

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: -- B. WING: --	(X3) DATE SURVEY COMPLETED: 12/30/2024
NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063		
STATE LICENSE NUMBER: 390102				
(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 Based on an Emergency Preparedness Survey completed on December 30, 2024, at Wesley Enhanced Living Main Line Rehab and Skilled Nursing, 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

WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING

STATE LICENSE NUMBER: 390102

SURVEY EXIT DATE: 12/30/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063
STATE LICENSE NUMBER: 390102	

(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 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 390102 Component 01 Care Center Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 30, 2024, it was determined that Wesley Enhanced Living Main Line Rehab And Skilled Nursing was not in compliance with the following requirements of the Life Safety Code for a 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 II (000), noncombustible construction building, that is fully sprinklered.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063		
STATE LICENSE NUMBER: 390102				
(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 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 penetrations were repaired using approved fireproof caulk. The Facility Director will inspect and audit all fire doors to ensure there is no penetrations. Audits will be conducted at time of repair and then quarterly thereafter.	Completion Date: 01/13/2025 Status: APPROVED Date: 01/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063		
STATE LICENSE NUMBER: 390102				
(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 0374 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to ensure doors in smoke barrier walls were maintained to resist the passage of smoke, affecting one of one level. Findings include: Observation on December 30, 2024, between 10:45 a.m., and 12:00 p.m. revealed, one of the double smoke doors, next to nurses station, had two hole penetrations through both sides of door, above the door closer. Interview at the exit conference with the Executive Director on December 30, 2024, at 12:00 p.m., confirmed the door holes.	K 0374		
K 0912 SS=E		K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING STATE LICENSE NUMBER: 390102	STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063
---	--

(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 0912 SS=E	Continued from page 3 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	The ground fault circuit interrupter (GFCI) receptacle in room 142 was replaced on 01/13/2025. The Facility Director or appointee will inspect, test, and audit all GFCI receptacles at time of repair and then quarterly thereafter.	Completion Date: 01/13/2025 Status: APPROVED Date: 01/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024	
NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING STATE LICENSE NUMBER: 390102		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063		
(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 0912 SS=E	<p>Continued from page 4</p> <p>Based on observation and interview, the facility failed to maintain electric systems in wet locations, affecting one level.</p> <p>Findings include:</p> <p>1. Observation on December 30, 2024, between 10:45 a.m. and 12:00 p.m., revealed, in resident room 142 that the Ground Fault Circuit Interrupter (GFCI) receptacle next to sink was damaged.</p> <p>Interview at the exit conference with the Executive Director on December 30, 2024, at 12:00 p.m., confirmed the damaged GFCI receptacle.</p> <p>Based on observation and interview, the facility failed to maintain electric receptacles affecting one level.</p> <p>2. Observation on December 30, 2024, between 10:45 a.m. and 12:00 p.m., revealed, in resident room 112 there was a electrical receptacle pulling</p>	K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063		
STATE LICENSE NUMBER: 390102				
(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 0912 SS=E	Continued from page 5 out of electrical box behind TV stand and a missing blank receptacle cover at the bottom right of the P-Tec, close to floor. Interview at the exit conference with the Executive Director on December 30, 2024, at 12:00 p.m., confirmed the damaged receptacles.	K 0912		
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	K 0920	The space heater was removed the day of inspection (12-30-2024). The extension cord in room 112 was removed on 1-14-2025. The Facility Director, or appointee, will inspect, and audit each room weekly to ensure space heaters and extension cords are not plugged into power strips.	Completion Date: 01/18/2025 Status: APPROVED Date: 01/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING STATE LICENSE NUMBER: 390102	STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063
---	--

(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 0920 SS=E	Continued from page 6 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024	
NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING STATE LICENSE NUMBER: 390102		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063		
(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 0920 SS=E	<p>Continued from page 7</p> <p>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 one level.</p> <p>Observations on December 30, 2024, revealed between 10:45 a.m and 12:00 p.m:</p> <p>a) DON office: Space heater plugged into power strip.</p> <p>b) Resident Room 112: Yellow extension cord powering a power strip with an orange extension cord powering another power strip, providing power to a TV.</p> <p>Interview at the exit conference with the Executive Director on December 30, 2024, at 12:00 p.m., confirmed the extension cords providing power to power strips.</p>	K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063		
STATE LICENSE NUMBER: 390102				
(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 0920 SS=E	Continued from page 8	K 0920		
K 0923 SS=E	<p>NFPA 101 Gas Equipment - Cylinder and Container Storage</p> <p>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.</p> <p>>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.</p> <p>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 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</p>	K 0923	<p>The door closer was adjusted on 01-06-2025 allowing the door to latch securely.</p> <p>The Facility Director, or appointee, will inspect and all storage room doors to ensure positive latching and closing properly at time of repair and then quarterly thereafter.</p>	<p>Completion Date: 01/06/2025 Status: APPROVED Date: 01/17/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063		
STATE LICENSE NUMBER: 390102				
(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 0923 SS=E	Continued from page 9 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: --+++++	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/30/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING STATE LICENSE NUMBER: 390102	STREET ADDRESS, CITY, STATE, ZIP CODE: 100 HALCYON DRIVE MEDIA, PA 19063
---	--

(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 0923 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain oxygen cylinder storage, on one of one level. Findings include: Observation on December 30, 2024, between 10:45 a.m. and 12:00 p.m., revealed the Meadow's oxygen storage room door did not latch and could not be secured. Interview at the exit conference with the Executive Director on December 30, 2024, at 12:00 p.m., confirmed the door did not latch.	K 0923		



Certified End Page

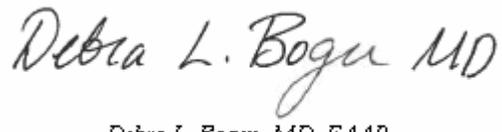
WESLEY ENHANCED LIVING MAIN LINE REHAB AND SKD NURSING

STATE LICENSE NUMBER: 390102

SURVEY EXIT DATE: 12/30/2024

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