

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395692 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____ | (X3) DATE SURVEY COMPLETED: 03/19/2025 |
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| NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE WASHINGTON PA | | STREET ADDRESS, CITY, STATE, ZIP CODE: 90 HUMBERT LANE WASHINGTON, PA 15301 | | |
| STATE LICENSE NUMBER: 085702 | | | | |
| (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 March 19, 2025, at Transitions Healthcare Washington LLC., 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

TRANSITIONS HEALTHCARE WASHINGTON PA

STATE LICENSE NUMBER: 085702

SURVEY EXIT DATE: 03/19/2025

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 | <p>INITIAL COMMENT</p> <p>Facility ID# 085702 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on March 19, 2025, it was determined that Transitions Healthcare Washington LLC. 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).</p> <p>This is a one-story, Type III (200), unprotected ordinary building, with a basement, that is fully sprinklered.</p> | K 0000 | | |

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| K 0100 SS=C | 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 | <ol style="list-style-type: none"> The facility has a Carbon Monoxide Evacuation and alarm policy that has been effective since 6/1/2018. The Director of Operations provided education to the Nursing Home Administrator and Director of Plant Operations as to the location of this policy. The policy will be reviewed by the Safety committee and a carbon monoxide alarm drill will be conducted. Additionally, the policy was taken to QAPI for review and placed in the emergency preparedness binder. | Completion Date: 05/05/2025 Status: APPROVED Date: 04/01/2025 |
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| K 0100 SS=C | Continued from page 2 Based on documentation review and interview, it was determined that the facility failed to maintain battery operated 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. Observation on March 19, 2025, at 8:48 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 Facility Administrator, Maintenance Personnel, and the Plant Operations Director on March 19, 2025, at 12:30 p.m. confirmed the Carbon Monoxide alarms deficiency. | K 0100 | | |
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| K 0351 SS=D | <p>NFPA 101 Sprinkler System - Installation</p> <p>Spinkler System - Installation 2012 EXISTING</p> <p>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>This REQUIREMENT is not met as evidenced by:</p> | K 0351 | <ol style="list-style-type: none"> Sprinkler heads were converted so that all sprinkler heads were standardized to the quick response sprinkler head No other variant sprinkler heads were identified within the facility. The Director of Plant operations or designee will audit sprinkler heads to ensure that they are all the quick response sprinkler heads monthly x 3 months Audits will be taken to the safety committee and submitted to the QAPI committee for review of findings and further interventions are warranted. | <p>Completion Date: 05/05/2025</p> <p>Status: APPROVED</p> <p>Date: 04/01/2025</p> |
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| K 0351 SS=D | Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain automatic sprinkler system installation requirements in one instance, in one of more than 30 sprinklered compartments inspected throughout the building. Findings Include: 1. Observation on March 19, 2025, between 10:35 a.m. and 10:55 a.m., revealed standard response sprinkler heads mixed with quick response sprinkler heads in the basement hallway. Interview with the Facility Administrator, Maintenance Personnel, and the Plant Operations Director on March 19, 2025, at 12:30 p.m., confirmed the mixed response sprinkler heads were present. | K 0351 | | |
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| K 0353 SS=D | <p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by:</p> | K 0353 | <p>1. The ceiling tile in the electrical/maintenance office was replaced so no gap exists. The escutcheon plate was replaced in the laundry room</p> <p>2. No further ceiling tiles were identified that had a gap. No other escutcheon plates were identified as missing.</p> <p>3. The Director of Plant operations or designee will audit ceiling tiles and escutcheon plates monthly x 3 months</p> <p>Audits will be taken to the safety committee and submitted to the QAPI committee for review of findings and further interventions are warranted.</p> | <p>Completion Date: 05/05/2025</p> <p>Status: APPROVED</p> <p>Date: 04/01/2025</p> |
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| K 0353 SS=D | Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in two instances, in two of over 30 rooms inspected. Findings include: 1. Observation and document review on March 19, 2025, revealed the following automatic sprinkler system deficiencies: a) 9:50 a.m., there was a large gap in the ceiling tile above an electrical panel in the Electrical Room/Maintenance Office which would allow the passage of heat and smoke, and may affect operation of the automatic sprinkler system; b) 10:10 a.m., a sprinkler head was missing an escutcheon plate in the laundry Room, near the washing machines. Interview with the Facility Administrator, Maintenance Personnel, and the Plant Operations | K 0353 | | |

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| K 0353 SS=D | Continued from page 7 Director on March 19, 2025, at 12:30 p.m., confirmed the above listed automatic sprinkler system deficiencies. | K 0353 | | |
| K 0363 SS=D | NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke | K 0363 | 1. The doors of room 124, 125 and 134 had the hinges tightened and the transitions trips have been exchanged to ensure an easy closure of the door. 2. No other doors were identified as not latching. 3. The Director of Plant operations or designee will audit the latching of doors monthly x 3 months 4. Audits will be taken to the safety committee and submitted to the QAPI committee for review of findings and further interventions are warranted. | Completion Date: 05/05/2025 Status: APPROVED Date: 04/01/2025 |

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| K 0363 SS=D | Continued from page 8 compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: | K 0363 | | |
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| K 0363 SS=D | Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain corridor doors in four instances, for four of more than 40 corridor doors inspected in the facility. Findings include: 1. Observation on March 19, 2025, revealed the following corridor doors would not close and latch when tested: a) 10:33 a.m., the door to resident room 124; b) 10:36 a.m., the door to resident room 125; c) 10:58 a.m., the door to resident room 134. Interview with the Facility Administrator, Maintenance Personnel, and the Plant Operations Director on March 19, 2025, at 12:30 p.m., confirmed the corridor door deficiencies. | K 0363 | | |
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| K 0374 SS=E | NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: | K 0374 | 1. The smoke door on ICF 1 is being evaluated by the vendor for repair or replacement if indicated. 2. No other smoke doors were identified with gaps 3. The Director of Plant operations or designee will audit smoke barrier doors monthly x 3 months 4. Audits will be taken to the safety committee and submitted to the QAPI committee for review of findings and further interventions are warranted. | Completion Date: 05/05/2025 Status: APPROVED Date: 04/01/2025 |
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| K 0374 SS=E | Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors in one instance, affecting two of nine smoke compartments. Findings include: 1. Observation on March 19, 2025, at 11:40 a.m., revealed the smoke barrier doors leading to rooms 100-132 (ICF-1), had an excessive gap between the meeting edges of the doors, which would not resist the passage of smoke. Interview with the Facility Administrator, Maintenance Personnel, and the Plant Operations Director on March 19, 2025, at 12:30 p.m., confirmed the smoke barrier doors had an excessive gap that would not resist the passage of smoke. | K 0374 | | |
| K 0521 SS=C | | K 0521 | | |

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| K 0521 SS=C | Continued from page 12 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 | 1. The damper inspection was completed on 2/27/2025 and a copy of the inspection was obtained from the vendor and is maintained at the facility. 3 motors were installed 3/10/24 and all dampers had passed inspection. 2. Education was completed by the NHA to the Director of Plant Operations on keeping documents in an orderly binder, 3. The document was placed in the life safety binder. 4. TELS was updated to reflect the next 4-year scheduled inspection due date | Completion Date: 05/05/2025 Status: APPROVED Date: 04/01/2025 |
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| K 0521 SS=C | Continued from page 13 Based on documentation review and interview, it was determined the facility failed to ensure smoke dampers were inspected within the required four year period, affecting the entire facility Findings include: 1. Review of documentation on March 19, 2025, at 9:00 a.m., revealed the facility lacked documentation to indicate that smoke dampers were inspected every four years in accordance with NFPA 105, Standard for the Installation of Smoke Door Assemblies and Other Opening Protectives. Interview with the Facility Administrator, Maintenance Personnel, and the Plant Operations Director on March 19, 2025, at 12:30 p.m., confirmed the smoke damper inspection documentation was not available at the time of the survey. | K 0521 | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395692 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 03/19/2025 |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE WASHINGTON PA | | STREET ADDRESS, CITY, STATE, ZIP CODE: 90 HUMBERT LANE WASHINGTON, PA 15301 | | |
| STATE LICENSE NUMBER: 085702 | | | | |
| (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 0918 SS=C | <p>NFPA 101 Electrical Systems - Essential Electric Syste</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing</p> <p>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.</p> <p>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.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> | K 0918 | <ol style="list-style-type: none"> The facility generator runs on a maintenance free battery. A battery voltage testing device has been obtained. The maintenance director or designee will conduct weekly battery voltage testing and monthly battery voltage testing and monthly conductive testing and document the findings. No other generator documentation was identified as missing. Education was provided to the Maintenance Director on K918 and the weekly and monthly testing has been added to the TELS system. The Director of Plant operations or designee will battery voltage and conductive testing monthly x 3 months | <p>Completion Date: 05/05/2025</p> <p>Status: APPROVED</p> <p>Date: 04/01/2025</p> |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395692 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | | (X3) DATE SURVEY COMPLETED: 03/19/2025 |
|---|--|---|--|--------------------|--|
| NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE WASHINGTON PA STATE LICENSE NUMBER: 085702 | | | STREET ADDRESS, CITY, STATE, ZIP CODE: 90 HUMBERT LANE WASHINGTON, PA 15301 | | |
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| K 0918 SS=C | Continued from page 15 | K 0918 | | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395692 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 03/19/2025 |
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| NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE WASHINGTON PA | | STREET ADDRESS, CITY, STATE, ZIP CODE: 90 HUMBERT LANE WASHINGTON, PA 15301 | | |
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| K 0918 SS=C | Continued from page 16 Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator in two instances, affecting the entire facility. Findings include: 1. Review of documentation on March 19, 2025, at 8:30 a.m., revealed the facility could not produce documentation for the following: a) weekly inspection for battery electrolyte levels or battery voltage; b) monthly electrolyte specific gravity or conductance testing. Interview with the Facility Administrator, Maintenance Personnel, and the Plant Operations Director on March 19, 2025, at 12:30 p.m., confirmed the lack of documentation at the time of the survey. | K 0918 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395692 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | | (X3) DATE SURVEY COMPLETED: 03/19/2025 |
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| K 0918 SS=C | Continued from page 17 | K 0918 | | | |



Certified End Page

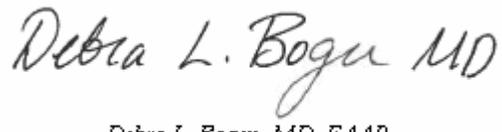
TRANSITIONS HEALTHCARE WASHINGTON PA

STATE LICENSE NUMBER: 085702

SURVEY EXIT DATE: 03/19/2025

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