STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395521	A. BLDG: __--_____ B. WING: _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LANGHORNE GARDENS HEALTH & REHABILITATION CENTER STATE LICENSE NUMBER: **120702**	**350 MANOR AVENUE LANGHORNE, PA 19047**

(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 November 14, 2024, at Langhorne Gardens Health & 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

LANGHORNE GARDENS HEALTH & REHABILITATION CENTER

STATE LICENSE NUMBER: 120702

SURVEY EXIT DATE: 01/08/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
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# 120702 Component 01 Based on a Revisit to a Medicare/Medicaid Recertification Survey completed on November 14, 2024, it was determined that Langhorne Gardens Health & Rehabilitation Center was not in substantial compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type V (000), unprotected wood frame building, that is fully sprinklered.	K 0000		

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

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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	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	Facility currently working with company Holstein and white to get plans submitted. 2.Plans were submitted on 12/5/2024.Tracking number #47765. 3. To prevent reoccurrence NHA educated environmental service director on the importance of collaborating with the corporate team to make sure correct procedures are followed. 4. NHA or Designee will check in with engineer company 1x monthly for an update on the submitted plans. All trends are brought to QAPI for further action	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/22/2025**

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 observation, interview, and documentation review, it was determined the facility failed to obtain required Pennsylvania Department of Health plan approval for changes to the facility's existing emergency power generator system, affecting the entire facility. Findings include: Observation, interview, and documentation review on November 14, 2024, between 8:30 a.m. and 11:30 a.m., revealed that the facility failed to obtain plan approval by the Department of Health (Department) prior to initiating alterations to the facilities emergency power generator system. Interview at the exit conference with the Director of Nursing and the Maintenance Director on November 14, 2024, at 2:30 p.m., confirmed the facility failed to secure plan approval by the Department of Health prior to initiating alterations. Reference: 28 Pa Code § 51.3. Notification (d)	K 0100		

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K 0100 SS=C	Continued from page 3 ********** Observations during an onsite Revisit conducted on January 8, 2025, between 10:15 a.m. and 11:30 a.m., determined the following: Item 1. - Not Completed. The facility failed to obtain plan approval by the Department of Health (Department) prior to initiating alterations to the facilities emergency power generator system. Interview at the exit conference with the Administrator and Maintenance Director on January 8, 2025, at 11:30 a.m., confirmed the above item was not completed.	K 0100		

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 0222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved,	K 0222	1. On 1/8/2025 Tilley fire was called for an update on the parts to repair the door. Service was scheduled for 1/10/2025 and door was repaired and back in working order. 2. To prevent reoccurrence a full house audit was conducted on 1/8/2025 3. On 1/8/2025 NHA provided education to the Maintenance staff on the importance of checking all doors as required and repairing any issues timely. 4. Maintenance will audit weekly for 4 weeks. Then monthly for 3 months after. All trends are brought to QAPI for further action	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/24/2025**

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 0222 SS=E	Continued from page 5 supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 0222		

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K 0222 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain exit egress doors equipped with delayed egress locking arrangements. Findings include: Observation on November 14, 2024, at 1:50 p.m., inside physical therapy suite, revealed the exit door equipped with delayed egress locking arrangements did not release after 15 seconds of applying pressure against the crash bar. Exit interview with the Director of Nursing and Maintenance Director on November 14, 2024, at 2:30 p.m., confirmed the doors did not release after 15 seconds of pressure against the crash bar. ********** Observations during an onsite Revisit conducted on January 8, 2025, between 10:15 a.m. and 11:30 a.m., determined the following:	K 0222		

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K 0222 SS=E	Continued from page 7 Item 1. - Not Completed. The exit door equipped with delayed egress locking arrangements did not release after 15 seconds of applying pressure against the crash bar. Interview at the exit conference with the Administrator and Maintenance Director on January 8, 2025, at 11:30 a.m., confirmed the above item was not completed.	K 0222		

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