

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: 02/11/2025
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.



Certified End Page

CHELTENHAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 032202

SURVEY EXIT DATE: 02/11/2025

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**

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: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/11/2025
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
K 0000	INITIAL COMMENT	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: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/11/2025
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
K 0000	Continued from page 1 Facility ID 032202 Component 01 West Building Based on a Revisit to a Medicare/Medicaid Recertification Survey completed on December 23, 2024, it was determined that Cheltenham Nursing And Rehabilitation Center - West Building 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, with a partial basement, that is fully sprinklered.	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/11/2025
--	---	---	--

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
---	--

(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 0353 SS=F		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/11/2025
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
K 0353 SS=F	Continued from page 3 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	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 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 1/31/2025 the Tustin Group gathered the make and model for heads on the "old part" of the building to order replacement parts for the upcoming UL testing. 3. On 2/11/2024 the Maintenance Director checked the most recent sprinkler inspection report for cited deficiencies. There were no other deficiencies. 4. On 2/11/2025 the NHA	Completion Date: 02/26/2025 Status: APPROVED Date: 02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/11/2025
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
K 0353 SS=F	Continued from page 4	K 0353	re-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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/11/2025	
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		
(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 0353 SS=F	<p>Continued from page 5</p> <p>Based on document review and interview, it was determined the facility failed to maintain automatic sprinkler system components, affecting the entire facility.</p> <p>Findings include:</p> <p>Document review on December 23, 2024, at 9:30 a.m., revealed the November 8, 2024, sprinkler inspection report listed the following deficiencies:</p> <p>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.</p> <p>Exit Interview with the Administrator and Maintenance Director on December 23, 2024, at 12:15 p.m., confirmed the sprinkler system deficiencies.</p> <p>*****</p> <p>Based on an onsite Revisit conducted on February 11, 2025, the following was determined:</p>	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/11/2025	
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		
(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 0353 SS=F	Continued from page 6 Item a. Not Completed. The sprinklers in the "old part" of the building are dated 1974 and are due for UL-Testing. Exit interview with the Administrator on February 11, 2025, at 11:15 a.m., confirmed the missing documentation. All other deficiencies listed under this tag were corrected.	K 0353		



Certified End Page

CHELTENHAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 032202

SURVEY EXIT DATE: 02/11/2025

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**

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: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/11/2025
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
K 0000	INITIAL COMMENT	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: 395330	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/11/2025
--	---	---	--

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
---	--

(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>Continued from page 1</p> <p>Facility ID 032202 Component 02 East & South Addition</p> <p>Based on a Revisit to a Medicare/Medicaid Recertification Survey completed on December 23, 2024, it was determined that Cheltenham Nursing And Rehabilitation Center - East & South Addition, was in substantial compliance with the 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		
--------	---	--------	--	--



Certified End Page

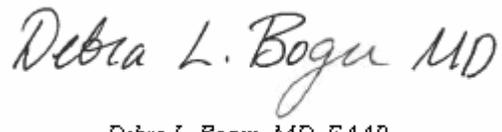
CHELTENHAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 032202

SURVEY EXIT DATE: 02/11/2025

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**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY