

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395686	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____		(X3) DATE SURVEY COMPLETED: 12/22/2025
NAME OF PROVIDER OR SUPPLIER: WEST PARK REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 4401 HAVERFORD AVENUE PHILADELPHIA, PA 19104		
STATE LICENSE NUMBER: 450602					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on December 22, 2025, at West Park Rehabilitation and Nursing Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

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

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.



Certified End Page

WEST PARK REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 450602

SURVEY EXIT DATE: 12/22/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID# 450602 Component 01 Main Building &; Sunroom Addition Based on a Medicare/Medicaid Recertification Survey completed on December 22, 2025, it was determined West Park Rehabilitation and Nursing Center- Main Building &; Sunroom Addition was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a five-story, Type II (000), unprotected non-combustible building, with a basement, that is fully sprinklered.	K 0000		
K 0161 SS=C		K 0161		

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(X6) DATE:

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K 0161 SS=C	Continued from page 1 NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small	K 0161	On CMS guidance, a Time Limited Waiver will be initiated related to this deficient practice. Subsequently, CMS changed the FSES calculation, relieving health care occupancies of the NFPA standard requiring fire-protective coating for structural steel supports in buildings of five stories or more. A life safety consultant will be contracted to perform an updated FSES related to this deficient practice.	Completion Date: 02/18/2026 Status: APPROVED Date: 01/21/2026

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K 0161 SS=C	Continued from page 2 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on document review, observation and interview, it was determined the facility failed to maintain the fire resistance rating of the building construction, affecting the entire facility. Findings include: Document review and observation on December 22, 2024, at 10:00 a.m., revealed the facility was classified as a five-story, Type II (000) unprotected non-combustible construction, with a basement, which is fully sprinklered. The story height exceeds the maximum allowance for this construction type by three stories. Exit Interview with the Administrator, Regional and Local Maintenance Director on December 22, 2025, at 1:30 p.m., confirmed the story height exceeded the maximum allowance for this construction type by three stories.	K 0161		
K 0222 SS=E		K 0222		

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K 0222 SS=E	Continued from page 3 NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door	K 0222	The combo pad lock on the exit gate door was immediately removed. The facility will replace this with a magnetic locking system. Plans for the magnetic locking system will be forwarded to Life Safety Plan Review for approval. The maintenance director will provide education to all staff on proper egress requirements and emergency access. The maintenance director or designated designee will perform weekly audits for 4 weeks and then monthly for 2 months on all egress doors to ensure ongoing compliance. Expected date of completion: 2/18/2026	Completion Date: 02/18/2026 Status: APPROVED Date: 01/21/2026

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K 0222 SS=E	Continued from page 4 assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 0222		

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K 0222 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain exit egress doors on one of one courtyard exit door. Findings include: Observation on December 22, 2025, at 1:20 p.m., revealed on the first floor, the exit egress through the outside courtyard had a combo pad lock on the exit gate door. Exit Interview with the Administrator, Regional and Local Maintenance Director on December 22, 2025, at 1:30 p.m., confirmed the combo padlock was discovered during survey for a second time in a calendar year.	K 0222		
K 0324 SS=E		K 0324		

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K 0324 SS=E	Continued from page 6 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	The kitchen hood suppression system remains operational and compliant. Inspection documentation was reviewed and updated. Preventive maintenance scheduling has been reinforced, and documentation will be maintained on site. The maintenance director and dietary director will be re-educated on the importance of maintaining documentation of the semi-annual kitchen hood suppression system testing that should occur every 6 months. The maintenance director or designated designee will perform bi-yearly audits to ensure the semi-annual kitchen hood suppression system testing is being completed and that documentation is maintained. Date of completion: 2/16/2025	Completion Date: 02/16/2026 Status: APPROVED Date: 01/21/2026

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K 0324 SS=E	Continued from page 7 Based on document review and interview, it was determined the facility failed to maintain and inspect the kitchen hood suppression system, affecting 1 of 2 inspection reports. Findings include: Document review on December 22, 2025, at 10:30 a.m., revealed the facility failed to provide documentation of the semi-annual kitchen hood suppression system testing within 6 months of 10/15/2025; Exit Interview with the Administrator, Regional and local Maintenance Director on December 22, 2025, at 1:30 p.m., confirmed missing documentation.	K 0324		
K 0345 SS=F		K 0345		

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K 0345 SS=F	Continued from page 8 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	EES was scheduled to be on site the week of January 12, 2026, to review and correct all identified fire alarm maintenance items, including panel notifications, documentation, and system reporting. A full inspection report will be retained in the Life Safety binder. The maintenance director will perform weekly audits for 4 weeks and then monthly audits for 2 months to ensure the facility fire alarm system components remain in operable conditions.	Completion Date: 02/16/2026 Status: APPROVED Date: 01/21/2026

