STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395449	A. BLDG: __--_____ B. WING: _____	12/23/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHAPEL MANOR STATE LICENSE NUMBER: **031602**	**1104 WELSH ROAD PHILADELPHIA, PA 19115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on December 23, 2024, it was determined that Chapel Manor had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0004 SS=C		E 0004		

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 0004 SS=C	Continued from page 1 483.73(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency	E 0004	Emergency preparedness plan has been reviewed and updated for 2024-2025 Maintenance Dir/designee will re-educate maintenance staff on timely updates and to keep the EPP book in one location. NHA/designee will complete quarterly audits to ensure EPP manual is updated and and its proper location Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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E 0004 SS=C	Continued from page 2 preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by:	E 0004		

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E 0004 SS=C	Continued from page 3 Based on documentation review and interview, it was determined the facility failed to ensure Emergency Preparedness Plan policies and procedures were reviewed and updated at least annually, affecting the entire facility. Findings include: Document review on December 23, 2024, at 8:30 a.m., revealed the Facility's Emergency Preparedness Plan had not been reviewed and updated at least annually. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the Emergency Preparedness Plan had not been reviewed and updated.	E 0004		
E 0007 SS=C		E 0007		

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E 0007 SS=C	Continued from page 4 483.73(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	Emergency preparedness plan has been reviewed and updated to include policies and procedures for person at risk has been reviewed and updated in the manual NPE/designee will re-educate maintenance staff on timely updates and to keep the EPP book in the maintenance office. NHA/designee will complete weekly audits to ensure EPP manual is updated and and its proper location Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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E 0007 SS=C	Continued from page 5 facilities.] This REQUIREMENT is not met as evidenced by:	E 0007		

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E 0007 SS=C	Continued from page 6 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 December 23, 2024, at 8:30 a.m., revealed the Facility's Emergency Preparedness Plan did include policies and procedures that addressed persons at-risk. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of documentation.	E 0007		

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E 0025 SS=C	483.73(b)(7) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(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:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7)	E 0025	Emergency preparedness plan has been reviewed and updated to include facility has made arrangements with other facilities and providers to receive residents in event of an emergency NPE/designee will re-educate maintenance staff on timely updates for policies and procedures relating to arrangements for residents in the event of an emergency NHA/designee will complete weekly audits to ensure EPP manual is updated and facility has made arrangements with other facilities and providers to receive residents in event of an emergency Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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E 0025 SS=C	Continued from page 8 The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by:	E 0025		

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E 0025 SS=C	Continued from page 9 Based on documentation review and interview, it was determined the facility failed to provide arrangements with other facilities, affecting the entire component. Findings include: Documentation review on December 23, 2024, at 8:30 a.m., revealed the facility failed to provide arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of arrangements with other facilities.	E 0025		

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E 0035 SS=C	483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by:	E 0035	Emergency preparedness plan has been reviewed and updated to include communication/notification to residents/representatives in an emergency situation Maintenance Dir/designee will re-educate maintenance staff on timely updates for policies and procedures relating to communication/notification to residents/representatives in an emergency situation NHA/designee will complete weekly audits x1 and monthly x2 to ensure EPP manual is updated and Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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E 0035 SS=C	Continued from page 11 Based on document review and interview, it was determined the facility failed to maintain and update an emergency preparedness communication plan that includes a method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families or representatives, affecting the entire facility. Findings include: Document review and interview on December 23, 2024, at 8:30 a.m., revealed the emergency communications plan did not include a method of sharing information from the emergency plan with residents and their families or representatives. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of documentation.	E 0035		

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E 0036 SS=C	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 reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The	E 0036	Emergency preparedness plan has been reviewed and updated to include the EPP training and testing staff based on the emergency plan Maintenance Dir/designee will re-educate maintenance staff on timely updates for policies and procedures relating to training and testing staff based on the emergency plan NHA/designee will complete weekly audits x1 and monthly x2 to ensure compliance. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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E 0036 SS=C	Continued from page 13 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		

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E 0036 SS=C	Continued from page 14 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 December 23, 2024, at 8:30 a.m., revealed the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of training and testing program.	E 0036		

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	395449	A. BLDG: __--_____ B. WING: _____	12/23/2024

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CHAPEL MANOR STATE LICENSE NUMBER: **031602**	**1104 WELSH ROAD PHILADELPHIA, PA 19115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0039 SS=C	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: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 0039	Emergency preparedness plan has been reviewed and updated to include an annual full scale/ table to review exercise. Maintenance Dir/designee will re-educate maintenance staff on timely updates for policies and procedures relating to annual full scale/ table to review exercise. NHA/designee will complete weekly audits x1 and monthly x2 to ensure annual full scale/ table to review exercise. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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E 0039 SS=C	Continued from page 16 (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 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		

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E 0039 SS=C	Continued from page 17 (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 (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	E 0039		

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E 0039 SS=C	Continued from page 18 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 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	E 0039		

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E 0039 SS=C	Continued from page 19 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 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	E 0039		

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E 0039 SS=C	Continued from page 20 (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. (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	E 0039		

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E 0039 SS=C	Continued from page 21 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. (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	E 0039		

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E 0039 SS=C	Continued from page 22 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. (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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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E 0039 SS=C	Continued from page 23 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 following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency	E 0039		

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E 0039 SS=C	Continued from page 24 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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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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 the Emergency Plan's required annual-full scale exercise or accepted substitution and the required additional exercise or accepted substitution, affecting the entire facility. Findings include: Document review on December 23, 2024, at 8:30 a.m., revealed the facility failed to conduct an annual full-scale exercise or accepted substitution and an additional exercise or accepted substitution within the previous 12 months. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of emergency preparedness exercises.	E 0039		

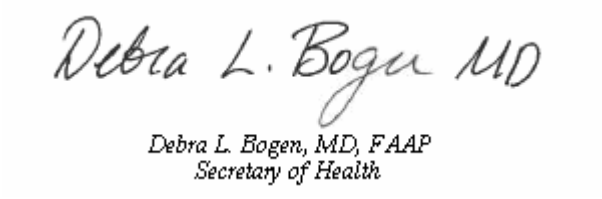
Certified End Page

CHAPEL MANOR

STATE LICENSE NUMBER: 031602

SURVEY EXIT DATE: 12/23/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0000	INITIAL COMMENT Facility ID# 031602 Component 01 Based on a Medicare/Medicaid Recertification Survey completed on December 23, 2024, it was determined that Chapel Manor was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two-story, Type II (222), fire resistive building, with a basement, that is fully sprinklered.	K 0000		
K 0100 SS=C		K 0100		

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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0100 SS=C	Continued from page 1 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	Carbon monoxide alarm evacuation plan has been completed NPE/designee will re-educate maintenance staff on timely completion of carbon monoxide evacuation Maintenance dir/designee will complete monthly x3 to ensure annual full scale/ table to review exercise. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0100 SS=C	Continued from page 2 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: Document review on December 23, 2024, at 8:30 a.m., revealed the facility failed to provide a carbon monoxide alarm evacuation plan. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed lack of documentation.	K 0100		
K 0291 SS=F		K 0291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395449	A. BLDG: __01_____ B. WING: _____	12/23/2024

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CHAPEL MANOR STATE LICENSE NUMBER: **031602**	**1104 WELSH ROAD PHILADELPHIA, PA 19115**

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K 0291 SS=F	Continued from page 3 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	Monthly 30 second testing and annual 90 minute testing Emergency lighting system has been inspected and documentation is kept in equipment maintenance binder Maintenance Dir/designee will re-educate maintenance staff on timely inspection of emergency lighting system monthly and annually Maintenance dir/designee will complete monthly x3 Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/16/2025**

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K 0291 SS=F	Continued from page 4 Based on document review and interview, it was determined the facility failed to maintain and inspect emergency lighting, affecting the entire facility. Findings include: Document review on December 23, 2024, at 8:30 a.m., revealed the facility could not provide documentation of the following: a. Monthly 30 second testing; b. Annual 90 minute testing. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of documentation.	K 0291		
K 0293 SS=F		K 0293		

