

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
NAME OF PROVIDER OR SUPPLIER: LUTHER WOODS NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 313 W COUNTY LINE ROAD HATBORO, PA 19040		
STATE LICENSE NUMBER: 640302				
(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 0026	483.73(b)(8) Roles Under a Waiver Declared by Secretary	E 0026	Paperwork has been downloaded regarding the waiver of the Secretary of State regarding section 1135 of the Act. This will be implemented and added to our Emergency Preparedness plan by January 1st, 2025.	Completion Date: 01/08/2025 Status: APPROVED Date: 01/10/2025
SS=C	§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			

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 0026 SS=C	Continued from page 1 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		

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E 0026 SS=C	Continued from page 2 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. Findings include: Document review on December 18, 2024, between 8:00 a.m. and 11:30 a.m., revealed the facility failed to develop an Emergency Preparedness Plan to include the role of the facility under a waiver declared by the Secretary of the Department of Health. Exit Interview with the Administrator, Administrator in training, and Maintenance Director on December 18, 2024, at 1:45 p.m., confirmed the lack of documentation.	E 0026		

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E 0026 SS=C	Continued from page 3	E 0026			



Certified End Page

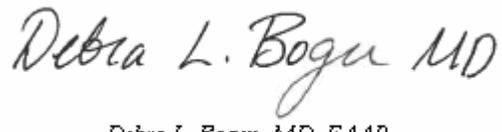
LUTHER WOODS NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 640302

SURVEY EXIT DATE: 12/18/2024

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

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 640302 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 18, 2024, it was determined that Luther Woods Nursing And Rehabilitation 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).</p> <p>This is a one-story, Type III (200), unprotected ordinary building, with a partial basement, that is fully sprinklered.</p>	K 0000		
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K 0100 SS=E		K 0100		
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K 0100 SS=E	Continued from page 2 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	1. The initial notification in writing of the generator had been completed. The addition of the Docking Station on 12/17/24 was just completed the day before the annual Life Safety survey, so we had not had the time yet to write a notification. Upon the exit interview there was confusion on our part that the notification needed to be done in writing. That is being submitted today, 1/8/25. 2. The Carbon Monoxide alarm evacuation policy plan has been attained and staffing education will be completed by Friday, January 10th, 2025. 3. Maintenance will update the floor plan to include the items that are needed to make the floor plan correct; They following will be added: a. Smoke Barrier Walls (outside wall to outside wall) b. Fire Barrier Walls (2-hour walls) c. Horizontal Exits d. Rated Rooms (Storage Rooms, Soiled Utility Rooms, designated Medical Gas Rooms) will be clearly designated. It is the facility's	Completion Date: 01/15/2025 Status: APPROVED Date: 01/14/2025

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K 0100 SS=E	Continued from page 3	K 0100	responsibility to have all Rated Rooms indicated on their Life Safety Code Floor Plan e. Required Exits should be clearly noted; and f. Shafts Walls This will be completed by January 15th, 2025	

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K 0100 SS=E	Continued from page 4 Based on observation, interview and documentation review, it was determined the facility failed to obtain required Pennsylvania Department of Health Final Occupancy Inspection approval for replacement to the facility's emergency power generator and other ESS components, affecting the entire facility. Findings include: 1. Observation, interview and documentation review on December 18, 2024, between 8:00 a.m. and 11:30 a.m., revealed that the facility failed to "Notify In Writing" the Norristown Department of DSI of approved PA DOH Stamped Drawing Index of H-22-0230 indicating when construction has started and when construction has been completed. Exit Interview with the Administrator, Administrator in training and Maintenance Director on December 18, 2024, at 1:45 p.m., confirmed no notification was made to the DOH Norristown Division of Safety Inspection. Reference: 28 Pa Code § 51.3. Notification (d) *****	K 0100		

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K 0100 SS=E	Continued from page 5 Based on document review and interview, it was determined the facility failed to update facility policies in accordance with the 2016 Act 48 - Care Facility Carbon Monoxide Alarms Standards Act, affecting the entire facility. Findings include: 1. Document review on December 18, 2024, between 8:00 a.m., and 11:30 a.m., revealed the facility failed to provide a carbon monoxide alarm evacuation policy plan and associated staff in-service to the plan. Exit Interview with the Administrator, Administrator in training and Maintenance Director on December 18, 2024, at 1:45 p.m., confirmed the lack of policy documentation. ***** Based on document review and interview, it was	K 0100		

