STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395833	A. BLDG: __--_____ B. WING: _____	01/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CARE CENTER AT WHITE HORSE VILLAGE, THE STATE LICENSE NUMBER: **235902**	**535 GRADYVILLE ROAD NEWTOWN SQUARE, PA 19073**

(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 13, 2025, it was determined that The Healthcare Center at White Horse Village had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0007 SS=B		E 0007		

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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STATE LICENSE NUMBER: **235902**	

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E 0007 SS=B	Continued from page 1 483.73(a)(3) EP Program Patient Population §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD	E 0007	Facility established policy to define the patient population served, patients at risk and the types of services that the community can provide in an emergency to ensure continuity. The Senior Director of Property and Facilities will ensure the Emergency Operations Manual and related policies are reviewed on an annual basis. Results of review will be submitted by The Senior Director of Property and Facilities to the Quality Assurance and Performance Improvement Committee on an annual basis	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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E 0007 SS=B	Continued from page 2 facilities.] This REQUIREMENT is not met as evidenced by:	E 0007		

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E 0007 SS=B	Continued from page 3 Based on document review and interview, it was determined the facility failed to ensure policies and procedures were in place addressing patient population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans, affecting the entire facility. Findings include: Document review on January 13, 2025, at 8:00 a.m., revealed the Facility's Emergency Preparedness Plan did include policies and procedures that addressed persons at-risk, affecting the entire facility. Exit interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:30 a.m., confirmed the lack of documentation.	E 0007		

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E 0023 SS=B	483.73(b)(5) Policies/Procedures for Medical Documentation §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.542(b)(5), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b) and REHs at §485.542(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A	E 0023	Facility established a policy for protection of privacy with appropriate users and disclosures of protected Health information during an emergency. The Senior Director of Property and Facilities will ensure the Emergency Operations Manual and related policies are reviewed on an annual basis. Results of review will be submitted by The Senior Director of Property and Facilities to the Quality Assurance and Performance Improvement Committee on an annual basis	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

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E 0023 SS=B	Continued from page 5 system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by:	E 0023		

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 0023 SS=B	Continued from page 6 Based on documentation review and interview, it was determined the facility failed to develop Emergency Plan policies and procedures that included a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records, affecting the entire facility. Findings include: Document review on January 13, 2025, at 8:00 a.m., revealed facility failed to develop Emergency Plan policies and procedures that included a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. Exit interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:30 a.m., confirmed the lack of documentation.	E 0023		

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 0024 SS=B	483.73(b)(6) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an	E 0024	Facility established policy for the use of volunteers in an emergency or other staffing strategies. The Senior Director of Property and Facilities will ensure the Emergency Operations Manual and related policies are reviewed on an annual basis. Results of review will be submitted by The Senior Director of Property and Facilities to the Quality Assurance and Performance Improvement Committee on an annual basis	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

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E 0024 SS=B	Continued from page 8 emergency. This REQUIREMENT is not met as evidenced by:	E 0024		

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E 0024 SS=B	Continued from page 9 Based on document review and interview, it was determined the facility failed to ensure policies and procedures were in place addressing the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency, affecting the entire facility. Findings include: Document review on January 13, 2025, at 8:00 a.m., revealed the Facilities Emergency Preparedness Plan did not have policy and procedures addressing the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency, affecting the entire facility. Exit interview with the Administrator and the Maintenance Director on January 13, 2025, at	E 0024		

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E 0024 SS=B	Continued from page 10 10:30 a.m., confirmed the lack of documentation.	E 0024		
E 0026 SS=B	483.73(b)(8) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the	E 0026	Facility established policy to establish roles for providing care during emergencies under blanket or specific $1135 waivers. The Senior Director of Property and Facilities will ensure the Emergency Operations Manual and related policies are reviewed on an annual basis. Results of review will be submitted by The Senior Director of Property and Facilities to the Quality Assurance and Performance Improvement Committee on an annual basis	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

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E 0026 SS=B	Continued from page 11 provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by:	E 0026		

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 0026 SS=B	Continued from page 12 Based on document review and interview, it was determined the facility failed to provide policy and procedure documentation concerning the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials, affecting the entire facility. Findings include: Document review on January 13, 2025, at 8:00 a.m., revealed the facility could not provide Emergency Preparedness Plan policy and procedure documentation concerning the Roles under a Waiver Declared by Secretary. Exit interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:30 a.m., confirmed the lack of documentation.	E 0026		

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E 0033 SS=B	483.73(c)(4)-(6) Methods for Sharing Information §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(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: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election	E 0033	The facility established policy to share appropriate information form the facility's emergency plan with resident's and their representatives. The Senior Director of Property and Facilities will ensure the Emergency Operations Manual and related policies are reviewed on an annual basis. Results of review will be submitted by The Senior Director of Property and Facilities to the Quality Assurance and Performance Improvement Committee on an annual basis	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

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E 0033 SS=B	Continued from page 14 statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by:	E 0033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395833	A. BLDG: __--_____ B. WING: _____	01/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CARE CENTER AT WHITE HORSE VILLAGE, THE STATE LICENSE NUMBER: **235902**	**535 GRADYVILLE ROAD NEWTOWN SQUARE, PA 19073**

(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 0033 SS=B	Continued from page 15 Based on document review and interview, it was determined the facility's emergency preparedness communication plan failed to include a method for sharing information and medical documentation for patients under the facility's care with other health care providers to maintain the continuity of care, affecting the entire facility. Findings include: Document review on January 13, 2025, at 8:00 a.m., revealed the facility's emergency preparedness communication plan lacked a method for sharing information and medical documentation for patients under the facility's care, with other health care providers to maintain the continuity of care. Exit interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:30 a.m., confirmed the lack of documentation.	E 0033		

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E 0034 SS=B	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. This REQUIREMENT is not met as evidenced by:	E 0034	Facility established policy to provide information about the community's occupancy, needs and its ability to provide assistance, to authorities having jurisdiction. The Senior Director of Property and Facilities will ensure the Emergency Operations Manual and related policies are reviewed on an annual basis. Results of review will be submitted by The Senior Director of Property and Facilities to the Quality Assurance and Performance Improvement Committee on an annual basis	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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E 0034 SS=B	Continued from page 17 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 ASC'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 13, 2025, at 8:00 a.m., revealed the facility's emergency preparedness communication plan did not include 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. Exit interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:30 a.m., confirmed the lack of documentation.	E 0034		

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E 0035 SS=B	483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC 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 annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID 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. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by:	E 0035	Facility established policy to share appropriate information from the facility's emergency plan with residents and their representatives. The Senior Director of Property and Facilities will ensure the Emergency Operations Manual and related policies are reviewed on an annual basis. Results of review will be submitted by The Senior Director of Property and Facilities to the Quality Assurance and Performance Improvement Committee on an annual basis	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

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E 0035 SS=B	Continued from page 19 Based on document review and interview, it was determined the facility failed to maintain and update an emergency preparedness communication plan that includes a method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families or representatives. Findings include: Document review January 13, 2025, at 8:00 a.m., revealed the emergency communications plan did not include a method of sharing information from the emergency plan with residents and their families or representatives, affecting the entire facility. Exit interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:30 a.m., confirmed the lack of documentation.	E 0035		

Certified End Page

HEALTH CARE CENTER AT WHITE HORSE VILLAGE, THE

STATE LICENSE NUMBER: 235902

SURVEY EXIT DATE: 01/13/2025

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:
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K 0000	INITIAL COMMENT Facility ID# 235902 Building 01 Health Care Center Based on a Medicare/Medicaid Recertification Survey completed on January 13, 2025, it was determined that The Health Care Center At White Horse Village 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 (111), protected noncombustible building, with a basement, 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.

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STATE LICENSE NUMBER: **235902**	

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K 0131 SS=E	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by:	K 0131	Rated Double Door has been adjusted to ensure the doors are smoke tight, close and positively latch to maintain their fire rating. Maintenance will conduct weekly audits for 4 weeks, then monthly audits to ensure doors are smoke tight. All audits will be reviewed by The Senior Director of Property and Facilities and submitted to the Quality Assurance Performance Improvement Committee on a monthly basis for 12 months.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/31/2025**

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K 0131 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to ensure common wall fire separations maintained a fire resistance rating, affecting one of three levels within the facility. Findings include: Observation made on January 13, 2025, at 9:00 a.m., revealed the rated double doors near the basement loading dock failed to fully close and positively latch when tested. Exit Interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:15 a.m., confirmed the doors failed to fully close and positively latch when tested.	K 0131		
K 0291 SS=E		K 0291		

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K 0291 SS=E	Continued from page 3 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	The emergency battery back-up light was replaced and tested as fully operable. Maintenance will conduct weekly audits for 4 weeks, then monthly audits to ensure the battery back-up light is fully operational. All audits will be reviewed by The Senior Director of Property and Facilities and submitted to the Quality Assurance Performance Improvement Committee on a monthly basis for 12 months.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/31/2025**

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K 0291 SS=E	Continued from page 4 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: Observation on January 13, 2025, at 9:30 a.m., revealed in the South Hall, in the basement Generator Room, the emergency battery back-up light nearest the generator failed to illuminate when tested. Exit Interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:15 a.m., confirmed the battery back-up lights failed to illuminate when tested.	K 0291		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 5 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	The proper documentation for the 3-year dry system full flow test and 5-year internal valve and pipe inspection was obtained from Metropolitan Fire Protection Co., Inc. The documentation will be kept on file and included in each annual documentation set as needed. Monthly audits will be done by the Maintenance Manager to ensure all documentation is current. All audits will be reviewed by the Director of Facilities and Plan Operations and submitted to the Quality Assurance Performance Improvement Committee monthly ongoing.	Completion Date: **01/16/2025** Status: **APPROVED** Date: **01/31/2025**

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K 0353 SS=F	Continued from page 6 Based on document review and interview, it was determined the facility failed to maintain and inspect the sprinkler system, affecting the entire facility. Findings include: Documentation review on January 13, 2025, at 8:00 a.m., revealed the facility could not provide documentation of the following: a. 3 year dry system full flow test; b. 5 year internal valve and pipe inspection. Exit interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:30 a.m., confirmed the lack of documentation.	K 0353		
K 0355 SS=F		K 0355		

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K 0355 SS=F	Continued from page 7 NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	The proper documentation was obtained from Clark Fire Protection. The certificate will be kept on file and updated as needed. Monthly audits will be done by the Maintenance Manager to ensure all documentation is current. All audits will be reviewed by the Director of Facilities and Plan Operations and submitted to the Quality Assurance Performance Improvement Committee monthly ongoing.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **01/31/2025**

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K 0355 SS=F	Continued from page 8 Based on documentation review and interview, it was determined the facility failed to maintain and inspect portable fire extinguishers, affecting the entire facility. Findings include: Documentation review on January 13, 2025, at 8:00 a.m., revealed the facility could not provide the certification for the technician performing the annual portable fire extinguisher maintenance. Exit interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:30 a.m., confirmed the lack of documentation.	K 0355		
K 0363 SS=E		K 0363		

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K 0363 SS=E	Continued from page 9 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	The heater fan was removed at the time of survey on 1/13/2025 to ensure clear access to an electrical panel. Maintenance will conduct a daily audit for 30 days, then weekly audits are ongoing to ensure clear access to the electrical panel. Housekeeping, Laundry, Transportation, Maintenance and Dining Staff will be in-serviced on keeping the electrical panels clear at all times. All audits will be reviewed by The Senior Director of Property and Facilities and results submitted to the Quality Assurance Performance Improvement Committee on a monthly basis ongoing.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395833	A. BLDG: __01_____ B. WING: _____	01/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CARE CENTER AT WHITE HORSE VILLAGE, THE STATE LICENSE NUMBER: **235902**	**535 GRADYVILLE ROAD NEWTOWN SQUARE, PA 19073**

(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 0363 SS=E	Continued from page 10 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: Based upon observation and interview, it was determined the facility failed to ensure that accessibility to electrical panels was kept clear, affecting one of three levels in the facility. Findings include: Observation on January 13, 2025, at 8:50 a.m., revealed a heater fan blocked the access to an electrical panel in the basement, next to the kitchen storage room. Exit Interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:15 a.m., confirmed the unauthorized use of the blocked electrical panel.	K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CARE CENTER AT WHITE HORSE VILLAGE, THE	**535 GRADYVILLE ROAD NEWTOWN SQUARE, PA 19073**
STATE LICENSE NUMBER: **235902**	

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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	Both sets of doors have been adjusted to ensure doors are smoke tight and maintain their fire rating. Maintenance will conduct weekly audits for 4 weeks then monthly audits to ensure doors are smoke tight. All audits will be reviewed by The Senior Director of Property and Facilities and results submitted to the Quality Assurance Performance Improvement Committee on a monthly basis ongoing.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CARE CENTER AT WHITE HORSE VILLAGE, THE STATE LICENSE NUMBER: 235902	535 GRADYVILLE ROAD NEWTOWN SQUARE, PA 19073

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K 0374 SS=E	Continued from page 12 Based on observation and interview, it was determined the facility failed to maintain smoke doors, affecting one of three levels. Findings include: Observation on January 13, 2025, at 10:15 a.m., revealed the double corridor smoke doors at room 108, would not close smoke tight. Exit Interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:15 a.m., confirmed the doors would not close smoke tight.	K 0374		
K 0920 SS=E		K 0920		

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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HEALTH CARE CENTER AT WHITE HORSE VILLAGE, THE STATE LICENSE NUMBER: **235902**	**535 GRADYVILLE ROAD NEWTOWN SQUARE, PA 19073**

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K 0920 SS=E	Continued from page 13 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	The refrigerator and microwave plugs were removed from surge protectors at the time of inspection. The staff were in-serviced on proper use of outlet strips for electronics only. Maintenance will conduct weekly audits for 4 weeks then monthly audits to ensure outlet strips are not used improperly. All audits will be reviewed by The Senior Director of Property and Facilities and submitted to the Quality Assurance Performance Improvement Committee on a monthly basis for 12 months. Emergency Plan - Plan of Correction	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/31/2025**

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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HEALTH CARE CENTER AT WHITE HORSE VILLAGE, THE STATE LICENSE NUMBER: **235902**	**535 GRADYVILLE ROAD NEWTOWN SQUARE, PA 19073**

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K 0920 SS=E	Continued from page 14 Based on observation and interview, it was determined the facility failed to prohibit the improper and unauthorized use of surge protectors, affecting one of three levels in the facility. Findings include: Observation on January 13, 2025, between 8:45 a.m. and 9:25 a.m., revealed the following deficiencies: a. inside the Driver's Office on the basement level, there was a refrigerator plugged into a surge protector; b. inside the Security Office on the basement level, there was a microwave plugged into a surge protector. Exit Interview with the Administrator and the Maintenance Director on January 13, 2025, at 10:15 a.m., confirmed the unauthorized use of a surge protector.	K 0920		

Certified End Page

HEALTH CARE CENTER AT WHITE HORSE VILLAGE, THE

STATE LICENSE NUMBER: 235902

SURVEY EXIT DATE: 01/13/2025

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