STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395687	A. BLDG: __--_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORK NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 023802	7101 OLD YORK ROAD PHILADELPHIA, PA 19126

(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 30, 2025, it was determined that York Nursing And Rehabilitation Center had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0034 SS=C		E 0034		

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORK NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **023802**	**7101 OLD YORK ROAD PHILADELPHIA, PA 19126**

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E 0034 SS=C	Continued from page 1 483.73(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E 0034	Step1 The facility reviewed and revised the Emergency Preparedness Manual to include a Policy detailing the means of providing information about the facility's needs and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Step2 NHA educated on the requirement to include the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee in its emergency communication plan. Step 3 NHA/ Designee will review the emergency preparedness manual annually to ensure that the emergency communication plan complies with federal and state laws.	Completion Date: **03/21/2025** 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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YORK NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 023802	7101 OLD YORK ROAD PHILADELPHIA, PA 19126

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E 0034 SS=C	Continued from page 2 This REQUIREMENT is not met as evidenced by:	E 0034		

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 0034 SS=C	Continued from page 3 Based on document review and interview, it was determined the facility's emergency preparedness communication plan did not include a means of providing information about the facility's needs and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee, affecting the entire facility. Findings include: Document review on January 30, 2025, at 8:30 a.m., revealed the facility's emergency preparedness communication plan did not include a means of providing information about the facility's needs and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the lack of documentation.	E 0034		

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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	E0039 Step 1 A full-scale disaster drill was completed on 1/10/2025. Evidence and signed documents of the drill were added to the emergency preparedness binder. Step2 NHA educated on the requirement to complete full-scale disaster drills annually and to maintain documentation of the drill in the emergency preparedness binder Step3 NHA/ Designee will review the emergency preparedness manual annually to ensure a full-scale disaster drill was completed within the last 12 months	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/24/2025**

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E 0039 SS=C	Continued from page 5 (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 6 (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		

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E 0039 SS=C	Continued from page 7 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 8 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 9 (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 10 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 11 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 12 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 13 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395687	A. BLDG: __--_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORK NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **023802**	**7101 OLD YORK ROAD PHILADELPHIA, PA 19126**

(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 0039 SS=C	Continued from page 14 Based on document review and interview, it was determined the facility failed to conduct the Emergency Plan's required annual-full scale exercise or accepted substitution, affecting the entire facility. Findings include: Document review on January 30, 2025, at 8:30 a.m., revealed the facility failed to conduct an annual full-scale exercise within the previous 12 months. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the lack of documentation.	E 0039		

Certified End Page

YORK NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 023802

SURVEY EXIT DATE: 01/30/2025

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:
	395687	A. BLDG: 01 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0000	INITIAL COMMENT Facility ID# 023802 Building 01 Center Building Based on a Medicare/Medicaid Recertification Survey completed on January 30, 2025, it was determined that York Nursing And Rehabilitation Center - Center Building was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a three-story, Type V (000), unprotected wood frame building, that is fully sprinklered.	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:
	395687	A. BLDG: 01 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORK NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **023802**	**7101 OLD YORK ROAD** **PHILADELPHIA, PA 19126**

(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 0161 SS=C	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 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by:	K 0161	The facility requests that DOH conduct an FSES review and time limited waiver for K0161 deficiency found during the life safety survey.	Completion Date: **03/21/2025** 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:
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K 0161 SS=C	Continued from page 2	K 0161		

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 0161 SS=C	Continued from page 3 Based on observation, document review and interview, it was determined the facility failed to maintain building construction requirements, affecting this entire building component. Findings include: Document review on January 30, 2025, at 8:30 a.m., revealed the Center Bldg. has been classified as a three story, Type V (000), unprotected wood frame construction, which is fully sprinklered. The building exceeded the maximum allowable story height for an unprotected wood frame construction by two stories. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the building exceeded the maximum allowable story height for this type of construction.	K 0161		

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 0241 SS=C	NFPA 101 Number of Exits - Story and Compartment Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by:	K 0241	The facility requests that DOH conduct an FSES review for K0241 deficiency found during the life safety survey.	Completion Date: 03/21/2025 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 0241 SS=C	Continued from page 5 Based on observation, document review and interview, it was determined the facility failed to provide two acceptable exits from each floor, affecting this entire building component. Findings include: Document review on January 30, 2025, at 9:30 a.m., revealed Center Bldg, all three floors lacked a second acceptable means of exiting from the building. Exiting from this component consisted exclusively of horizontal exits into adjacent health care buildings. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the lack of a second acceptable means of egress from each floor.	K 0241		
K 0324 SS=E		K 0324		

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 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	Step1 The facility has partnered with AVDC for the cleaning of the Main Kitchen Hood Exhaust Systems Every 6 months. Documentation of a semi-annual kitchen exhaust hood/duct cleaning will be added to the life safety binder. Step2 The maintenance director and Food and Nutrition Services Director were educated on the requirement to ensure a semi-annual kitchen hood/duct cleaning is completed and maintain proof of documentation. Step 3 NHA/ designee will audit documentation and ensure this requirement is met semiannually.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/24/2025

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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 kitchen hood exhaust suppression system, affecting one of two inspection. Findings include: Document review on January 30, 2025, at 8:30 a.m., revealed the facility could not produce documentation of a semi-annual kitchen exhaust hood/duct cleaning prior to August 2, 2024. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the lack of documentation.	K 0324		
K 0712 SS=E		K 0712		

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 0712 SS=E	Continued from page 8 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	Step 1 Moving forward, the facility will ensure that fire drills are completed quarterly on each shift. Step 2 The maintenance director was educated on the requirement to conduct quarterly fire drills on each shift. Step 3 The maintenance director/designee will audit fire drill documentation monthly x 4 to ensure that fire drills are completed as required. Findings will be reported in QAPI meeting.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/24/2025

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K 0712 SS=E	Continued from page 9 Based on document review and interview, it was determined the facility failed to conduct and properly document required fire drills, affecting three of twelve quarters. Findings include: Document review on January 30, 2025, at 8:30 a.m., revealed the facility failed to provide documentation of fire drills for the following quarters: a. 1st quarter, 1st shift, 2024 b. 1st quarter, 2nd shift, 2024 c. 1st quarter, 3rd shift, 2024 Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the missing fire drills.	K 0712		

Certified End Page

YORK NURSING AND REHABILITATION CENTER

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Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

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K 0000	INITIAL COMMENT Facility ID# 023802 Building 02 South Building Based on a Medicare/Medicaid Recertification Survey completed on January 30, 2025, it was determined that York Nursing And Rehabilitation Center - South Building was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a three-story, Type II (000), unprotected noncombustible building, that is fully sprinklered.	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.

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K 0133 SS=E	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by:	K 0133	Step 1 The maintenance team used 3M fire barrier sealant CP25B+ to seal penetration around data lines above the double door by the staff development office. Hardware on double doors repaired. Doors now positively latch and are closing appropriately. Step 2 The maintenance director/designee completed an audit of all doors to ensure safe operation. Smoke barriers were inspected throughout the building to ensure that there were no other unsealed penetrations Repairs were completed for any deficiencies found. Step3 The maintenance team was educated on the requirement to ensure the safe operation of all doors in the facility and to ensure that smoke barrier walls have no unsealed penetration. Step 4 The maintenance director/ designee will complete a random audit of doors monthly x 4 to ensure safe operation. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/24/2025**

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K 0133 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain the fire resistance of fire barriers, affecting one of three floors. Findings include: Observation on January 30, 2025, between 9:05 a.m. and 9:15 a.m., revealed on the first floor, common fire wall separation deficiencies: a. above the double doors by the Staff Development Office, an unsealed penetration around data lines; b. by the Staff Development Office, double doors failed to close and positively latch when tested and had broken hardware on the door. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the penetration around data lines.	K 0133		

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 0133 SS=E	Continued from page 3	K 0133		
K 0161 SS=C	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)	K 0161	The facility requests that DOH conduct an FSES review and time limited waiver for K0161 deficiency found during the life safety survey.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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	395687	A. BLDG: 02 B. WING:	01/30/2025

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YORK NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **023802**	**7101 OLD YORK ROAD** **PHILADELPHIA, PA 19126**

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K 0161 SS=C	Continued from page 4 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 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by:	K 0161		

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K 0161 SS=C	Continued from page 5 Based on document review and interview, it was determined the facility failed to maintain building construction requirements, affecting this entire building component. Findings include: Document review on January 30, 2025, at 8:30 a.m., revealed South Building had been classified as a three-story, Type II (000), unprotected non combustible construction, fully sprinklered. The building exceeded the maximum allowable story height for an unprotected non-combustible construction by one story. Exit Interview with the Assistant Administrator and Maintenance Director on April 30, 2024, at 12:45 p.m., confirmed the facility exceeded the maximum allowable story height for this type of construction.	K 0161		

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K 0211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	Step1 Means of egress next to the admissions offices cleared. Step 2 The maintenance team checks all exits to ensure that all means of egress are free of obstruction. Step 3 Facility staff educated on the requirement to ensure that all exits are free of obstruction. Step 4 The maintenance director/ designee will audit all means of egress monthly x4 to ensure that they are free of obstruction. Findings will be reviewed during QAPI	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0211 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain the means of egress free of obstructions, affecting one of three floors. Findings include: Observation on January 30, 2025, at 9:55 a.m., revealed ground floor exit, next to Admissions Office was blocked with boxes, carts and a large indoor plant. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 am, confirmed the means of egress obstructions.	K 0211		
K 0281 SS=E		K 0281		

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K 0281 SS=E	Continued from page 8 NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by:	K 0281	Step 1 Lights on the first-floor South main stair tower repaired Step 2 The maintenance team completed a facility-wide audit of all stairways to ensure that all exit stairways had adequate illumination. Step 3 The maintenance team was educated on the requirement to maintain the Illumination of the exit stairways. Step 4 The maintenance director or designee will audit monthly x4 to ensure that the illumination of the exit stairways is properly maintained. Findings will be reviewed in QAPI	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0281 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain the Illumination of the exit stairways, affecting one of three floors. Findings include: Observation on January 30, 2025, at 9:20 a.m., revealed first floor South, main stair tower had lights that failed to illuminate. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 am, confirmed the exit stair tower lights did not illuminate.	K 0281		
K 0291 SS=E		K 0291		

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K 0291 SS=E	Continued from page 10 NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	Step 1 Back-up lighting on the second floor South next to resident room 230 was repaired. Back-up lighting on the second floor South next to resident room 238 was repaired. Step 2 A facility-wide audit of all emergency battery backup lights was completed to ensure that they operate as required. Step 3 The maintenance team was educated on the requirement to ensure that Emergency lighting of at least 1-1/2-hour duration is provided automatically. Step 4 The maintenance director/ designee will complete a random audit of backup lighting monthly x 4 to ensure safe operation. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0291 SS=E	Continued from page 11 Based on observation and interview, it was determined the facility failed to ensure battery back-up lighting was maintained in operable condition, affecting one of three floors. Findings include: 1. Observation on January 30, 2025, from 10:50 a.m. to 10:55 a.m., revealed the following battery back-up light deficiencies: a. 10:50 a.m., second floor South next to resident room 230, emergency back-up lights failed to illuminate when tested. b. 10:55 a.m., second floor South next to resident room 238, emergency back-up lights failed to turn off after being tested. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 am, confirmed the emergency back-up light deficiencies.	K 0291		

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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 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 0321	Step1 Hardware and self-closer installed on the ground floor Infectious Waste Room. Step 2 A facility-wide audit was completed to ensure that all doors leading to a hazardous area had self-closer and the appropriate hardware installed. Step 3 The maintenance team was educated on the requirement to have the appropriate hardware and self-closer on doors leading to hazardous areas. Step 4 The maintenance director/ designee will audit the infectious waste room to ensure that appropriate hardware and self-closers are installed as required. Findings will be reviewed during QAPI.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0321 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain doors to hazardous areas, affecting one of three levels. Findings Include: 1. Observation on January 30, 2025, at 10:15 a.m., revealed inside the ground floor Environmental Room, the Infectious Waste Room was missing its door hardware and a self-closer. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 am, confirmed the missing hardware and self-closer.	K 0321		
K 0345 SS=F		K 0345		

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K 0345 SS=F	Continued from page 14 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	Step1 Trouble on the fire alarm panel at the ground floor main entrance cleared. Step2 The maintenance team was educated to ensure that the fire alarm system including the fire panel is monitored, tested, and maintained in accordance with the NFPA 70 requirement. Step 3 The maintenance director/ designee will audit the fire panel weekly to ensure safe operation. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0345 SS=F	Continued from page 15 Based on observation 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 30, 2025, at 9:50 a.m., revealed the facility fire alarm panel at ground floor main entrance, displayed Trouble Code #1. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 am, confirmed fire alarm trouble code.	K 0345		
K 0353 SS=E		K 0353		

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K 0353 SS=E	Continued from page 16 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	Step 1 The escutcheon plate by the supervisor's office on 1 South was replaced. The escutcheon plate by room 142 was replaced. Utility box containing six spare sprinkler heads and wrench mounted in the ground floor South Sprinkler Room. Step 2 The maintenance team was educated on the requirement to have a utility box mounted in the sprinkler room and to ensure that the Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25. Step 3 The maintenance director/ designee will audit the sprinkler room monthly x 4 to ensure that all requirements are met. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0353 SS=E	Continued from page 17 Based on observation and interview, it was determined the facility failed to ensure the automatic sprinkler system and its components were maintained, affecting two of three floors. Findings include: 1. Observations made on January 30, 2025, from 9:35 a.m. to 10:25 a.m., revealed the following sprinkler system deficiencies: a. 10:20 a.m., first floor South, by Supervisors Office, a sprinkler was missing escutcheon plate; b. 10:25 a.m., first floor South, by resident room 142, a sprinkler was missing escutcheon plate; c. 9:35 a.m. ground floor South Sprinkler Room, was missing mounted utility box containing six spare sprinkler heads and wrench. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed missing escutcheon plates, spare sprinkler heads and wrench.	K 0353		

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K 0353 SS=E	Continued from page 18	K 0353		
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	Step 1 The maintenance team used 3M fire barrier sealant CP25B+ to seal penetration around data lines above the smoke doors by room 142. Step 2 Smoke barrier walls were inspected throughout the building to ensure that there was no other unsealed penetration. Repairs completed for any deficiencies found. Step3 The maintenance team was educated on the requirement to ensure that there is no unsealed penetration around the data line on smoke barrier walls. Step 4 The maintenance director/ designee will complete a random audit of smoke barrier walls monthly x 4. Findings will be reviewed during the QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0372 SS=E	Continued from page 19 Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls free of unsealed penetrations, affecting one of three floors. Findings include: Observation on January 30, 2025, at 9:30 a.m., revealed first floor South, above the smoke doors by room 142, an unsealed penetration around a data wire. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 am, confirmed smoke wall penetration.	K 0372		
K 0521 SS=E		K 0521		

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K 0521 SS=E	Continued from page 20 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	Step 1 The portable air conditioning unit was removed from the ground floor South Elevator Mechanical Room. Step 2 A facility-wide audit was completed to ensure that no other portable air conditioning units were venting directly into the ceiling. Step 3 The maintenance team was educated on the requirement to ensure that portable air conditioner units are not vented directly into the ceiling. Step 4 The maintenance director/ designee will complete a random audit monthly x 4 to ensure that no portable AC units are vented directly into the ceiling. Findings will be reviewed during QAPI	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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	395687	A. BLDG: __02_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORK NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 023802	7101 OLD YORK ROAD PHILADELPHIA, PA 19126

(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=E	Continued from page 21 Based on document review and interview, it was determined the facility did not properly maintain HVAC systems, affecting one of three floors. Findings include: 1. Observation on January 30, 2025, at 9:55 a.m., revealed ground floor South Elevator Mechanical Room, a portable air conditioning unit being ducted into the ceiling. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 am, confirmed the air conditioning unit being ducted into the ceiling.	K 0521		
K 0918 SS=F		K 0918		

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 22 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 power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	Step 1 The emergency generator was reset to auto Step2 The maintenance team educated on the requirement to ensure that the emergency generator is set to auto to ensure that service can be automatically provided within 10 seconds as required. Step3 The maintenance director will audit the generator setting weekly and ensure that the annunciator panel is set on auto. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0918 SS=F	Continued from page 23 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the generator was maintained, affecting the entire facility. Findings include: Observation on January 30, 2025, at 9:55 a.m., revealed the emergency generator annunciator panel at ground floor main entrance, warning lamp illuminated " Not in Auto " trouble code. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 am, confirmed generator trouble warning.	K 0918		

Certified End Page

YORK NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 023802

SURVEY EXIT DATE: 01/30/2025

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# 023802 Building 03 North Building Based on a Medicare/Medicaid Recertification Survey completed on January 30, 2025, at York Nursing And Rehabilitation Center - North Building, was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two-story, Type II (000), unprotected noncombustible building, with a ground floor, that is fully sprinklered.	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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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	Step1 Ceiling tiles near the sprinkler head on the Second floor North, Stairwell replaced Step 2 A Facility-wide audit was completed to ensure that all ceiling tiles were in good condition. Step 3 The maintenance team was educated on the requirement to ensure that ceiling tiles around sprinkler heads are in good condition and do not negatively affect the activation of the sprinkler system. Step 4 The maintenance director will complete a random audit monthly x4. Findings will be reviewed during QAPI meeting	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0353 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to ensure the automatic sprinkler system and its components were maintained, affecting one of three floors. Findings include: Observations made on January 30, 2025, at 11:05 a.m., revealed on the second floor North, Stairwell had multiple missing and damaged ceiling tiles near a sprinkler head that could negatively affect the activation of the sprinkler system. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the missing and damaged ceiling tiles.	K 0353		
K 0521 SS=E		K 0521		

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 0521 SS=E	Continued from page 3 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	Step 1 The portable air conditioning unit was removed from the dietary office. Step 2 A facility-wide audit was completed to ensure that no other portable air conditioning units were venting directly into the ceiling. Step 3 The maintenance team was educated on the requirement to ensure that portable air conditioner units are not vented directly into the ceiling. Step 4 The maintenance director/ designee will complete a random audit monthly x 4 to ensure that no portable AC units are vented directly into the ceiling. Findings will be reviewed during QAPI	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0521 SS=E	Continued from page 4 Based on document review and interview, it was determined the facility did not properly maintain HVAC systems, affecting one of three floors. Findings include: Observation on January 30, 2025, at 9:40 a.m., revealed on the ground floor, North, Kitchen Dietary Office, a portable air conditioning unit being ducted into the ceiling. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the air conditioning unit being ducted into the ceiling.	K 0521		
K 0911 SS=E		K 0911		

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K 0911 SS=E	Continued from page 5 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	Step 1 Latch placed on the electrical panel labeled MR1 in the ground floor Mechanical Room. Step 2 A facility-wide audit of all electrical panels was completed to ensure that all panels have covers that positively close. Step 3 The maintenance team was educated on the requirement for electrical panels to have covers that are positively closed. Step 4 The maintenance director/ designee will complete the audit monthly x 4 and findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0911 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain protection of electrical wiring, affecting one of three floors. Findings include: Observation made on January 30, 2025, at 10:30 a.m., revealed on the ground floor, Mechanical Room, had an electrical panel labeled MR1 with a missing latch that prevented the cover from closing. Exit interview with the Administrator and the Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the missing latch on the electrical panel.	K 0911		
K 0923 SS=E		K 0923		

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K 0923 SS=E	Continued from page 7 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	Step 1 Caution signage was installed in 1north and 2 North nursing station med room. Step 2 A facility-wide audit was completed to ensure that oxygen storage areas have the appropriate caution signage. Step 3 The maintenance team was educated on the requirement to monitor the oxygen storage area and ensure they have appropriate caution signage. Step 4 The maintenance director/ designee will audit oxygen storage areas monthly x4. Findings will be reviewed during QAPI meeting.	Completion Date: **03/21/2025** Status: **APPROVED** Date: **02/25/2025**

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K 0923 SS=E	Continued from page 8 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

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K 0923 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain oxygen storage requirements, affecting two of three floors. Findings include: Observations on January 30, 2025, between 11:00 a.m. and 11:15 a.m., revealed there were 2 locations that did not have signage required for oxygen storage: a. 11:00 a.m., on the second floor, North Nurses Station, Med Room, missing precautionary signage on entry door; b. 11:15 a.m., on the first floor, North Nurses Station, Med Room, missing precautionary signage on entry door. Precautionary signs shall include the wording: "CAUTION: OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING". Exit interview with the Administrator and the	K 0923		

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K 0923 SS=E	Continued from page 10 Maintenance Director on January 30, 2025, at 11:30 a.m., confirmed the missing signage.	K 0923		

Certified End Page

YORK NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 023802

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