STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395461	A. BLDG: __--_____ B. WING: _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
TUCKER HOUSE NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **369402**	**1001-11 WALLACE STREET PHILADELPHIA, PA 19123**

(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 12, 2024, at Tucker House Nursing and Rehabilitation Center it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

TUCKER HOUSE NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 369402

SURVEY EXIT DATE: 12/12/2024

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
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0000	INITIAL COMMENT Facility ID #369402 Component 01 Based on a Medicare/Medicaid Recertification Survey completed on December 12, 2024, it was determined that Tucker House 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). This is a four-story, Type II (222), fire resistive building, ground, Second, Third, Fourth floors, and basement, that is fully sprinklered.	K 0000		

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

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K 0211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	Padlocks removed to ensure means of egress NHA will educate the Maintenance Director on maintaining means egress. An initial audit was completed to ensure means of egress throughout the facility. NHA/designee will audit weekly x 4, then monthly X 3. Findings will be reviewed in the monthly QAPI.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **12/20/2024**

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K 0211 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain the means of egress on one of five floors. Findings include; 1. Observation on December 12, 2024, at 11:22 a.m., revealed the right side exit door from the ground floor dining room was fitted with a padlock on the corridor side. This door is designated as an exit with an illuminated exit sign in the dining room. Interview at the time of the exit conference on December 12, 2024, at 11:45 a.m., with the administrator, maintenance representative, and regional facility representative confirmed the exit was locked against egress.	K 0211		
K 0225 SS=E		K 0225		

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K 0225 SS=E	Continued from page 3 NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	Stair tower door fixed to ensure positive latch, environmental supplies removed from stair tower. NHA educated the Maintenance Director on maintaining stair towers. An initial audit was completed to ensure maintenance of the stair towers. NHA/designee will audit weekly x 4, then monthly X 3. Findings will be reviewed in the monthly QAPI.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **12/20/2024**

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K 0225 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain stairways in two locations affecting two of five floors. Findings include; 1. Observation on December 12, 2024, at 10:23 a.m., revealed the 3rd floor ,South stairtower door failed to latch in the frame when tested. Interview at the time of the exit conference on December 12, 2024, at 11:45 a.m., with the administrator, maintenance representative, and regional facility representative confirmed the door lacked positive latching. 2. Observation on December 12, 2024, at 11:18 a.m., revealed environmental services supplies were being stored in the East stairtower on the ground floor. Interview at the time of the exit confrence on December 12, 2024, at 11:45 a.m., with the	K 0225		

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K 0225 SS=E	Continued from page 5 administrator, maintenance representative, and regional facility representative confirmed the wet floor signs and various supplies were being stored in the stair tower.	K 0225		
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 0321	The doors observed were fixed to ensure self-closing and positive latching. NHA educated the Maintenance Director on maintaining doors to hazardous areas. An initial audit was completed to ensure self-closing and positive latching of doors to hazardous areas. NHA/designee will audit weekly x 4, then monthly X 3. Findings will be reviewed in the monthly QAPI.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **12/20/2024**

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K 0321 SS=E	Continued from page 6 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain doors to hazardous areas on two of five floors. Findings include: 1. Observation on December 12, 2024, between 10:58 a.m., and 11:13 a.m., revealed the following hazardous area doors failed to latch in the corresponding frame or lacked self closing capabilities: a. At 10:58 a.m., basement level medical waste room. b. At 10:59 a.m., basement level elevator equipment room. c. At 11:13 a.m., the Business office on the ground floor contained excess combustible storage without a self or automatic closing door. Interview at the time of the exit conference on December 12, 2024, at 11:45 a.m., with the administrator, maintenance representative, and regional facility representative confirmed the	K 0321		

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K 0321 SS=E	Continued from page 8 hazardous area door deficiencies.	K 0321		
K 0325 SS=E	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 0325	The hand sanitizer dispenser was removed. NHA educated the Maintenance Director on monitoring the location and installation of alcohol-based hand rub dispensers. An initial audit was completed to ensure location and installation of all alcohol-based hand rub dispensers. NHA/designee will audit weekly x 4, then monthly X 3. Findings will be reviewed in the monthly QAPI.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **12/20/2024**