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K 0293 SS=F	Continued from page 5 NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	The monthly Exit signage inspection have been completed NPE/designee will re-educate maintenance staff on maintaining the monthly inspection documentation NHA/designee will complete monthly audits to ensure compliance. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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K 0293 SS=F	Continued from page 6 Based on document review and interview, it was determined the facility failed to maintain exit signage, affecting the entire facility. Findings include: Document review on December 23, 2024, at 8:30 a.m., revealed the facility could not provide documentation of monthly exit sign testing after March of 2024. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of documentation.	K 0293		
K 0324 SS=E		K 0324		

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K 0324 SS=E	Continued from page 7 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	Documentation for the semi-annual kitchen exhaust hood/duct has been completed and placed in the life safety book Maintenance Dir/designee will re-educate maintenance staff on maintaining the monthly inspection documentation on kitchen hood/exhaust NHA/designee will complete monthly audits to ensure compliance. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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K 0324 SS=E	Continued from page 8 Based on document review, observation, and interview, it was determined the facility failed to maintain and inspect the kitchen hood suppression system, affecting one of three levels. Findings include: 1. Document review on December 23, 2024, at 8:30 a.m., revealed the facility could not provide documentation of a semi-annual kitchen exhaust hood/duct cleaning since December 17, 2023. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of documentation. 2. Observation on December 23, 2024, at 10:34 a.m., revealed in the Basement Kitchen, the kitchen hood suppression system lacked monthly inspections. Exit interview with the Assistant Administrator and	K 0324		

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K 0324 SS=E	Continued from page 9 the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of monthly inspections.	K 0324		
K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	Documentation for the quarterly sprinkler inspection has been completed and placed in the life safety book Maintenance Dir/designee will re-educate maintenance staff on maintaining quarterly inspection documentation on sprinkler system NHA/designee will complete monthly audits to ensure compliance. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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K 0353 SS=E	Continued from page 10 Based on document review and interview, it was determined the facility failed to maintain and inspect the sprinkler system, affecting one of four quarters. Findings include: Document review on December 23, 2024, at 8:30 a.m., revealed the facility could not provide documentation of a quaterly sprinkler inspection for the third quarter. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of documentation.	K 0353		
K 0355 SS=F		K 0355		

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K 0355 SS=F	Continued from page 11 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	Annual portable fire extinguisher inspection has been completed. Certification of the inspector has been placed in the life safety book Portable fire extinguisher in the basement electrical/data room has been completed Maintenance Dir/designee will re-educate maintenance staff on maintaining monthly and annual inspection of portable fire extinguisher NHA/designee will complete monthly audits to ensure compliance. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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K 0355 SS=F	Continued from page 12 Based on document review, observation, 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 December 23, 2024, at 8:30 a.m., revealed the facility could not provide documentation of the following: a. Annual portable fire extinguisher maintenance/inspection; b. Certification of the inspector conducting the annual inspection. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of documentation. 2. Observation on December 23, 2024, at 10:39 a.m., revealed in the Basement Electrical/Data	K 0355		

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K 0355 SS=F	Continued from page 13 Room, the portable fire extinguisher lacked monthly inspections after September of 2024. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of monthly inspections.	K 0355		
K 0511 SS=E		K 0511		

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K 0511 SS=E	Continued from page 14 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	Electrical wiring in the elevator room has been repaired Maintenance Dir/designee will re-educate maintenance staff on maintaining wiring are not exposed Maintenance dir/designee will complete initial audit to ensure electrical wires are not exposed NHA/designee will complete weekly audits x3 and monthly x 1 to ensure compliance. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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K 0511 SS=E	Continued from page 15 Based on observation and interview, it was determined the facility failed to maintain and protect electrical wiring in accordance with NFPA 70, affecting one of three levels in the facility. Findings include: Observation on December 23, 2024, at 10:40 a.m., revealed in the Basement, in Elevator Machine Room, the covers were not mounted on the elevator control panels. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the missing covers.	K 0511		
K 0712 SS=E		K 0712		

