STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395666	A. BLDG: __--_____ B. WING: _____	04/08/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SPRING HILL REHABILITATION AND NURSING CENTER	**2170 RHINE STREET PITTSBURGH, PA 15212**
STATE LICENSE NUMBER: **192902**	

(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 April 8, 2025, it was determined that Spring Hill Rehabilitation and Nursing Center, was not in compliance with the requirements of 42 CFR 483.73.	E 0000		
E 0039 SS=C		E 0039		

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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E 0039 SS=C	Continued from page 1 483.73(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:	E 0039	1.There were no negative outcomes due to the lack of disaster drills. 2.The facility will schedule and conduct a full-scale facility based disaster drill and will conduct drills semi-annually thereafter. 3.The minutes of the drill will be submitted to the facility QAPI committee for review and approval.	Completion Date: **05/19/2025** Status: **APPROVED** Date: **04/24/2025**

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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E 0039 SS=C	Continued from page 2 (A) A second full-scale exercise that is community-based or 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 [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	E 0039		

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E 0039 SS=C	Continued from page 3 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 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	E 0039		

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E 0039 SS=C	Continued from page 4 (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 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	E 0039		

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E 0039 SS=C	Continued from page 5 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 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	E 0039		

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E 0039 SS=C	Continued from page 6 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 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.	E 0039		

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E 0039 SS=C	Continued from page 7 (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 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.	E 0039		

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E 0039 SS=C	Continued from page 8 (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 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.	E 0039		

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E 0039 SS=C	Continued from page 9 (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 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	E 0039		

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E 0039 SS=C	Continued from page 10 following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency 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 11 Based on a review of the facility's Emergency Preparedness (EP) Plan, it was determined the facility failed to maintain documentation for the two required exercises to test the emergency plan. Findings include: 1. Interview and documentation review on April 8, 2025 at 8:50 a.m., revealed the facility lacked documentation for the two exercises required annually, to test the emergency plan. Interview with the Interim Facility Administrator and Plant Operations Manager on April 8, 2025, at 1:30 p.m., confirmed documentation for the two exercises were not available at the time of the survey.	E 0039		

Certified End Page

SPRING HILL REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 192902

SURVEY EXIT DATE: 04/08/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID# 192902 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on April 8, 2025, it was determined that Spring Hill Rehabilitation and Nursing Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two-story, Type II (222), fire resistive building, with a basement, that is fully sprinklered.	K 0000		
K 0100 SS=C		K 0100		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0100 SS=C	Continued from page 1 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.There were no negative outcomes due to not having an Evacuation and Alarm Protocol policy in place. 2.The facility will write and implement an Evacuation and Alarm Protocol policy for the Carbon Monoxide detectors/alarms. 3.The policy will be reviewed by facility leadership and approved by the facility QAPI committee.	Completion Date: **05/19/2025** Status: **APPROVED** Date: **04/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395666	A. BLDG: __01_____ B. WING: _____	04/08/2025

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K 0100 SS=C	Continued from page 2 Based on documentation review and interview, it was determined the facility failed to maintain carbon monoxide alarms in accordance with the 2016 Act 48-Care Facility Carbon Monoxide Alarms Standards Act, in one instance, affecting the entire facility. Findings include: 1. Documentation review on April 8, 2025, at 8:55 a.m., revealed the facility failed to write and implement an Evacuation and Alarm Protocols policy for the Carbon Monoxide detectors/alarms. Interview with the Interim Facility Administrator and Plant Operations Manager on April 8, 2025, at 1:30 p.m., confirmed the facility failed to write and implement an Evacuation and Alarm Protocols policy for the Carbon Monoxide detectors/alarms.	K 0100		

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K 0100 SS=C	Continued from page 3	K 0100		
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 0321	1.The lack of a door in central supply room created no negative outcomes. 2.The door separating the combustible supplies from other supplies in the Central Supply storage room will be replaced.	Completion Date: **05/19/2025** Status: **APPROVED** Date: **04/24/2025**

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K 0321 SS=E	Continued from page 4 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in one instance, affecting one of seven smoke compartments. Findings include: 1. Observation on April 8, 2025, at 10:30 a.m., revealed the door to a storage room containing combustible storage in Central Supply, had been removed due to repair issues and had not been replaced. Interview with the Interim Facility Administrator and Plant Operations Manager on April 8, 2025, at 1:30 p.m., confirmed the listed hazardous area enclosure deficiency.	K 0321		

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K 0321 SS=E	Continued from page 6	K 0321		
K 0353 SS=E	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.The missing ceiling tile had no negative effect. 2.The ceiling tile in the Central Supply storage room will be replaced.	Completion Date: **05/19/2025** Status: **APPROVED** Date: **04/24/2025**

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 0353 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in one instance, affecting one of seven smoke compartments. Findings include: 1. Observation on April 8, 2025, at 10:50 a.m., revealed there was a ceiling tile missing in the Central Supply room, which would allow the passage of heat and smoke, and may affect operation of the automatic sprinkler system. Interview with the Interim Facility Administrator and Plant Operations Manager on April 8, 2025, at 1:30 p.m., confirmed the automatic sprinkler system deficiency.	K 0353		

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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	1.The unhung fire extinguisher had no negative effects. 2.The fire extinguisher adjacent to the Administrator's office has been rehung on the wall.	Completion Date: **05/19/2025** Status: **APPROVED** Date: **04/24/2025**

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K 0355 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain the portable fire extinguishers in one instance, affecting one of seven smoke compartments. Findings include: 1. Observation on April 8, 2025, at 8:05 a.m., revealed a portable fire extinguisher located next to the Administrators office was sitting on the floor. The extinguisher's mount was pulled out from the wall and hanging loosely. Interview with the Interim Facility Administrator and Plant Operations Manager on April 8, 2025, at 1:30 p.m., confirmed the portable fire extinguisher deficiency.	K 0355		
K 0712 SS=F		K 0712		

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K 0712 SS=F	Continued from page 10 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	The facility cannot retroactively complete the fire drills that were not conducted. An annual calendar will be developed outlining when fire drills will be conducted to ensure one fire drill will be conducted on all three shifts each quarter.	Completion Date: **05/19/2025** Status: **APPROVED** Date: **04/24/2025**

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K 0712 SS=F	Continued from page 11 Based on documentation review and interview, it was determined the facility failed to perform ten of the twelve required fire drills, affecting the entire facility. Findings include: 1. Review of documentation on April 8, 2025, at 8:25 a.m., revealed the facility lacked fire drill documentation for: a) A fire drill performed on the third shift, first quarter; b) A fire drill performed on the first, second, and third shifts in the second, third, and fourth quarters in the previous twelve months. Interview with the Interim Facility Administrator and Plant Operations Manager on April 8, 2025, at 1:30 p.m., confirmed the facility lacked documentation for these listed fire drills performed in the previous twelve months.	K 0712		

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K 0712 SS=F	Continued from page 12	K 0712		
K 0911 SS=E	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	The light fixture in the Janitors closet will be replaced and exposed wires secured out of sight by the maintenance director.	Completion Date: **05/19/2025** Status: **APPROVED** Date: **04/24/2025**

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K 0911 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain electrical wiring in one instance, affecting one of seven smoke compartments. Installation shall be in accordance with *NFPA 70, National Electric Code*. 19.5.1.1, NFPA 101 (2012) Findings Include: 1. Observation on April 8, 2025, at 10:15 a.m., revealed a broken fluorescent light fixture, with exposed electrical wires hanging low, in the Janitor's closet across from Room 108, in the West Hall. Interview with the Interim Facility Administrator and Plant operations Manager on April 8, 2025, at 1:30 p.m., confirmed the exposed electrical wiring.	K 0911		
K 0920 SS=E		K 0920		

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K 0920 SS=E	Continued from page 14 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	1.The was no negative outcome from the microwave oven being plugged into a power strip in the business office. 2.The microwave oven will be relocated so as to be plugged directly into the electrical outlet.	Completion Date: **05/19/2025** Status: **APPROVED** Date: **04/24/2025**

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K 0920 SS=E	Continued from page 15 Based on observation and interview, it was determined the facility failed to maintain electrical wiring systems and equipment in one instance, affecting one of seven smoke compartments. Findings include: 1. Observation on April 8, 2025, at 8:45 a.m., revealed a microwave plugged into a power strip in the first floor Business Office. Interview with the Interim Facility Administrator and Plant Operations Manager on April 8, 2025, at 1:30 p.m., confirmed the misuse of a power strip being used to power a microwave.	K 0920		

Certified End Page

SPRING HILL REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 192902

SURVEY EXIT DATE: 04/08/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

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