

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/23/2024
NAME OF PROVIDER OR SUPPLIER: CHELTENHAM NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 600 WEST CHELTENHAM AVENUE PHILADELPHIA, PA 19126		
STATE LICENSE NUMBER: 032202				
(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 Emergency Preparedness Survey completed on December 23, 2024, at Cheltenham Nursing And Rehabilitation Center, it was determined there were no deficiencies identified with 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.



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CHELTENHAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 032202

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

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THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID 032202 Component 01 West Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 23, 2024, it was determined that Cheltenham Nursing And Rehabilitation Center - West Building 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).</p> <p>This is a one-story, Type V (000) unprotected wood frame building, with a partial basement, that is fully sprinklered.</p>	K 0000		

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TITLE:

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K 0211 SS=E		K 0211		

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K 0211 SS=E	Continued from page 2 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	Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance. 1. On 12/23/2024 the Maintenance immediately removed the screw from the panic bar on the emergency exit door in the music room. The door was tested and opened without restriction. 2. On 12/26/2024 the maintenance team adjusted the stair tower D emergency exit door. The door opens without the use of excessive force. 3. On 12/26/2024 the maintenance team inspected all emergency exit doors to verify that there were no	Completion Date: 02/02/2025 Status: APPROVED Date: 01/13/2025

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K 0211 SS=E	Continued from page 3	K 0211	<p>obstructions to egress.</p> <p>4. On 12/30/2024 the NHA educated the maintenance team on maintaining that the means of egress are free of obstructions.</p> <p>5. The Maintenance Director/designee will conduct weekly audits for 4 weeks to verify the proper functionality of all emergency exit doors in accordance with NFPA 101 requirements. Results of the audits will be reviewed at the QAPI meeting held monthly.</p>	

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K 0211 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain means of egress free of obstructions, affecting one of two levels. Findings include: 1. Observation on December 23, 2024, at 10:45 a.m., revealed on the first floor, the music room emergency exit door had a screw inserted into its panic bar, rendering the door inoperable. After removal of the screw the door again failed to open. Exit Interview with the Administrator and Maintenance Director on December 23, 2024, at 12:15 p.m., confirmed the obstructed emergency exit door. 2. Observation on December 23, 2024, at 10:55 a.m., revealed on the first floor, the stair tower D emergency exit door required excessive force to open.	K 0211		

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K 0211 SS=E	Continued from page 5 Exit Interview with the Administrator and Maintenance Director on December 23, 2024, at 12:15 p.m., confirmed the obstruction to egress.	K 0211		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 6 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	1. On 1/6/2025 the Maintenance Director contacted The Tustin Group to schedule UL testing for the sprinklers in the "old part" of the building. 2. On 1/6/2025 the Maintenance Director contacted The Tustin Group to have the FDC hydrotested. Testing is scheduled for 2/2/2025. 3. On 12/24/2024 the Maintenance Director checked all sprinkler inspection reports for cited deficiencies. There were no other deficiencies. 4. On 12/30/2024 the NHA educated the maintenance team on correcting deficiencies cited following a sprinkler inspection. 5. The Maintenance Director/designee will conduct weekly audits for 4 weeks to verify that the deficiencies cited following an inspection are corrected timely. Results of the audits will be reviewed at the QAPI meeting held monthly.	Completion Date: 02/02/2025 Status: APPROVED Date: 01/13/2025

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K 0353 SS=F	Continued from page 7 Based on document review and interview, it was determined the facility failed to maintain automatic sprinkler system components, affecting the entire facility. Findings include: Document review on December 23, 2024, at 9:30 a.m., revealed the November 8, 2024, sprinkler inspection report listed the following deficiencies: a. The sprinklers in the "old part" of the building are dated 1974 and are due for UL-Testing. b. FDC needs to be hydrotested. Exit Interview with the Administrator and Maintenance Director on December 23, 2024, at 12:15 p.m., confirmed the sprinkler system deficiencies.	K 0353		