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K 0712 SS=E	Continued from page 16 NFPA 101 Fire Drills Fire Drills 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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	Fire drills will be conducted monthly for all three shifts quarterly. Maintenance Dir/designee will re-educate maintenance staff on conducting fire drills on every shift quarterly. NHA/designee will complete monthly audits to ensure compliance. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

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K 0712 SS=E	Continued from page 17 Based on document review and interview, it was determined the facility failed to properly document required fire drills, affecting three of twelve shifts. Findings include: Document review on December 23, 2024, 8:30 a.m., revealed the facility failed to document the following fire drills: a. 2nd quarter, 3rd shift; b. 4th quarter, 1st shift; c. 4th quarter, 2nd shift. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the missing fire drills.	K 0712		

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K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	The generator will be visually inspected weekly. Battery voltage will be weekly inspected Annual 90 min load bank and fuel quality has been completed 3 year, 4 hour load test will be completed timely. Maintenance Dir/designee will re-educate maintenance staff on proper maintenance of the generator NHA/designee will complete weekly audits x 3 and monthly audits x1 to ensure compliance. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/21/2025**

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K 0918 SS=F	Continued from page 19	K 0918		

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CHAPEL MANOR STATE LICENSE NUMBER: **031602**	**1104 WELSH ROAD PHILADELPHIA, PA 19115**

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K 0918 SS=F	Continued from page 20 Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator, affecting the entire facility. Findings include: Document review on December 23, 2024, at 8:30 a.m., revealed the facility could not provide document of the following tests and inspections: a. Weekly visual inspections; b. Weekly battery electrolyte level or battery voltage; c. Annual 90 minute load bank; d. 3 year, 4 hour load test; e. Annual fuel quality test. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the lack of documentation.	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395449	A. BLDG: 01 B. WING:	12/23/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHAPEL MANOR STATE LICENSE NUMBER: **031602**	**1104 WELSH ROAD** **PHILADELPHIA, PA 19115**

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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 This REQUIREMENT is not met as evidenced by:	K 0920	Electrical power strips/extension cords have been removed from 1st floor nurses station and Scheduler's office Maintenance Dir/designee will re-educate staff to reframe from using power strips/extension cords Maintenance Dir/designee will complete initial audits to ensure no power strips/extension cords are being used Maintenance will conduct random weekly audits of 5 offices/rooms to ensure no power strips/extension are being used Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: **02/17/2025** Status: **APPROVED** Date: **01/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395449	A. BLDG: __01_____ B. WING: _____	12/23/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHAPEL MANOR STATE LICENSE NUMBER: **031602**	**1104 WELSH ROAD PHILADELPHIA, PA 19115**

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K 0920 SS=E	Continued from page 22 Based on observation and interview, it was determined the facility failed to prohibit the use of power strips and electrical extension cords, affecting two of three levels in the facility. Findings include: Observations on December 23, 2024, between 10:09 a.m. and 10:27 a.m., revealed the following: a. 10:09 a.m., on the first floor, Nurse Manager Office, a coffee pot plugged into an outlet strip; b. 10:27 a.m., in the Basement Manager of Center Scheduling office, a refrigerator plugged into an outlet strip. Exit interview with the Assistant Administrator and the Maintenance Director on December 23, 2024, at 11:00 a.m., confirmed the above deficiencies.	K 0920		

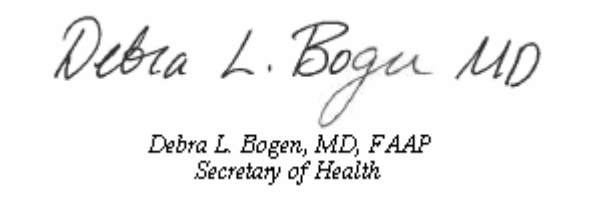
Certified End Page

CHAPEL MANOR

STATE LICENSE NUMBER: 031602

SURVEY EXIT DATE: 12/23/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY