STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395961	A. BLDG: __--_____ B. WING: _____	06/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PHILADELPHIA PROTESTANT HOME STATE LICENSE NUMBER: **681002**	**6500 TABOR ROAD PHILADELPHIA, PA 19111**

(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 June 30, 2025, it was determined that Philadelphia Protestant Home had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0004 SS=C	483.73(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:	E 0004	Policy has been reviewed and updated. Policy will be reviewed and updated annually and as needed.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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

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

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

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E 0004 SS=C	Continued from page 1 (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by:	E 0004		

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E 0004 SS=C	Continued from page 2 Based on documentation review and interview, it was determined the facility failed to ensure Emergency Preparedness Plan policies and procedures were reviewed and updated at least annually, affecting the entire facility. Findings include: Interview and document review on June 30, 2025, at 8:30 a.m., revealed the Facility's Emergency Preparedness Plan had not been reviewed and updated at least annually. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security on June 30, 2025, at 3:15 p.m., confirmed the documentation was not available.	E 0004		
E 0007 SS=C		E 0007		

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E 0007 SS=C	Continued from page 3 483.73(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	Policy in place and will ensure that policy is present in emergency preparedness binder for future surveys.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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E 0007 SS=C	Continued from page 4 facilities.] This REQUIREMENT is not met as evidenced by:	E 0007		

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E 0007 SS=C	Continued from page 5 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 can provide in an emergency; and continuity of operations, including delegations of authority and succession plans, affecting the entire facility. Findings include: Interview and document review on June 30, 2025, at 8:30 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 Maintenance Supervisor and Director of Safety/ Security on June 30, 2025, at 3:15 p.m., confirmed the documentation was not available.	E 0007		

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E 0009 SS=C	483.73(a)(4) Local, State, Tribal Collaboration Process §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by:	E 0009	Policy in place and will ensure that policy is present in emergency preparedness binder for future surveys.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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E 0009 SS=C	Continued from page 7 Based on document review and interview, it was determined the facility failed to develop and maintain an emergency preparedness plan that included a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts, affecting the entire facility. Findings include: Interview and document review on June 30, 2025, at 8:30 a.m., revealed the facility failed to develop and maintain an emergency preparedness communication plan that included a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency	E 0009		

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E 0009 SS=C	Continued from page 8 situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the documentation was not available.	E 0009		
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:	E 0039	Disaster drills have been scheduled for 2025. Director of Safety & Security will develop schedule and ensure at least two drills are scheduled annually. Facility emergency preparedness plan was activated in May 2025 due to elopement. Documentation added to emergency preparedness binder. Community based drill is scheduled for September 2025.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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

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E 0039 SS=C	Continued from page 10 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: (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:	E 0039		

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E 0039 SS=C	Continued from page 11 (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 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	E 0039		

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E 0039 SS=C	Continued from page 12 [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 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	E 0039		

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E 0039 SS=C	Continued from page 13 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 (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):]	E 0039		

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(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 (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 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.	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395961	A. BLDG: __--_____ B. WING: _____	06/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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E 0039 SS=C	Continued from page 15 *[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 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.	E 0039		

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E 0039 SS=C	Continued from page 16 *[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 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	E 0039		

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E 0039 SS=C	Continued from page 17 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 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.	E 0039		

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E 0039 SS=C	Continued from page 18 (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:
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E 0039 SS=C	Continued from page 19 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 and the required additional exercise or accepted substitution, affecting the entire facility. Findings include: Interview and document review on June 30, 2025, at 8:30 a.m., revealed the facility failed to conduct an annual full-scale exercise or accepted substitution and an additional exercise or accepted substitution within the previous 12 months. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the documentation was not available.	E 0039		

Certified End Page

PHILADELPHIA PROTESTANT HOME

STATE LICENSE NUMBER: 681002

SURVEY EXIT DATE: 06/30/2025

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:
	395961	A. BLDG: 01 B. WING:	06/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0000	INITIAL COMMENT Facility ID# 681002 Building 01 Pathways Based on a Medicare/Medicaid Recertification Survey completed on June 30, 2025, it was determined that Philadelphia Protestant Home 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 four-story, Type II (222), fire resistive 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:
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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	Approval for window renovation received from DSI on 5/15/25. Facility will ensure that approval is obtained prior to beginning any future renovations. Facility will ensure that floor plans are readily available for future surveys. Carbon monoxide policy in place. Staff will be educated on carbon monoxide policy.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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 0100 SS=C	Continued from page 2 28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met. 35 P.S. § 448.808. Issuance of license. (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met: (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered. Based on observation, document review and	K 0100		

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K 0100 SS=C	Continued from page 3 interview, it was determined the facility failed to notify the Department of Health of an event at the facility that compromised quality assurance or patient safety, affecting the entire facility. Findings include: 1. Observation on June 30, 2025, between 8:30 a.m., and 11:00 a.m., revealed the facility failed to notify the Pennsylvania Department of Health before initiating external window renovations throughout the facility and additional interior renovations to a "shut down" wing on the ground floor after a water damage. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the facility failed to obtain Department-approved plans prior to initiating alterations and renovations. ***28 Pa Code § 51.3. Notification (d)*** 2. Document review on June 30, 2025, between	K 0100		

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K 0100 SS=C	Continued from page 4 8:30 a.m., and 11:00 a.m., revealed the facility failed to provide portable Life Safety Code Floor Plans that included the following information: a. Smoke barrier walls b. Fire barrier walls; (outside wall to outside wall); c. Horizontal exits; d. Rated rooms (storage rooms, soiled utility rooms, designated medical gas rooms) will be clearly designated. It is the facility's responsibility to have all rated rooms indicated on its Life Safety Code Floor Plan; e. Required exits should be clearly noted; f. Shafts walls. Exit Interview with the Maintenance Supervisor, and Director of Safety/ Security on June 30, 2025, at 3:15 p.m., confirmed portable floor plans were unavailable at time of survey. 3. Document review on June 30, 2025, between 8:00 a.m., and 11:00 a.m., revealed the facility failed	K 0100		

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K 0100 SS=C	Continued from page 5 to provide a carbon monoxide alarm evacuation policy plan and associated staff in-service to the plan. in accordance with the 2016 Act 48 - Care Facility Carbon Monoxide Alarms Standards Act; affecting the entire facility. Exit Interview with the Maintenance Supervisor, and Director of Safety/ Security on June 30, 2025, at 3:15 p.m., confirmed the lack of documentation.	K 0100		

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K 0225 SS=F	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	All non-latching doors have been adjusted and doors now latch appropriately. Doors will be monitored during environmental rounds by maintenance staff. The hollow area identified was tested and no door present behind sheetrock. That areas consists of two layers of 5/8" sheetrock. Inspection holes were filled with red fire stop caulking to maintain fire barrier.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/04/2025**

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 0225 SS=F	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain the fire resistive rating of exit stair tower enclosures, affecting four of four levels within the component. Findings include: 1. Observation made on June 30, 2025, at 1:45 p.m, on the ground floor, revealed all four rated doors, inside stairwell enclosure, to the stair tower in between Personal Care and Skilled Nursing, failed to positively latch. 2. Observation made on June 30, 2025, at 2:00 p.m, on the ground floor, revealed a hallow wooden door was sealed within a door frame, within the cinder block wall, within the stairway enclosure. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the doors failed to latch and that an unknown rated wooden door was sealed into a fire rated wall.	K 0225		

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K 0225 SS=F	Continued from page 8	K 0225		
K 0291 SS=C	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	90 minute test of battery back up lighting completed and on file. Facility will ensure that proof of testing is available for survey team during all inspections.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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 0291 SS=C	Continued from page 9 Based on document review and interview, it was determined the facility failed to ensure testing of battery back up lighting was conducted and documented affecting the entire facility. Findings include: Document review on June 30, 2025, between 8:30 a.m. and 11:00 a.m., revealed the facility could not produce documentation of the annual 90 minute testing of the battery back up lighting during the time of the survey. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the missing annual 90 minute testing report.	K 0291		
K 0321 SS=E		K 0321		

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 0321 SS=E	Continued from page 10 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)	K 0321	Door has been fixed and is latching appropriately. Doors will be monitored during environmental rounds by maintenance staff.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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 0321 SS=E	Continued from page 11 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to hazardous area enclosures are self-closing and positively latching, affecting one of four levels in the component. Findings include: Observation on June 30, 2025, at 12:10 p.m, revealed the rated door, to the trash room on the third floor, failed to self-close and positively latch. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the door failed to self-close and positively latch.	K 0321		

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K 0324 SS=F	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	Semi-annual inspections were completed. Facility will ensure documentation of testing is available for survey team during all inspections.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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K 0324 SS=F	Continued from page 13 Based on interview and documentation review, it was determined the facility failed to ensure the kitchen fire suppression system was inspected for two of two semi-annual inspections. Findings include: Documentation review on June 30, 2025, between 8:30 a.m. and 11:00 a.m., revealed the facility could not produce documentation that semi-annual inspections had been performed on the kitchen fire suppression system. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed two semi-annual inspection reports were not presented at time of survey.	K 0324		
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	Fire alarm system was inspected on January 6th & 7th, 2025 and documentation received from contractor. Facility will ensure documentation is available for survey team. Facility will ensure that any troubles identified on fire panel are promptly addressed and contractor is notified if necessary.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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K 0345 SS=F	Continued from page 15 Based on document review and interview, it was determined the facility failed to maintain and inspect the fire alarm system, affecting the entire facility. Findings include: 1. Document review on June 30, 2025, between 8:30 a.m., and 11:00 a.m., revealed the facility could not provide documentation of: a. Smoke detector sensitivty testing within the past 2 years. b. Annual Inspection / Testing. c. Semi-annual visual inspection. d. Valve Supervisory Switches (semi-annual) e. Vane and Pressure Switch waterflow alarm devices (semi-annual) 2. Observation on June 30, 2025, at 2:30 p.m., revealed that the fire alarm panel had listed 95 device troubles at time of survey. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15	K 0345		

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K 0345 SS=F	Continued from page 16 p.m., confirmed the lack of documentation and the alarm panel indicated device troubles.	K 0345		
K 0346 SS=F	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by:	K 0346	Fire watch policy in place. Facility will ensure policy is available for survey team during all inspections.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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K 0346 SS=F	Continued from page 17 Based on document review and interview, it was determined the facility failed to maintain required policies for the fire alarm system, affecting the entire facility. Findings include: Document review on June 30, 2025, between 8:30 a.m. and 11:00 a.m., revealed the facility did not have a fire watch policy to implement in the event the required fire alarm system was out of service for more than four hours in a 24-hour period. Interview at the exit conference with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the missing policy.	K 0346		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 18 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	Sprinkler system was inspected January 20th – 24th, 2025 and documentation received from contractor. Facility will ensure documentation is available for survey team during all inspections. Contractor has been contacted to repair broken sprinkler head identified during survey. Maintenance team will monitor sprinkler heads during environmental rounds.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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K 0353 SS=F	Continued from page 19 Based on document review, observation, and interview, it was determined the facility failed to maintain, inspect, and test fire sprinkler systems in four of four annual quarters. Findings include: 1. Document review on June 30, 2025, between 8:30 a.m. and 11:00 a.m., revealed the facility lacked documentation to indicate that testing of the fire sprinkler system was performed for the following: a. Supervisory Devices b. Mechanical waterflow alarm devices. (Qtrly) c. Main Drain test - (Annual) d. Control Valves - (Annual) e. Sprinkler Guages (5 year) f. Internal Valve Inspection (5 year) g. Internal Pipe Inspection (5 Year) h. Obstruction Investigation. 2. Observation on June 30, 2025, at 2:15 p.m.,	K 0353		

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K 0353 SS=F	Continued from page 20 revealed, on the first floor outside main supply room, a frangible bulb inside a sprinkler head did not have fluid (alcohol) inside. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security on June 30, 2025, at 3:15 p.m., confirmed the above fire sprinkler inspection reports were not on-site during the time of the survey and the sprinkler head was damaged.	K 0353		
K 0355 SS=F	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	Fire extinguisher inspection was completed on 3/7/2025. Facility will ensure documentation of inspection and technician's certificate are available for survey team during all inspections. Cart removed from in front of blocked fire extinguisher. Staff will be educated to ensure fire extinguishers are not blocked. Supervisors will audit weekly for 4 weeks to ensure fire extinguisher is not blocked.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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K 0355 SS=F	Continued from page 21 Based on observation, document review, and interview, it was determined the facility failed to maintain and inspect portable fire extinguishers, affecting the entire facility. Findings include: 1. Document review on June 30, 2025, between 8:30 a.m. and 11:00 a.m., revealed the facility could not produce the annual maintenance report and certificate for the technician who conducted the annual fire extinguisher maintenance/testing in January 2025. 2. Observation on June 30, 2025 at 2:45 p.m., inside main kitchen, revealed a blocked fire extinguisher on the kitchen side wall of the dietary office. Exit interview with the Maintenance Supervisor and Director of Safety / Security, on June 30, 2025, at 3:15 p.m., confirmed the lack of documentation and blocked extinguishers.	K 0355		

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K 0355 SS=F	Continued from page 22	K 0355		
K 0363 SS=E	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	K 0363	Door stops have been removed from doors. All other rooms checked for door stops and none noted. Staff will be educated to not use door stops. Residents and families will be educated upon admission that door stops cannot be used and current residents will be educated regarding door stops at next resident council meeting. Resident welcome book has been updated to include education regarding door stops and will be distributed to all residents upon admission and to all current residents.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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K 0363 SS=E	Continued from page 23 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=E	Continued from page 24 Based on observation and interview, it was determined the facility failed to maintain corridor doors affecting two of four levels. Findings include: Observation on June 30, 2025, between 11:00 p.m. and 2:45 p.m., revealed: a. Resident room, on the forth floor, # 4815 had a wooden door wedge holding door open. b. Resident room, on the second floor, # 2819 had a wooden door wedge holding door open. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the door wedges inhibited the door from closing.	K 0363		

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K 0712 SS=E	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	Missing fire drill documentation is on hand. Director of Safety & Security will ensure fire drills are conducted and that documentation is available for survey team during all inspections.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **07/23/2025**

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K 0712 SS=E	Continued from page 26 Based on interview and document review, it was determined the facility failed to ensure that nine of twelve required quarterly fire drills were conducted within this component. Findings include: Interview and document review on June 30, 2025, between 8:30 a.m. and 11:00 a.m., revealed the facility could not provide documentation logs that quarterly fire drills had been conducted as follows: a. All Shifts for the 1st quarter. b. All Shifts for the 3rd quarter. c. All Shifts for the 4th quarter. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the facility could not provide documentation that fire drills had been conducted for the shifts/quarters listed above.	K 0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395961	A. BLDG: __01_____ B. WING: _____	06/30/2025

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K 0918 SS=F	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 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	Contractor has been contacted to schedule annual 90-minute load test and fuel quality test. Director of Maintenance will ensure tests are conducted annually and that documentation is available for survey team during all inspections.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **07/23/2025**

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 0918 SS=F	Continued from page 28 Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator, affecting the entire facility. Findings include: Document review on June 30, 2025, between 8:30 a.m. and 11:00 a.m., revealed the facility could not provide documentation of the following tests and inspections: a. Annual 90 Minute Load Test. b. Annual Fuel Quality Test. Interview at the exit conference with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the missing testing documentation.	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 0920 SS=E	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	Extension cord and outlet multiplier have been removed. Resident rooms will be audited with weekly environmental rounds. Staff will be educated to notify maintenance if extension cord is found. Residents will be educated at next resident council meeting. All new residents and families will be educated upon admission.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/01/2025**

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 0920 SS=E	Continued from page 30 Based upon observation and interview, it was determined the facility failed to ensure extension cords were not used as a substitute for fixed wiring and outlet multipliers were not used in place of permanent wiring on one of four floors within the facility. Findings include: Observation made on June 30, 2025, at 12:20 p.m., revealed resident room on third floor #3802 had an outlet multiplier and extension cord in use. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at 3:15 p.m., confirmed the unauthorized use of extension cord and an outlet multiplier.	K 0920		
K 0923 SS=F		K 0923		

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 0923 SS=F	Continued from page 31 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	Oxygen storage capacity will be limited to 12 full tanks on 2nd, 3rd, and 4th floor and 50 full tanks on 1st floor. Staff educated on storage capacity and that all tanks must be placed in holders and not free standing. Nurses will audit at beginning of each shift and supervisors will perform random audits to monitor compliance.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **07/23/2025**

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K 0923 SS=F	Continued from page 32 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=F	Continued from page 33 Based on observation and interview, it was determined the facility failed to properly store and identify medical gas cylinders, affecting four of four levels within the component. Findings include: Observations on June 30, 2025, between 11:00 a.m. and 2:45 p.m., revealed improper storage in the following locations: a. On the fourth floor, the oxygen closet next to 4815. More than 12 tanks stored. b. On the third floor, the oxygen closet next to 3815. More than 12 tanks stored and 2 freestanding. c. On the second floor, the oxygen closet next to 2815. More than 12 tanks stored. d. On the first floor, the oxygen closet in service corridor. Approx 50 stored and 15 freestanding. Exit Interview with the Maintenance Supervisor and Director of Safety/ Security, on June 30, 2025, at	K 0923		

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K 0923 SS=F	Continued from page 34 3:15 p.m., confirmed the improper storage.	K 0923		

Certified End Page

PHILADELPHIA PROTESTANT HOME

STATE LICENSE NUMBER: 681002

SURVEY EXIT DATE: 06/30/2025

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