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K 0345 SS=F	<p>Continued from page 9</p> <p>Based on document review and interview, it was determined the facility failed to maintain fire alarm system components in operable condition, affecting the entire facility.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. Documentation reviewed on December 22, 2025, at 9:15 a.m., revealed the fire alarm report dated November 8, 2025, listed the following deficiencies: <ol style="list-style-type: none"> a) 1st Fl Utility Closet Altronix BPS Batteries failed load test. b) Control Unit: The Piezoelectric buzzer is not functioning at the FACP. 5th Fl Horn strobes are not tied into the FACP soft key NAC disablements. Multiple pull stations throughout the building do not have the "in case of fire, call 911" sign above the device. approx. 23 signs. c) 1st Fl Elec rm altronix batt LT 12v9AH. Failed load test- Flat battery. d) Smoke Detector- Top of center stairs- Fail- reported as a supervisory (labeled as old smoke) e) Heat Detector- Hall by Boiler - 02-043 - Fail - reported as a heat alarm but labeled on FACP as a smoke. <p>Exit Interview with the Administrator, Regional and local Maintenance Director on December 22, 2025, at 1:30 p.m., confirmed the fire alarm deficiencies were not corrected yet.</p>	K 0345		

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K 0355 SS=E	<p>NFPA 101 Portable Fire Extinguishers</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to maintain portable fire extinguishers, affecting 1 of 6 levels within the component.</p> <p>Findings include: Observation on December 22, 2025, at 11:37 a.m., revealed that an extinguisher was blocked next to room 425. Exit Interview with the Administrator, Regional and local Maintenance Director on December 22, 2025, at 1:30 p.m., confirmed the blocked extinguisher.</p>	K 0355	<p>The facility immediately freed the fire extinguisher next to room 425 from blockage. The maintenance director will re-educate all staff on maintaining clear access to all fire extinguishers.</p> <p>The maintenance director or designated designee will perform weekly audits for 4 week and then monthly audits for 2 months to ensure the facility is maintaining clear access to all fire extinguishers.</p> <p>Date of completion: 2/16/2026</p>	<p>Completion Date: 02/16/2026 Status: APPROVED Date: 01/21/2026</p>
K 0521 SS=E		K 0521		

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K 0521 SS=E	Continued from page 11 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	The facility reached out to LLS and Reed Electric to correct all identified fire damper deficiencies. Repairs and reinspection are due to be completed the week of January 12th, 2026. Documentation will be retained for life safety review. The maintenance director or designated designee will perform weekly audits for 4 weeks and then monthly for 2 months to ensure fire damper compliance. Date of completion: 2/16/2026	Completion Date: 02/16/2026 Status: APPROVED Date: 01/21/2026

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K 0521 SS=E	Continued from page 12 Based on document review and interview, it was determined the facility failed to maintain inspection of Heating, Ventilating and Air Conditioning (HVAC) equipment at required intervals, affecting fourteen dampers. Findings include: 1. Document review on December 22, 2025, between 9:00 a.m. and 11:00 a.m., revealed the July 12, 2022, fire damper inspection report listed the following deficiencies: a) B-SD-01 - No power to motor. b) 4-SD-20 - Motor does not actuate. New motor needed. c) 3-FD-19B - Requires duct access door. d) 3-FD-19A - No Damper present. e) 2-FD-11 - Damper outside of fire wall. f) 2-FD-18 - Damper does not fall. New damper required. g) 2-FD-17 - Damper does not fall. New damper required. h) 2-FD-19 - Damper does not fall. New damper required. i) 2-FD-20 - Damper does not fall. New damper required. j) 1-SD-03 - Wall does not extend to deck/sheetrock missing. k) B-SD-07 - No power to motor. l) B-SD-6 - No power to motor. m) B-SD-01 - No power to motor. n) 1-SD-03 - No power to motor. Exit interview with the Administrator, Regional and Local Maintenance Director, on December 22, 2025, at 1:30 p.m.,	K 0521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395686	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/22/2025
NAME OF PROVIDER OR SUPPLIER: WEST PARK REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 4401 HAVERFORD AVENUE PHILADELPHIA, PA 19104		
STATE LICENSE NUMBER: 450602				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0521 SS=E	Continued from page 13 confirmed the fire damper deficiencies exist without corrective actions at time of survey.	K 0521		
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 obstructing cart was removed immediately, freeing the 2nd floor electrical panel of blockage. The maintenance director will re-educate all staff on maintaining clear access to all electrical panels. The maintenance director or designated designee will perform weekly audits for 4 4 weeks and then monthly audits for 2 months to ensure the facility is maintaining clear access to all electrical panels. Date of completion: 2/16/2026	Completion Date: 02/16/2026 Status: APPROVED Date: 01/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395686	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/22/2025
NAME OF PROVIDER OR SUPPLIER: WEST PARK REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 4401 HAVERFORD AVENUE PHILADELPHIA, PA 19104		
STATE LICENSE NUMBER: 450602				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0911 SS=E	Continued from page 14 Based on observation and interview, it was determined the facility failed to ensure that electrical panel were assessable in accordance with NFPA 70 2011 Section 110.26 on one of six levels within this facility. Findings include: Observation made on December 22, 2025, at 12:25 p.m., 2nd floor, revealed inside nurse station supply closet, an electrical panel was blocked by a large cart. Exit conference with the Administrator and Maintenance Director on December 22, 2025, at 1:30 p.m., confirmed the electrical panel was blocked.	K 0911		



Certified End Page

WEST PARK REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 450602

SURVEY EXIT DATE: 12/22/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY