STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395662	A. BLDG: __--_____ B. WING: _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **127502**	**TWO FRANKLIN TOWN BOULEVARD PHILADELPHIA, PA 19103**

(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 January 21, 2025, it was determined that Logan Square Rehabilitation And Healthcare Center had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0004 SS=C		E 0004		

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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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(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 0004 SS=C	Continued from page 1 483.73(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency	E 0004	1)EPP reviewed and signed 2)ED of construction to Inservice Plant Operations supervisor policy and procedure on how to review and update EPP annually. 3)Supervisor of Plant Operations or Delegate to complete audits 3x per week x 4 weeks to ensure compliance with policy and procedure audits to be submitted to quality assurance performance improvement committee monthly for further review. Further audit frequency will be determined based on the outcome of the previously completed audit findings.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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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E 0004 SS=C	Continued from page 2 preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by:	E 0004		

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E 0004 SS=C	Continued from page 3 Based on documentation review and interview, it was determined the facility failed to ensure Emergency Preparedness Plan policies and procedures were reviewed and updated at least annually, affecting the entire facility. Findings include: Document review on January 21, 2025, at 8:45 a.m., revealed the Facility's Emergency Preparedness Plan had not been reviewed and updated at least annually. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., acknowledged no signatures provided for annual review or update.	E 0004		
E 0030 SS=C		E 0030		

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E 0030 SS=C	Continued from page 4 483.73(c)(1) Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.	E 0030	1)Updated communication plan and list completed by facility. 2)ED of construction to Inservice supervisor of plant OPS on policy and procedure of keeping communications plan and list up to date. 3)ED of construction or delegate to complete audits 3x per week x 4 weeks to ensure communication plan and list are completed in accordance with policies and procedures. Audits findings will be submitted to QAPI committee monthly for further reviews and recommendations as needed. Further audits frequently will be determined based of the outcome of the survey.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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E 0030 SS=C	Continued from page 5 *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 0030		

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E 0030 SS=C	Continued from page 6 (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by:	E 0030		

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E 0030 SS=C	Continued from page 7 Based on document review and interview it was determined that the facility failed to develop an Emergency Preparedness Plan to include required names and contact information. Findings include: Document review on January 21, 2025, at 8:45 a.m, revealed the facility failed to develop an Emergency Preparedness Plan to include names and contact information for the following: a. Staff. b. Entities providing services under arrangement. c. Patients' physicians d. Other [facilities]. e. Volunteers. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed a contact information template was included in EP, but the names and contact information of facility based individuals was	E 0030		

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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E 0030 SS=C	Continued from page 8 not included or referenced.	E 0030		
E 0031 SS=C	483.73(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman.	E 0031	1)Emergency list has been updated 2)ED of construction to Inservice supervisor of Plant Operations on policy and procedure on emergency contact information. 3)Supervisor of Plant Operations or Delegate to complete audits 3x per week x 4 weeks to ensure document is completed in accordance with policy and procedure.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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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E 0031 SS=C	Continued from page 9 (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by:	E 0031		

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E 0031 SS=C	Continued from page 10 Based on document review and interview, it was determined the facility failed to ensure the Emergency Preparedness Plan included contact information for required Emergency Officials, affecting the entire facility. Findings include: Document review on January 21, 2025, at 8:45 a.m., revealed there was no contact information included in the Emergency Preparedness plan for the State Licensing and Certification Agency and the Office of the State Long-Term Care Ombudsman. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the facility failed to develop an Emergency Preparedness Plan to include contact information for the above listed emergency officials.	E 0031		

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STATE LICENSE NUMBER: **127502**	

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E 0031 SS=C	Continued from page 11	E 0031		
E 0037 SS=C	483.73(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 0037	1) EPP Inservice of staff to be completed. 2) ED of construction to Inservice supervisor of plant operations on EPP training program policy and procedure. 3) Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to ensure compliance audit findings will be monthly for further review and recommendations as needed. Further audits frequency will be determined based on the outcome of the previously completed audit findings.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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E 0037 SS=C	Continued from page 12 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures.	E 0037		

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E 0037 SS=C	Continued from page 13 (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least	E 0037		

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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LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **127502**	**TWO FRANKLIN TOWN BOULEVARD PHILADELPHIA, PA 19103**

(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 0037 SS=C	Continued from page 14 annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing	E 0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395662	A. BLDG: __--_____ B. WING: _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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E 0037 SS=C	Continued from page 15 of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by:	E 0037		

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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E 0037 SS=C	Continued from page 16 Based on document review and interview, it was determined that the facility failed to provide documentation of initial and annual Emergency Preparedness training for staff and individuals providing services to the facility including volunteers, affecting entire facility. Findings include: Document review on January 21, 2025 at 8:45 a.m., revealed the facility failed to to provide the maintained annual documentation of Emergency Preparedness training of staff members demonstrating their knowledge of emergency procedures. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the facility failed to to provide annual records of employee training.	E 0037		

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E 0039 SS=C	483.73(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 0039	1) Emergency prep exercise will be completed. 2) ED of construction to Inservice Supervisor of Plant Operations on policy and procedure for ensuring proper requirements are meet. 3) Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to compliance with policy and procedure audit findings will be submitted to QAPI committee monthly for review and recommendations as needed.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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E 0039 SS=C	Continued from page 18 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 0039		

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E 0039 SS=C	Continued from page 19 (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem	E 0039		

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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E 0039 SS=C	Continued from page 20 statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a	E 0039		

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E 0039 SS=C	Continued from page 21 facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or	E 0039		

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E 0039 SS=C	Continued from page 22 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based	E 0039		

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E 0039 SS=C	Continued from page 23 or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or	E 0039		

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E 0039 SS=C	Continued from page 24 an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may	E 0039		

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E 0039 SS=C	Continued from page 25 include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency	E 0039		

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E 0039 SS=C	Continued from page 26 events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by:	E 0039		

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E 0039 SS=C	Continued from page 27 Based on document review and interview, it was determined the facility failed to conduct the required two exercises to test the emergency preparedness plan, affecting the entire facility. Findings include: Document review on January 21, 2025, at 8:45 a.m., revealed the facility failed to conduct the required exercises to test the emergency preparedness plan within the previous 12 months. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the documentation was not available.	E 0039		

Certified End Page

LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 127502

SURVEY EXIT DATE: 01/21/2025

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:
	395662	A. BLDG: __01_____ B. WING: _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **127502**	**TWO FRANKLIN TOWN BOULEVARD PHILADELPHIA, PA 19103**

(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
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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0000	Continued from page 1 Facility ID # 127502 Component 01 Based on a Medicare/Medicaid Recertification Survey completed on January 21, 2025, it was determined that Logan Square Rehabilitation and Healthcare Center 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). This is a twenty-four story, Type II (222), fire resistive building, with two lower-level garages and a basement, that is fully sprinklered. Complete automatic sprinkler protection is provided on the first through fourth floors, as well as the smoke towers and fire exit stair towers used by healthcare residents.	K 0000		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER	**TWO FRANKLIN TOWN BOULEVARD PHILADELPHIA, PA 19103**
STATE LICENSE NUMBER: **127502**	

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K 0100 SS=E	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	1) Facility obtained accurate floor plans. 2) ED of construction to Inservice on policy and procedure for ensuring the safe storage of floor plans 3) Supervisor of Plant Operations or Delegate to complete audits 3x per week x 4 weeks to ensure plans are completed and available in accordance with policy and procedure.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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=E	Continued from page 3 Based on observation and interview, it was determined the facility failed to maintain portable, accurate floor plans, affecting one floor plan. Findings include: Document review on January 21, 2025, at 9:30 a.m., revealed the facility failed to provide accurate portable Life Safety Code Floor Plans that included the following information: a. Smoke Barrier Walls (outside wall to outside wall) b. Fire Barrier Walls (2-hour walls) c. Horizontal Exits d. Rated Rooms (Storage Rooms, Soiled Utility Rooms, designated Medical Gas Rooms) will be clearly designated. It is the facility's responsibility to have all Rated Rooms indicated on their Life Safety Code Floor Plan. e. Required Exits should be clearly noted; and f. Shafts Walls. Exit interview with the Executive Director of	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 0100 SS=E	Continued from page 4 Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed inaccurate portable floor plans.	K 0100		
K 0345 SS=F		K 0345		

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 0345 SS=F	Continued from page 5 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	ED of construction to in-service the Maintenance staff of proper reading of the fire panel and report any trouble alarms immediately to their Supervisor. - The Facility is working with the current Vendor (Johnson Controls) and an additional Vendor (Independence) to make repairs or replace the aged fire panel so trouble alarms stop randomly reporting. - Due to the difficulty of parts or replacement of the fire panel, the Facility is requesting a 120-day time-limited waiver. - The fire panel will be audited daily with a record of any current trouble signals recorded until repairs are completed - TLW request sent via email - Johnson Control letter sent to center and forwarded to DOH stating that they estimate that work can be completed 90 days from March 7th 2025 which June 5th 2025. If further extension is required center will update doh with further correspondence from Johnson Controls.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **03/20/2025**

