

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395575	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/31/2025
NAME OF PROVIDER OR SUPPLIER: GARDENS AT STEVENS, THE			STREET ADDRESS, CITY, STATE, ZIP CODE: 400 LANCASTER AVENUE STEVENS, PA 17578		
STATE LICENSE NUMBER: 041102					
(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 March 31, 2025, at The Gardens at Stevens, 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.

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GARDENS AT STEVENS, THE
STATE LICENSE NUMBER: 041102
SURVEY EXIT DATE: 03/31/2025

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, FAAP
Secretary of Health



Pennsylvania
Department of Health

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THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID #041102 Component 01 74 Building Based on a Medicare/Medicaid Recertification Survey completed on March 31, 2025, it was determined that The Gardens of Stevens was not in compliance with the following requirements of the Life Safety Code for an existing 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 structure, without a basement, which is fully sprinklered.	K 0000		
K 0161 SS=E		K 0161		

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K 0161 SS=E	Continued from page 1 NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small	K 0161	1. The common wall doors between Components 01 and 02 have been adjusted to positively latch. 2. The corrective action was completed on 4/1/2025 3. The Maintenance Director or Designee will conduct audits of the common wall doors between Components 01 and 02 quarterly for 1 year. 4. Findings of Audits will be submitted to QAPI for review.	Completion Date: 04/10/2025 Status: APPROVED Date: 04/21/2025

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K 0161 SS=E	Continued from page 2 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by:	K 0161		

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K 0161 SS=E	Continued from page 3 Based on observation and interview, it was determined the facility failed to maintain common wall doors to positively latch, on two of two floors within the component. Findings include: 1. Observation on March 31, 2025, between 12:00 PM and 2:00 PM, revealed the common wall doors failed to positively latch, at the following locations: a. 12:00 PM, upper level, common wall between Components 01 and 02; b. 2:00 PM, lower level, common wall between Components 01 and 02. Interview with the Director of Maintenance on March 31, 2025, at 2:20 PM, confirmed the common wall doors failed to positively latch.	K 0161		

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K 0225 SS=E	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	1. The 1st floor stairtower doors by Resident Room 215 have been adjusted to have gaps less than 3/16 inch. 2. The corrective action was completed on 4/10/2025. 3. The Maintenance Director or Designee will conduct audits of the all facility stairtower doors to have gaps less than 3/16-inch quarterly for 1 year. 4. Findings of Audits will be submitted to QAPI for review.	Completion Date: 04/10/2025 Status: APPROVED Date: 04/23/2025

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K 0225 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain stairtower doors to be within the allowed gap margins, on one of two floors within the component. Findings include: 1. Observation on March 31, 2025, at 1:40 PM, revealed the 1st floor stairtower doors, by Resident Room 215 had gaps greater than 3/16 inch. Interview with the Director of Maintenance on March 31, 2025, at 1:40 PM, confirmed the stairtower door exceeded the allowed gap margins.	K 0225		
K 0363 SS=E		K 0363		

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K 0363 SS=E	Continued from page 6 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.	K 0363	<ol style="list-style-type: none"> 1. The corridor doors to Resident Rooms 205 and 215 have been adjusted to close and latch. 2. The corrective action was completed on 4/1/2025 3. The Maintenance Director or Designee will conduct a facility wide audit of all facility corridor doors for closure and latch then random door checks monthly. 4. Findings of Audits will be submitted to QAPI for review. 	Completion Date: 04/10/2025 Status: APPROVED Date: 04/24/2025

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K 0363 SS=E	Continued from page 7 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. This REQUIREMENT is not met as evidenced by:	K 0363		

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K 0363 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain corridor doors to positively latch, on one of two floors within the component. Findings include: 1. Observation on March 31, 2025, at 1:45 PM, revealed the corridor door to Resident Room 215 failed to close and latch. Interview with the Director of Maintenance on March 31, 2025, at 1:45 PM, confirmed the door failed to close and latch. 2. Observation on March 31, 2025, at 2:00 PM, revealed the corridor door to Resident Room 205 failed to close and latch. Interview with the Director of Maintenance on March 31, 2025, at 2:00 PM, confirmed the door failed to close and latch.	K 0363		

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K 0754 SS=E	<p>NFPA 101 Soiled Linen and Trash Containers</p> <p>Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0754	<p>1. The soiled linen and trash containers were removed from outside resident room 221.</p> <p>2. The corrective action was completed on 4/1/2025.</p> <p>3. The Maintenance Director or Designee will conduct audits of the 1st and 2nd floor corridors for soiled linen and trash containers daily until compliance is achieved, then weekly on all 3 shifts x 4 and then randomly for 2 months.</p> <p>4. Findings of Audits will be submitted to QAPI for review.</p>	<p>Completion Date: 04/10/2025 Status: APPROVED Date: 04/24/2025</p>

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K 0754 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to provide a protected space for soiled-linen and trash containers, exceeding 32 gallons, on one of two floors within the component. Findings include: 1. Observation on March 31, 2025, at 12:50 PM, revealed soiled-linen and trash containers were being stored in the 1st floor corridor, outside Resident Room 221, and not in a 1-hour protected rated room. Interview with the Director of Maintenance on March 31, 2025, at 12:50 PM, confirmed the soiled-linen and trash containers were not being stored in a rated assembly.	K 0754		



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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID #041102 Component 02 88 Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on March 31, 2025, it was determined that The Gardens of Stevens it was determined there were no deficiencies identified under the requirements of the Life Safety Code for an existing 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 two-story, Type II (000), unprotected noncombustible structure, without a basement, which is fully sprinklered.</p>	K 0000		
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