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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	1. On 12/26/2024 the Maintenance Director repaired the magnetic housing device. 2. On 12/23/2024 the Maintenance Director inspected all smoke doors to verify that the magnetic housing devices were secure. 3. On 12/30/2024 the NHA educated the maintenance team on maintaining smoke barrier doors in accordance with NFPA 101 requirements. 4. The Maintenance Director/designee will conduct weekly audits for 4 weeks to verify that smoke barrier doors are in accordance with NFPA 101 requirements. Results of the audits will be reviewed at the QAPI meeting held monthly.	Completion Date: 02/02/2025 Status: APPROVED Date: 01/13/2025

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K 0374 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to ensure smoke barrier doors were maintained, affecting one of two levels. Findings include: Observation on December 23, 2024, revealed the smoke doors near resident room B-1, the magnetically held fire door device had a broken housing. Exit Interview with the Administrator and Maintenance Director on December 23, 2024, at 12:15 p.m., confirmed the damaged device.	K 0374		
K 0918 SS=F		K 0918		

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K 0918 SS=F	Continued from page 10 NFPA 101 Electrical Systems - Essential Electric System 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	K 0918	<ol style="list-style-type: none"> 1. On 1/3/2025 the Maintenance Supervisor completed conductance testing of the generator's maintenance free batteries. 2. On (Insert Date) the Maintenance Director revised the generator testing documentation to include monthly conductance testing. 3. On 12/30/2024 the NHA educated the maintenance team on maintaining the required testing of emergency generator components in accordance with NFPA 101 requirements. 4. The Maintenance Director/designee will conduct audits monthly for 3 months to verify proper documentation for generator testing is present. Results of the audits will be reviewed at the QAPI meeting held monthly. 	Completion Date: 02/02/2025 Status: APPROVED Date: 01/13/2025

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K 0918 SS=F	Continued from page 11 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined the facility failed to maintain required testing of emergency generator components, affecting one generator. Findings Include: Document review on December 23, 2024, at 9:30 a.m., revealed the facility lacked verifying documentation of monthly conductance testing of the generator's maintenance free batteries. Exit Interview with the Administrator and Maintenance Director on December 23, 2024, at 12:15 p.m., confirmed the missing documentation.	K 0918		



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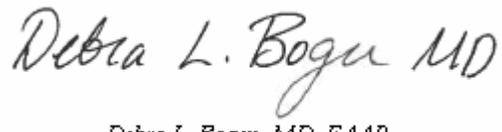
CHELTENHAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 032202

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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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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID 032202 Component 02 East & South Addition</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 23, 2024, it was determined that Cheltenham Nursing And Rehabilitation Center - East & South Addition 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).</p> <p>This is a four-story, Type II (000), unprotected non-combustible building, that is fully sprinklered.</p>	K 0000		

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K 0161 SS=C		K 0161		

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K 0161 SS=C	Continued from page 2 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	The facility will be engaging a certified external auditor to conduct a comprehensive Fire Safety Evaluation System (FSES) audit. This audit will evaluate the facility's fire safety measures across all designated zones, ensuring that each area meets or exceeds the rigorous standards set forth by the FSES. A passing score for each zone is a critical requirement, as it will demonstrate the facility's commitment to maintaining a safe environment for all residents, staff, and visitors. Upon successfully achieving a passing score in all zones, the facility will become eligible for the Centers for Medicare & Medicaid Services (CMS) approved time-limited waiver. This waiver will grant the facility an extension to comply with any remaining fire safety requirements that may need additional time or adjustments, while ensuring that essential safety measures are already in place to safeguard occupants in the interim. The FSES audit will cover a range of	Completion Date: 02/02/2025 Status: APPROVED Date: 01/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/23/2024	
NAME OF PROVIDER OR SUPPLIER: CHELTENHAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 032202		STREET ADDRESS, CITY, STATE, ZIP CODE: 600 WEST CHELTENHAM AVENUE PHILADELPHIA, PA 19126		
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K 0161 SS=C	Continued from page 3 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by:	K 0161	critical fire safety aspects, including but not limited to: fire detection and alarm systems, emergency evacuation plans, fire suppression systems, staff training and preparedness, and overall compliance with both local fire codes and CMS regulations. Each zone will be meticulously assessed to identify potential vulnerabilities and areas for improvement, and the results will be used to implement necessary corrective actions. Achieving a passing score not only ensures eligibility for the CMS time-limited waiver but also reflects the facility's proactive approach to maintaining a high standard of fire safety, protecting both the health and safety of all those within the facility and mitigating the risk of fire-related incidents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/23/2024	
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K 0161 SS=C	Continued from page 4 Based on document review and interview, it was determined the facility failed to maintain the building construction requirements, affecting the entire building. Findings include: Documentation review on December 23, 2024, at 8:45 a.m., revealed the facility has been classified as a four story, Type II (000), unprotected non-combustible construction, which is fully sprinklered. The building story height exceeds the maximum allowance for unprotected non-combustible construction by two stories. Exit Interview with the Administrator and Maintenance Director on December 23, 2024, at 12:15 p.m., confirmed the construction type and building height.	K 0161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/23/2024
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K 0347 SS=E	<p>NFPA 101 Smoke Detection</p> <p>Smoke Detection 2012 EXISTING</p> <p>Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0347	<ol style="list-style-type: none"> 1. On 12/23/2024 the Maintenance Director removed the plastic cover and tape from the obstructed smoke detector in the kitchen washroom. 2. On 12/23/2024 the maintenance team inspected all smoke detectors in the building to verify there were no obstructions. 3. On 12/30/2024 the NHA educated the Maintenance team on properly maintaining the smoke detection system in accordance with NFPA 101 requirements. 4. The Maintenance Director/designee will conduct weekly audits for 4 weeks to verify that smoke detectors are not obstructed. Results of the audits will be reviewed at the QAPI meeting held monthly. 	<p>Completion Date: 02/02/2025</p> <p>Status: APPROVED</p> <p>Date: 01/13/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/23/2024	
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K 0347 SS=E	Continued from page 6 Based upon observation and interview, it was determined the facility failed to maintain smoke detectors, affecting one of four levels. Findings include: Observation made on December 23, 2024, at 11:20 a.m, revealed on the first floor, the kitchen in the wash room, had a smoke detector obstructed with a plastic cover and tape. Exit Interview with the Administrator and Maintenance Director on December 23, 2024, at 12:15 p.m., confirmed the smoke detector obstruction.	K 0347		
K 0541 SS=E		K 0541		

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K 0541 SS=E	Continued from page 7 NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by:	K 0541	<ol style="list-style-type: none"> 1. On 1/3/2025 the Maintenance team replaced the existing hardware on the 2nd and 3rd floor South Wing linen chutes. 2. On 12/23/24 the Maintenance Director inspected the linen chutes on the other units and verified the proper functionality. 3. On 12/30/2024 the NHA educated the maintenance team on maintaining the fire resistance rating of the linen chutes in accordance with NFPA 101 requirements. 4. The Maintenance Director/designee will conduct weekly audits for 4 weeks to verify positive latching and the proper functionality of the linen chute doors. Results of the audits will be reviewed at the QAPI meeting held monthly. 	Completion Date: 02/02/2025 Status: APPROVED Date: 01/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/23/2024
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K 0541 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain the fire resistance rating of chutes and discharge rooms, affecting two of four levels. Findings include: Observation on December 23, 2024, from 11:45 a.m. to 12:05 p.m., revealed the linen chute doors failed to close and latch when tested in the following locations: a. On the third floor, South Wing: b. On the second floor, South Wing Exit Interview with the Administrator and Maintenance Director on December 23, 2024, at 12:15 p.m., confirmed the chute doors failed to close and latch.	K 0541		



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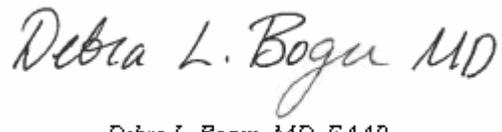
CHELTENHAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 032202

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


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