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K 0100 SS=E	Continued from page 6 determined the facility failed to provide portable, accurate floor plans, affecting the entire facility. 1. Document review on December 18, 2024, between 8:00 a.m. and 11:30 a.m., revealed the facility failed to provide a set of accurate portable floor plans. The portable plan provided at time of survey had no indication of items a, b, c, d and f (noted below). The Division of Safety Inspection is requiring that all facilities under our jurisdiction have a portable, accurate floor plan on site to be used during the course of the Life Safety Code Survey. The Life Safety Code Floor Plans shall include the following: a. Smoke Barrier Walls (outside wall to outside wall) b. Fire Barrier Walls (2-hour walls) c. Horizontal Exits d. Rated Rooms (Storage Rooms, Soiled Utility Rooms, designated Medical Gas Rooms) will be clearly designated. It is the facility's responsibility to	K 0100		

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K 0100 SS=E	Continued from page 7 have all Rated Rooms indicated on their Life Safety Code Floor Plan; e. Required Exits should be clearly noted; and f. Shafts Walls Exit Interview with the Administrator, Administrator in training and Maintenance Director on December 18, 2024, at 1:45 p.m., confirmed the lack of portable, accurate indicating floor plans.	K 0100		
K 0223 SS=E		K 0223		

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K 0223 SS=E	Continued from page 8 NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:	K 0223	All doorways will be kept closed at all times. Maintenance will do daily audits each day times 30 days. Then they will do weekly checks times 60 days. All stops whether portable or installed have been removed. New door latch has been installed on door on A Wing A door will be installed at the Sprinkler Room as we have been unable to fix the gap. This will be completed by 1/30/25.	Completion Date: 01/30/2025 Status: APPROVED Date: 01/14/2025

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K 0223 SS=E	Continued from page 9 Based on observation and interview, facility failed to maintain doors with self closing devices on two of two levels of the facility. Findings include: Observation on December 18, 2024, between 11:30 a.m. and 1:45 p.m., revealed the following deficiencies: a) Staff lounge ice room: Door with closer propped open with door wedge. b) A Wing lining closet: Door with closer does not latch. c) B wing break room: Door with closer held open with tied into knot trash bag from door handle to handrail. d) Chapel: Door with closure propped open with a chair. e) Sprinkler/ Janitor room: Door with closer has large gap between door and frame when latched. f) Basement storage: Door with closure was propped open with an installed kick down door	K 0223		

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K 0223 SS=E	Continued from page 10 stop. g) C wing Clean lining: Door with closure propped open with door stop. Exit Interview with the Facility Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed the doors with closer hardware were propped open at time of survey.	K 0223		
K 0291 SS=E	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	All emergency signs will be repaired by January 31st, 2025. They will be audited weekly times one month. After one month they will be checked monthly. All auditing will be done by Maintenance and logged in an audit book.	Completion Date: 01/31/2025 Status: APPROVED Date: 01/14/2025

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K 0291 SS=E	Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain lighting in operable condition, affecting one of two levels. Findings Include: Observation made on December 18, 2024, at 11:37 a.m., in the loading dock/ maintenance shop, revealed the Emergency Lighting / Exit sign combo had damaged emergency spot lighting detached from sign housing and hanging from combo device. Exit Interview with the Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed the emergency spot lighting was damaged..	K 0291		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 13 This REQUIREMENT is not met as evidenced by:	K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024	
NAME OF PROVIDER OR SUPPLIER: LUTHER WOODS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 640302		STREET ADDRESS, CITY, STATE, ZIP CODE: 313 W COUNTY LINE ROAD HATBORO, PA 19040		
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K 0321 SS=E	Continued from page 14 Based on observation and interview, it was determined the facility failed to maintain a hazardous area enclosure on one of two levels of the facility. Findings include: Observation on December 18, 2024, between 11:30 a.m. and 1:45 p.m., revealed the following: a) All laundry room doors (approx 4) were propped open with door wedges. b) C wing Soiled Laundry: No door closer installed on door. c) Maintenance area: Double doors propped open with door wedges. Exit Interview with the Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed the hazardous area enclosure deficiencies.	K 0321		

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K 0324 SS=F	<p>NFPA 101 Cooking Facilities</p> <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>	K 0324	<p>Kitchen Hood Fire Suppression system was inspected on December 19th, 2024, by an outside vendor. The equipment has been placed on an automatic inspection schedule with this vendor. Maintenance will monitor the automatic scheduling dates.</p>	<p>Completion Date: 01/08/2025</p> <p>Status: APPROVED</p> <p>Date: 01/10/2025</p>

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K 0324 SS=F	Continued from page 16 Based on document review and interview, it was determined the facility failed to maintain and inspect the kitchen hood suppression system, affecting the entire facility. Findings include: 1. Document review on December 18, 2024, between 8:00 a.m., and 11:30 a.m., revealed the facility failed to provide semi-annual kitchen hood suppression system testing within 6 months of 2/27/2024. Exit Interview with the Administrator, Administrator in training, and Maintenance Director on December 18, 2024, at 1:45 p.m., confirmed the lack of documentation. 2. Observation and interview on December 18, 2024 at 12:40 p.m, revealed inside Kitchen that the kitchen hood suppression system did not have monthly quick checks occur for entire survey year.	K 0324		

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K 0324 SS=F	Continued from page 17 Exit Interview with the Administrator, Administrator in training, and Maintenance Director on December 18, 2024, at 1:45 p.m., confirmed the lack of monthly quick checks.	K 0324		
K 0345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	We have contacted Johnson Controls who is our service contractor. They are scheduled to come to the facility on January 18th, 2025. We are anticipating that all needed repairs will be completed by January 20th, 2025.	Completion Date: 01/20/2025 Status: APPROVED Date: 01/14/2025

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K 0345 SS=F	Continued from page 18 Based on observation, document review, and interview, it was determined the facility failed to maintain fire alarm system components in operable condition, affecting the entire facility. Findings Include: Documentation reviewed on December 18, 2024, between 8:00 a.m. and 11:30 a.m., revealed the fire alarm report dated December 16, 2024, listed the following two deficiencies and one high priority recommendation without verification of repair of deficiencies at the time of survey. a) General Deficiencies: Cannot use Xaap to inspect system, since the FACP is in the basement and that area has no cellular reception for the Xaap device to operate, and no Wifi reception. b) Device Deficiencies: Location: on the first floor, the C Wing by activities room. Device: Pull station. Reason: Functional Failure. (Repeat deficiency from 2023 FA annual dated 12/14/2023) c) High Priority: Recommend to update all smoke detectors to current Simplex model, 4098-9714, for better sensitivity testing and for better trouble	K 0345		

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K 0345 SS=F	Continued from page 19 indicating and troubleshooting. Exit Interview with the Facility Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed the fire alarm annual inspection report findings.	K 0345		
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	K 0353	C Wing closet repairs have been completed. Maintenance will check sprinkler heads for damage monthly times 6 months then quarterly on going. All audits will be logged in the Maintenance Audit Binder.	Completion Date: 01/08/2025 Status: APPROVED Date: 01/10/2025

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K 0353 SS=E	Continued from page 20 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: Based on document review and interview, it was determined the facility failed to maintain and inspect the sprinkler systems, affecting the entire facility. Findings include: Observation on December 18, 2024, at 12:40 p.m., inside C wing supply closet that there was physical damage to the ceiling grid and sprinkler escutcheon around the sprinkler head. Exit Interview with the Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed ceiling and sprinkler escutcheon damage.	K 0353		

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K 0371 SS=C	<p>NFPA 101 Subdivision of Building Spaces - Smoke Compar</p> <p>Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING</p> <p>Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2</p> <p>Detail in REMARKS zone dimensions including length of zones and dead-end corridors.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0371	Ken Walters, Director of Maintenance, will contact the Department of Health to request a FSES	<p>Completion Date: 01/08/2025</p> <p>Status: APPROVED</p> <p>Date: 01/10/2025</p>
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K 0371 SS=C	Continued from page 22 Based on document review and interview, it was determined the facility failed to provide smoke compartments not greater than 22,500 square feet, with a travel distance not to exceed 200 feet, affecting one of four smoke compartments. Findings include: Observation and document review on December 18, 2024, between 8:00 a.m. and 11:30 a.m., revealed smoke compartments, front and back hallways, exceed 22,500 square feet in length. Exit Interview with the Administrator and Maintenance Director on December 18, 2024, at 1:45 p.m., confirmed the B Wing smoke compartment exceeded 22,500 square feet.	K 0371		
K 0372 SS=E		K 0372		

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K 0372 SS=E	Continued from page 23 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	Fire caulk has been used to fill in the opening Created by the installation of the Data Line. Maintenance will check smoke barriers on a routine monthly basis and document findings in the Maintenance Audit Book. All penetrations have been and will be corrected moving forward using an UL approved stop gap penetration system.	Completion Date: 01/08/2025 Status: APPROVED Date: 01/14/2025

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K 0372 SS=E	Continued from page 24 Based on observation and interview, it was determined that the facility failed to ensure that smoke barrier walls were complete and maintained free of unsealed penetrations one of two levels within this facility. Findings include: Observations made on December 18, 2024, at 12:15 p.m., revealed next to room 110, unsealed penetrations above smoke barrier doors due to a newly run data line. Exit Interview with the Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed the unsealed penetration.	K 0372		
K 0511 SS=E		K 0511		

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K 0511 SS=E	Continued from page 25 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	A GFCI has been installed in the Ladies Locker Room. Maintenance will check quarterly to make sure all GFCIs are working properly. All checks will be documented in the Maintenance Audit Log.	Completion Date: 01/08/2025 Status: APPROVED Date: 01/13/2025

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K 0511 SS=E	Continued from page 26 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 one of two levels. Findings include: Observation on December 18, 2024, at 11:43 a.m., revealed, in woman's room/ locker room, 1 non-GFCI outlet located within 6 feet of a sink. Per NFPA 70 210.8(B)5, a GFCI outlet is required where receptacles are installed within 6 ft of the outside edge of the sink. Exit Interview with the Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed non-GFCI outlet in the woman's room.	K 0511		

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K 0712 SS=E	<p>NFPA 101 Fire Drills</p> <p>Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0712	<p>While paperwork was present there was missing information. Fire Drill paperwork will be completely redone by January 15th, 2025, to fill in the missing information. Information will be checked monthly for accuracy</p>	<p>Completion Date: 01/08/2025</p> <p>Status: APPROVED</p> <p>Date: 01/13/2025</p>

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K 0712 SS=E	Continued from page 28 Based on document review and interview, it was determined the facility failed to conduct fire drills once per shift per quarter, affecting the entire facility. Finding Include: Document review on December 18, 2024, between 8:00 a.m. and 11:30 a.m., revealed the facility could not produce correct and accurate shift and staff participation documentation of monthly fire drills for months July 2024 thru November 2024. Exit Interview with the Facility Administrator, Administrator in training, and the Director of Maintenance, on December 18, 2024, at 1:45 p.m., confirmed the reuse of shift and participation documentation for July through November 2024.	K 0712		
K 0911 SS=E		K 0911		

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K 0911 SS=E	Continued from page 29 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	The electrical panel has been replaced. Maintenance will check all electrical panels quarterly to make sure all covers in place. Findings will be documented in the Maintenance Audit Log.	Completion Date: 01/08/2025 Status: APPROVED Date: 01/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
NAME OF PROVIDER OR SUPPLIER: LUTHER WOODS NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 313 W COUNTY LINE ROAD HATBORO, PA 19040		
STATE LICENSE NUMBER: 640302				
(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 0911 SS=E	Continued from page 30 Based on observation and interview, the facility failed to maintain and inspect electrical system requirements, per NFPA 70 and NFPA 99, on one of two levels of facility. Findings include: Observation on December 18, 2024, at 11:43 a.m., in the basement, in the electrical room revealed an electrical panel without and electrical panel cover. Reference: NFPA 70-314.17, NFPA 70-314.28 (C), and NFPA 300.11 Exit Interview with the Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed the electrical panel without a cover.	K 0911		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024	
NAME OF PROVIDER OR SUPPLIER: LUTHER WOODS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 640302		STREET ADDRESS, CITY, STATE, ZIP CODE: 313 W COUNTY LINE ROAD HATBORO, PA 19040		
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K 0918 SS=F	Continued from page 31 NFPA 101 Electrical Systems - Essential Electric System 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 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	K 0918	An outside vendor was brought in to do required testing on our generator: Annual Fuel Quality and 3 year, 4 hour load test. We were told the report would be given to us by January 22nd, 2025. The over cranking was repaired the same day as the survey.	Completion Date: 01/22/2025 Status: APPROVED Date: 01/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
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NAME OF PROVIDER OR SUPPLIER: LUTHER WOODS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 640302	STREET ADDRESS, CITY, STATE, ZIP CODE: 313 W COUNTY LINE ROAD HATBORO, PA 19040
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K 0918 SS=F	Continued from page 32 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024	
NAME OF PROVIDER OR SUPPLIER: LUTHER WOODS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 640302		STREET ADDRESS, CITY, STATE, ZIP CODE: 313 W COUNTY LINE ROAD HATBORO, PA 19040		
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K 0918 SS=F	Continued from page 33 Based on observation, document review, and interview, it was determined the facility failed to maintain and inspect the emergency generator, affecting the entire facility. Findings include: 1. Document review on December 18, 2024, between 8:00 a.m., and 11:30 a.m., revealed the facility could not provide documentation of the following tests and inspections: a) Annual Fuel Quality Test. b) 3 year, 4 hour load test 2. Observation on December 18, 2024 between 11:30 a.m. and 1:45 p.m. ,revealed that the newly installed generator was in alarm for "over-cranking". Exit Interview with the Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed the missing documentation and that the emergency	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
NAME OF PROVIDER OR SUPPLIER: LUTHER WOODS NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 313 W COUNTY LINE ROAD HATBORO, PA 19040		
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K 0918 SS=F	Continued from page 34 generator was in alarm during survey.	K 0918		
K 0920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 0920	All extension cords were removed from Holiday decorations the day of the survey. Power strips were removed and replaced with hospital grade outlet extenders. Office hand dryer will be removed and replaced with paper towels by Friday, January 10th, 2025. Maintenance will do random audits to check facility for continued compliance.	Completion Date: 01/08/2025 Status: APPROVED Date: 01/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
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NAME OF PROVIDER OR SUPPLIER: LUTHER WOODS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 640302	STREET ADDRESS, CITY, STATE, ZIP CODE: 313 W COUNTY LINE ROAD HATBORO, PA 19040
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K 0920 SS=E	Continued from page 35 This REQUIREMENT is not met as evidenced by:	K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024	
NAME OF PROVIDER OR SUPPLIER: LUTHER WOODS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 640302		STREET ADDRESS, CITY, STATE, ZIP CODE: 313 W COUNTY LINE ROAD HATBORO, PA 19040		
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K 0920 SS=E	Continued from page 36 Based on observation and interview, it was determined the facility failed to ensure that electrical wiring and equipment was maintained and the improper and unauthorized use of power strips, extension cords, and outlet multipliers are prohibited on one of two levels within this component Observations on December 18, 2024, revealed between 11:30 a.m and 1:45 p.m: a) Lobby: Two outside lighted decorative Christmas trees were being powered by extension cords through windows. b) Environmental services: Orange extension cord in use. c) Laundry room: Refrigerator plugged into power strip. d) Main office bathroom: (Plug in not hardwired) Heat/ blower hand dryer utilized power from an outlet multiplier located in adjacent hallway. e) Administrator office: Refrigerator and microwave plugged into power strip.	K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024	
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K 0920 SS=E	Continued from page 37 Exit Interview with the Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed the use of prohibited electrical devices at time of survey	K 0920		
K 0923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are	K 0923	All observations were corrected the same day as the survey. Maintenance will check weekly times one month for compliance and then will check quarterly. All audits will be documented in the Maintenance Log.	Completion Date: 01/08/2025 Status: APPROVED Date: 01/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
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K 0923 SS=E	Continued from page 38 not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		
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K 0923 SS=E	Continued from page 39 Based on observation and interview, it was determined the facility failed to maintain oxygen / gas cylinder storage, affecting one of two levels. Findings include: Observation on December 18, 2024, revealed freestanding oxygen / gas cylinders in the following locations: a) 1:15 p.m., C wing oxygen room. 3 oxygen cylinders. b) 1:30 p.m., Activities Room: 2 helium tanks. c) 12: 35 p.m. B Wing oxygen room. Door propped open with a full to capacity oxygen cylinder storage rack. Exit Interview with the Administrator, Administrator in training, and the Director of Maintenance on December 18, 2024, at 1:45 p.m., confirmed the freestanding cylinders and propped door utilizing oxygen storage as door stop.	K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 12/18/2024
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K 0923 SS=E	Continued from page 40	K 0923			



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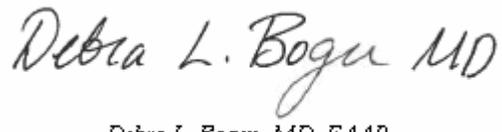
LUTHER WOODS NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 640302

SURVEY EXIT DATE: 12/18/2024

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

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