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K 0345 SS=F	Continued from page 6 Based on observation review and interview, it was determined the facility failed to maintain the fire alarm system in proper operating condition, affecting the entire facility. Findings Include: Observation on January 21, 2025, at 10:45 a.m., revealed the facility fire alarm panel displayed multiple trouble codes at the time of survey. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the fire alarm panel trouble codes.	K 0345		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 7 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	- ED of construction to Inservice supervisor of Plants Operations on policy and procedure ensuring sprinkler system maintained. - All items A-D have been completed 4th quarter report received after surveyor departed. - Supervisor of Plants Operations or delegate to complete 3x per week x 4 weeks all items A-D to ensure compliance. - Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to compliance with policy and procedure audit findings will be submitted to QAPI committee monthly for review and recommendations as needed.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0353 SS=F	Continued from page 8 Based on document review, observation and interview, it was determined the facility failed to ensure automatic sprinkler components were maintained, affecting the entire facility. 1. Observations and document review on January 21, 2025, at 11:30 a.m., revealed the following sprinkler system deficiencies: a. 8:30 a.m., missing 3-year, full flow trip test of the dry automatic sprinkler system. b. 8:30 a.m., missing 4th quarter 2024 sprinkler inspection. c. 11:15 a.m., basement, next to upper garage elevator, data wires strapped to the ceiling sprinkler pipe. d. 11:20 am, 3rd floor Activities closet. sprinkler missing its escutcheon. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the sprinkler system deficiencies.	K 0353		

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K 0353 SS=F	Continued from page 9	K 0353		
K 0355 SS=E	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	- ED of construction to Inservice supervisor of Plant Operations on policy and procedure for portable fire extinguishers. - Document was received after surveyor exited. - Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to ensure compliance audit findings will be submitted to QAPI committee monthly for further review.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0355 SS=E	Continued from page 10 Based on document review and interview, it was determined the facility failed to maintain and inspect the portable fire extinguishers, affecting the entire facility. Findings include: Document review on January 21, 2025, at 8:30 a.m., revealed the facility could not produce a certificate for the technician conducting the annual fire extinguisher inspections. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the missing documentation.	K 0355		
K 0363 SS=E		K 0363		

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K 0363 SS=E	Continued from page 11 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	- ED of construction to Inservice supervisor of plants operations on policy and procedure regarding corridor doors. - Door closures will be installed in the same open mounting holes at top of frame to ensure smoke doesn't pass. - Supervisor of Plant Operations to conduct audits 3x per week x 4 weeks to ensure all corridor doors are smoke tight in accordance with policies and procedures. - Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to compliance with policy and procedure audit findings will be submitted to QAPI committee monthly for review and recommendations as needed.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0363 SS=E	Continued from page 12 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 13 Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings can resist the passage of smoke, affecting one of twenty-four floors. Findings include: Observations made on January 21, 2025, at 12:03 p.m., revealed, on the third floor, the double doors near resident room 310, metal door frame with open penetrations above closer. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 pm, confirmed the metal door frame penetrations.	K 0363		

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K 0372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	- ED of construction to Inservice supervisor of Plant Operations on policy and procedure for maintaining smoke barrier walls. - Penetration filled using 3M fire barrier sealant FD 150 + Red color and CP 25 WB+ - Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to compliance with policy and procedure audit findings will be submitted to QAPI committee monthly for review and recommendations as needed.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0372 SS=E	Continued from page 15 Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls free of unsealed penetrations, affecting one of twenty-four floors. Findings include: Observation on January 21, 2025, at 10:55 a.m., revealed in the basement, next to upper garage elevator, penetrations around data wires and sprinkler pipe. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the unsealed penetrations.	K 0372		
K 0521 SS=F		K 0521		

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K 0521 SS=F	Continued from page 16 NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	- ED of construction to Inservice supervisor of Plants Operations on policy and procedure on smoke dampers. - Damper inspection was completed by facility on 11-06-2024 - Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to compliance with policy and procedure audit findings will be submitted to QAPI committee monthly for review and recommendations as needed	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/25/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395662	A. BLDG: __01_____ B. WING: _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: 127502	TWO FRANKLIN TOWN BOULEVARD PHILADELPHIA, PA 19103

(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
K 0521 SS=F	Continued from page 17 Based on document review and interview, it was determined the facility failed to maintain and inspect HVAC systems, affecting the entire facility. Findings include: Document review on January 21, 2025, at 8:30 a.m., revealed the facility could not provide documentation of a fire/smoke dampers inspection performed within the past 4 years. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the missing fire/smoke dampers inspection report.	K 0521		
K 0541 SS=E		K 0541		

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 0541 SS=E	Continued from page 18 NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu 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	- ED of construction to Inservice supervisor of Plant Operations on policy and procedures for trash, laundry chutes. - Trash chute replaced. - Supervisor of Plants Operation or delegate to complete audits 3x per week x 4 weeks to ensure compliance of chute doors policy and procedure. - Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to compliance with policy and procedure audit findings will be submitted to QAPI committee monthly for review and recommendations as needed.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0541 SS=E	Continued from page 19 Based on observation and interview, it was determined the facility failed to maintain the fire resistance rating of chutes and discharge rooms, affecting one of twenty-four levels. Findings include: Observation on January 21, 2025, at 12:20 p.m., revealed on the second-floor, the trash chute door failed to close and latch when tested. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the trash chute door failed to close and latch.	K 0541		
K 0911 SS=E		K 0911		

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K 0911 SS=E	Continued from page 20 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	- ED of construction to Inservice Supervisor of Plants Operations on policy and procedure for electrical panels. - Replaced open breakers with circuit breaker protective cover . - Supervisor of Plant Operations or delegate to complete audits of main electrical room 3x per week x 4 weeks to ensure compliance. - Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to compliance with policy and procedure audit findings will be submitted to QAPI committee monthly for review and recommendations as needed.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395662	A. BLDG: __01_____ B. WING: _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0911 SS=E	Continued from page 21 Based on observation and interview, it was determined the facility failed to maintain protection of electrical wiring, affecting one of twenty-four floors. Findings include: Observation on January 21, 2025, at 10:55 a.m., revealed in main garage electrical room, multiple electrical panels were missing a circuit breaker protective blank. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the missing blanks.	K 0911		
K 0914 SS=E		K 0914		

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 0914 SS=E	Continued from page 22 NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0914	- ED of construction to Inservice supervisor or Plants Operation on policy and procedure for testing electrical receptacles. - Electircal receptacle test completed. - Supervisor of Plant Operations or delegate to complete audits 3x per week x 4 weeks to compliance with policy and procedure audit findings will be submitted to QAPI committee monthly for review and recommendations as needed.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/21/2025

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0914 SS=E	Continued from page 23 Based on document review and interview, it was determined the facility failed to ensure electrical receptacles were tested at patient bed locations within the facility. Findings include: Document review on January 21, 2025, at 8:30 a.m., revealed electrical receptacles at patient bed locations were not tested as required for non-hospital grade receptacles at intervals not exceeding 12 months. Receptacle testing should include the following: a. visual inspection of physical integrity; b. correct polarity of the hot and neutral connections; c. retention force of the grounding blade (except locking-type receptacles) shall not be less than 4 oz. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p.m., confirmed the missing	K 0914		

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 0914 SS=E	Continued from page 24 documentation.	K 0914		
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste 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	K 0918	- ED of construction to Inservice supervisor of Plant Operations on ensuring generator battery testing, fuel samples and 90 min load. - Fuel test, load bank and battery conductance testing - Director of Plants Operations or delegate to complete audits 3x per week x 4 weeks to ensure generator battery testing and fuel quality sample and 90 min load test is completed audit findings will be submitted to the QAPI committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/24/2025**

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 0918 SS=F	Continued from page 25 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 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

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K 0918 SS=F	Continued from page 26 Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator, affecting the entire facility. Findings include: Document review on January 21, 2025, at 8:30 a.m., revealed the facility could not produce documentation of the following tests and inspections: a. Monthly testing of battery electrolyte specific gravity or conductance testing; b. Annual 90 minute load bank test; c. Annual fuel quality test. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 pm, confirmed the missing documentation.	K 0918		
K 0920 SS=E		K 0920		

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K 0920 SS=E	Continued from page 27 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 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	- ED of construction to Inservice supervisor of Plant Operations on policy and procedure of power cords, extension cords and power strips. - Extension cord removed from room #331 - Director of Plants Operations or delegate to complete audits 3x per week x 4 weeks to ensure Power cords, extension cords and power strips audit is completed findings will be submitted to the QAPI committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **02/21/2025**

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 0920 SS=E	Continued from page 28 Based on observation and interview, it was determined the facility failed to prohibit the improper and unauthorized use of electrical devices, affecting one of twenty four levels. Findings include: Observation on January 21, 2025, at 12:45 p.m., on the third floor, inside resident room #331, there was an extension cord powering a personal refridgerators. Exit interview with the Executive Director of Construction and Ancillary Services on January 21, 2025, at 1:15 p/m., confirmed the extension cord in use.	K 0920		

Certified End Page

LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 127502

SURVEY EXIT DATE: 01/21/2025

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