>The Maintenance Director will ensure that the kitchen hood suppression system is inspected monthly.</p> <p>Monthly audits will be conducted for 3 months to ensure compliance</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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K 0324 SS=E	Continued from page 10	K 0324	with the kitchen hood suppression system inspection requirement. 4. Timeline: The inspection will be completed by 01/28/25. Monthly inspections will continue, with audits conducted for 3 months to ensure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
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K 0324 SS=E	Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain and inspect the kitchen hood suppression system, affecting one of three levels in the facility. Findings include: Observation on November 20, 2024, at 10:33 a.m., revealed on the first floor, the kitchen hood suppression system lacked monthly inspections. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the missing monthly inspections. ***** Not Completed- Observation during an onsite Revisit conducted on January 8, 2025, between 12:00 p.m. and 12:30 p.m., revealed on the first floor, the kitchen hood suppression system lacked monthly inspections.	K 0324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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K 0324 SS=E	Continued from page 12 Exit interview with the Administrator and the Regional Maintenance Director on January 8, 2025, at 12:45 p.m., confirmed the missing monthly inspections.	K 0324		
K 0353 SS=F		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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K 0353 SS=F	Continued from page 13 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	Plan of Correction for TAG K353: Sprinkler System Maintenance and Inspection 1. Deficiency: Based on document review and interview, it was determined the facility failed to maintain and inspect the sprinkler system, affecting the entire facility. Document review on November 20, 2024, at 8:00 a.m., revealed the following deficiencies noted during the fourth quarter sprinkler inspection, with no documentation of the correction of these issues: a. Tamper in the backflow preventer pit were not reporting to the fire alarm panel. b. FDC hydrotest is overdue. c. Dry system main drain is piped to a shower drain, which cannot handle the full flow from the drain (note: this was not considered a deficiency, but	Completion Date: 02/08/2025 Status: APPROVED Date: 01/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
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K 0353 SS=F	Continued from page 14	K 0353	<p>a note).</p> <p>Residents Affected:</p> <p>No residents were directly affected by these deficiencies. However, all residents have the potential to be affected if these issues with the sprinkler system are not addressed properly, as the sprinkler system is a key safety feature for the entire facility.</p> <p>2. Corrective Action:</p> <p>a. The necessary repairs will be made to ensure that the tampers in the backflow preventer pit report to the fire alarm panel. This repair will be completed by 02/08/25.</p> <p>b. The FDC hydrotest was completed on 12/27/24.</p> <p>c. The issue with the dry system main drain was identified as a note by the inspector and is not</p>	

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K 0353 SS=F	Continued from page 15	K 0353	<p>considered a deficiency an addendum to the original report will be obtained from the sprinkler inspection vendor indicating that the main drain item is not considered a "deficiency" and was identified as a note This documentation will be available to review by the life safety inspector on the day of the revisit</p> <p>3. Monitoring:</p> <p>The Maintenance Director will ensure that the sprinkler system, including the backflow preventer and fire alarm panel connections, is fully functional and reporting correctly.</p> <p>A follow-up audit will be conducted on 02/08/25 to ensure all necessary corrections have been completed and that the sprinkler system is in full compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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K 0353 SS=F	Continued from page 16	K 0353	4. Timeline: The repairs for the tampers in the backflow preventer pit will be completed by 02/08/25. The FDC hydrotest has been completed as of 12/27/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
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K 0353 SS=F	Continued from page 17 Based on document review and interview, it was determined the facility failed to maintain and inspect the sprinkler system, affecting the entire facility: Findings include: Document review on November 20, 2024, at 8:00 a.m., revealed the following deficiencies on the fourth quarter sprinkler inspection. There was no documentation of the correction of these deficiencies: a. Tamper in the backflow preventer pit were not reporting to the fire alarm panel; b. FDC hydrotest is overdue; c. Dry system main drain is piped to a shower drain. The drain cannot handle the full flow from the drain. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the above deficiencies. ***** *****	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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K 0353 SS=F	Continued from page 18 Not Completed - Document review during an onsite Revisit conducted on January 8, 2025, between 12:00 p.m. and 12:30 p.m., revealed the following deficiencies on the fourth quarter sprinkler inspection. There was no documentation of the correction of these deficiencies: a. Tamperers in the backflow preventer pit were not reporting to the fire alarm panel; b. FDC hydrotest is overdue; c. Dry system main drain is piped to a shower drain. The drain cannot handle the full flow from the drain. Exit interview with the Administrator and the Regional Maintenance Director on January 8, 2025, at 12:45 p.m., confirmed the above deficiencies.	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
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NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302	STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083
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K 0355 SS=C		K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
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(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 0355 SS=C	Continued from page 20 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	Plan of Correction for TAG K355: Portable Fire Extinguishers 1. Deficiency: 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 November 20, 2024, at 8:00 a.m., revealed the facility could not produce the certification for the inspector conducting the annual portable fire extinguisher inspection. Observation on November 20, 2024, at 10:42 a.m., revealed that on the first floor, the portable fire extinguisher next to resident room 125 was blocked by wheelchairs. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m.,	Completion Date: 01/28/2025 Status: APPROVED Date: 01/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
(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 0355 SS=C	Continued from page 21	K 0355	<p>confirmed the lack of documentation and the blocked fire extinguisher.</p> <p>Residents Affected:</p> <p>No residents were directly affected by these deficiencies. However, all residents have the potential to be affected in the event of a fire emergency if fire extinguishers are not properly maintained or accessible.</p> <p>2. Corrective Action:</p> <p>1. The certificate for the inspector conducting the annual portable fire extinguisher inspection was obtained and filed on 01/08/25.</p> <p>2. The portable fire extinguisher located next to resident room 125 was immediately cleared of all wheelchairs and is now accessible.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
STATE LICENSE NUMBER: 081302				
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K 0355 SS=C	Continued from page 22	K 0355	<p>3. Monitoring:</p> <p>The Maintenance Director will review the portable fire extinguisher inspection records to ensure that certifications are maintained properly.</p> <p>Monthly inspections will be conducted to ensure all fire extinguishers are accessible and not blocked by any items, with audits documented.</p> <p>4. Timeline:</p> <p>The certificate for the fire extinguisher inspector was obtained and filed on 01/08/25.</p> <p>The wheelchairs were removed, and the fire extinguisher is now accessible as of 11/20/24.</p> <p>Ongoing monthly checks will be conducted to ensure compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025	
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 081302		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
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K 0355 SS=C	Continued from page 23 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: 1. Document review on November 20, 2024, at 8:00 a.m., revealed the facility could not produce the certification for the inspector conducting the annual portable fire extinguisher inspection. Exit interview with the Administrator and the Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed lack of documentation. 2. Observation on November 20, 2024, at 10:42 a.m., revealed on the first floor, the portable fire extinguisher next to resident room 125 was blocked by wheelchairs. Exit interview with the Administrator and the	K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/08/2025
NAME OF PROVIDER OR SUPPLIER: WESTGATE HILLS REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 2050 OLD WEST CHESTER PIKE HAVERTOWN, PA 19083		
STATE LICENSE NUMBER: 081302				
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K 0355 SS=C	Continued from page 24 Maintenance Director on November 20, 2024, at 11:00 a.m., confirmed the blocked portable fire extinguisher. ***** ***** Item 1. Not Completed - Document review during an onsite Revisit conducted on January 8, 2025, between 12:00 p.m. and 12:30 p.m., revealed the facility could not produce the certification for the inspector conducting the annual portable fire extinguisher inspection. Exit interview with the Administrator and the Regional Maintenance Director on January 8, 2025, at 12:45 p.m., confirmed the lack of documentation.	K 0355		



Certified End Page

WESTGATE HILLS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 081302

SURVEY EXIT DATE: 01/08/2025

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, 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