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K 0325 SS=E	Continued from page 9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to monitor the location and installation of alcohol based hand rub dispensers (ABHR) on one of five floors. Findings include: 1. Observation on December 12, 2024, at 10:18 a.m., revealed an alcohol based hand rub dispenser installed directly over a light switch in the 3rd floor dining room. Interview at the time of the exit conference on December 12, 2024, at 11:45 a.m., with the administrator, maintenance representative, and regional facility representative confirmed the ABHR was installed to close to an ignition source.	K 0325		

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K 0363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 0363	All the observed doors were fixed to ensure positive latch and smoke tightness. NHA educated the Maintenance Director on maintaining corridor doors. An initial audit was completed to ensure positive latch and smoke tightness of corridor doors. NHA/designee will audit weekly x 4, then monthly X 3. Findings will be reviewed in the monthly QAPI.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **12/20/2024**

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K 0363 SS=E	Continued from page 11 This REQUIREMENT is not met as evidenced by:	K 0363		

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K 0363 SS=E	Continued from page 12 Based on observation and interview, it was determined the facility failed to maintain corridor doors on three of five floors. Findings include: 1. Observation on December 12, 2024, between 9:50 a.m., and 10:48 a.m., revealed the following corridor doors were not smoke tight when latched or failed to positively latch in the frame. a. At 9:50 a.m., 4th floor room 419, not smoke tight. b. At 10:11 a.m., 3rd floor nurse lounge no latch. c. At 10:33 a.m., room 203, 2nd floor, no latch. d. At 10:38 a.m., room 217, 2nd floor, not smoke tight. e. At 10:48 a.m., room 227, 2nd floor, not smoke tight. Interview at the time of the exit confrence on December 12, 2024, at 11:45 a.m., with the administrator, maintenance representative, and	K 0363		

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K 0363 SS=E	Continued from page 13 regional facility representative confirmed the corridor door deficiencies.	K 0363		
K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	The east corridor smoke barrier doors were fixed to close smoke tight. NHA educated the Maintenance Director on maintaining smoke barrier doors. An initial audit was completed to ensure smoke tightness of all smoke barrier doors. NHA/designee will audit weekly x 4, then monthly X 3.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **12/20/2024**

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K 0374 SS=E	Continued from page 14 Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors on one of five floors. Findings include: 1. Observation on December 12, 2024, at 10:12 a.m., revealed the East corridor smoke barrier doors failed to close smoke tight. Interview at the time of the exit confrence on December 12, 2024, at 11:45 a.m., with the administrator, maintenance representative, and regional facility representative confirmed the doors did not fit together smoke tight.	K 0374		
K 0912 SS=D		K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395461	A. BLDG: 01 B. WING:	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0912 SS=D	Continued from page 15 NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0912	An outlet cover was installed in the Nurse lounge on the 4th floor. NHA educated the Maintenance Director on maintaining electrical outlets. An initial audit was completed to ensure compliance of electrical outlets. NHA/designee will audit weekly x 4, then monthly X 3. Findings will be reviewed in the monthly QAPI.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **12/20/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395461	A. BLDG: __01_____ B. WING: _____	12/12/2024

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K 0912 SS=D	Continued from page 16 Based on observation and interview, it was determined the facility failed to maintain electrical outlets in one location in one of nine smoke compartments. Findings include: 1. Observation on December 12, 2024, at 9:56 a.m., revealed an outlet cover missing in the Nurse lounge on the 4th floor. Interview at the time of the exit confrence on December 12, 2024, at 11:45 a.m., with the administrator, maintenance representative, and regional facility representative confirmed the outlet cover was missing.	K 0912		

Certified End Page

TUCKER HOUSE NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 369402

SURVEY EXIT DATE: 12/12/2024

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
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