STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395989	A. BLDG: __--_____ B. WING: _____	01/21/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PROVIDENCE REHAB AND HEALTHCARE CENTER AT MERCY FITZGERALD STATE LICENSE NUMBER: **074902**	**600 S WYCOMBE AVENUE YEADON, PA 19050**

(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 21, 2025, it was determined Providence Rehab And Healthcare Center At Mercy Fitzgerald had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0026 SS=B		E 0026		

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

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

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E 0026 SS=B	Continued from page 1 483.73(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 provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by:	E 0026	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To maintain compliance with all federal and state regulation, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. The Emergency Prepared Plan policy and procedure documentation concerning the Roles under a Waiver Declared by Secretary was located an placed in the emergency Prepared Plan The Maintenance Director was in-serviced on ensuring that the Emergency Prepared Plan is complete and updated.	Completion Date: **03/15/2025** Status: **APPROVED** Date: **02/21/2025**

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E 0026 SS=B	Continued from page 2	E 0026	The Maintenance Director will monitor and review this plan of correction at the monthly Quality Assurance Performance Improvement meeting to ensure compliance is maintained	

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E 0026 SS=B	Continued from page 3 Based on document review and interview, it was determined the facility's emergency preparedness plan did not include policy and procedure documentation concerning the role of the Ambulatory Surgical Center 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: 1. Document review on January 21, 2025, at 8:00 am, 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 21, 2025, at 10:15 a.m., confirmed the lack of documentation.	E 0026		

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E 0026 SS=B	Continued from page 4	E 0026		

Certified End Page

PROVIDENCE REHAB AND HEALTHCARE CENTER AT MERCY FITZGERALD

STATE LICENSE NUMBER: 074902

SURVEY EXIT DATE: 01/21/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID# 074902 Component 01 Based on a Medicare/Medicaid Recertification Survey completed on January 21, 2025, it was determined that Providence Rehab And Healthcare Center At Mercy Fitzgerald 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 non-combustible building, with an attic, that is fully sprinklered.	K 0000		

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

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K 0211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	The emergency magnetic door release at the stairwell door across from resident room 131, 121, and 114 are now fully functioning. The facility has determined that all emergency magnetic doors have the potential to be affected. The Maintenance Director was in-serviced on ensuring that the emergency magnetic doors are fully functioning. The Maintenance Director will monitor the emergency magnetic doors weekly. The Maintenance Director will review this plan of correction at the monthly Quality Assurance Performance Improvement meeting to ensure compliance is maintained.	Completion Date: **03/15/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0211 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain egress doors free from all obstructions, affecting one of two floors in the facility. Findings include: Observations on January 21, 2025, between 9:54 a.m. and 10:05 a.m., revealed the emergency magnetic door release would not function at the following locations: a. 9:54 a.m., on the first floor, stairwell door across from resident room 131; b. 10:01 a.m., on the first floor, stairwell door across from resident room 121; c. 10:05 a.m., on the first floor, stairwell door across from resident room 114. Exit interview with the Administrator and the Maintenance Director on January 21, 2025, at 10:15 a.m., confirmed the emergency magnetic door releases failed to operate.	K 0211		

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K 0222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved,	K 0222	The delay egress door across from room 231 was fixed and is now functioning. The facility has determined that all egress doors have the potential to be affected. The Maintenance director was in-serviced on ensuring that the egress doors alarm and open. The Maintenance Director will monitor the functioning of the egress doors weekly. The Maintenance Director will review this plan of correction at the monthly Quality Assurance Performance Improvement meeting to ensure compliance is maintained	Completion Date: **03/15/2025** Status: **APPROVED** Date: **02/21/2025**

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

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K 0222 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain delayed egress doors, affecting one of two floors in the facility. Findings include: Observation on January 21, 2025, at 9:31 a.m., revealed, on the first floor, the delayed egress door across from resident room 231 failed to alarm and open. Exit interview with the Administrator and the Maintenance Director on January 21, 2025, at 10:15 a.m., confirmed the door failed to alarm and open.	K 0222		
K 0345 SS=F		K 0345		

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K 0345 SS=F	Continued from page 6 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	The documentation of the semiannual visual fire alarm inspection was missed. Annual was performed and semi annual is scheduled. The Maintenance Director was in-serviced on ensuring that the semi- annual visual fire alarm inspection takes place every 6 months. The Maintenance Director has scheduled in TELs, our work order system, the testing of the semi-annual visual fire alarm inspection. The Maintenance Director will review this plan of correction at the monthly Quality Assurance Performance Improvement meeting to ensure compliance is maintained.	Completion Date: **03/15/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0345 SS=F	Continued from page 7 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: Document review on January 21, 2025, at 8:00 a.m., revealed the facility could not provide documentation of a semi-annual visual fire alarm inspection within six months of December 12, 2024. Exit interview with the Administrator and the Maintenance Director on January 21, 2025, at 10:15 a.m., confirmed the lack of documentation.	K 0345		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 8 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 items in the storage room across from the occupational therapy gym and the elevator machine room that was within 18" of the ceiling has been removed. The facility has determined that storage in the facility have the potential to be affected. The Maintenance Director in-serviced staff on ensuring that nothing gets stored within 18" from the ceiling through out the building. The Maintenance Director will conduct weekly audits of through out he building weekly. This audit will be completed weekly for four weeks and then monthly for three months. This plan of correction will be monitored at the monthly Quality Assurance Performance Improvement meeting until such time consistent substantial compliance has been met.	Completion Date: **03/15/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0353 SS=F	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain the sprinkler system, affecting the entire facility. Findings include: Observations on January 21, 2025, between 9:38 a.m. and 9:42 a.m., revealed storage within 18" of a sprinkler in the following locations: a. 9:38 a.m., on the first floor, Storage room across from Occupational Therapy; b. 9:42 a.m., on the first floor, Storage room across from the Elevator Machine Room; c. This condition was observed throughout the facility. Exit interview with the Administrator and the Maintenance Director on January 21, 2025, at 10:15 a.m., confirmed the storage within 18" of a sprinkler.	K 0353		

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PROVIDENCE REHAB AND HEALTHCARE CENTER AT MERCY FITZGERALD	**600 S WYCOMBE AVENUE YEADON, PA 19050**
STATE LICENSE NUMBER: **074902**	

(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 0355 SS=E	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 portable fire extinguisher in the elevator room was unblock. The facility has determined that all fire extinguishers have the potential to be affected. The Maintenance Director in-serviced staff to ensure that the fire extinguishers in the building do not get blocked. The Maintenance Director will randomly audit the fire extinguishers throughout the building. This plan of correction will be monitored at the monthly Quality Assurance Performance Improvement meeting until such time consistent substantial compliance has been met.	Completion Date: **03/15/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395989	A. BLDG: __01_____ B. WING: _____	01/21/2025

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K 0355 SS=E	Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain portable fire extinguishers, affecting one of two floors in the facility. Findings include: Observation on January 21, 2025, at 9:40 a.m., revealed, on the first floor, the portable fire extinguisher in the Elevator Machine Room was blocked by storage. Exit interview with the Administrator and the Maintenance Director on January 21, 2025, at 10:15 a.m., confirmed the blocked portable fire extinguisher.	K 0355		
K 0511 SS=E		K 0511		

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K 0511 SS=E	Continued from page 12 NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by:	K 0511	The storage within three feet of the electrical panels across form the Occupational Therapy room and the laundry dryer room have been removed. The facility has determined that all electrical panels in the building have the potential to be affected. The Maintenance Director has in-serviced the staff to ensuring that storage remains three feet from the electoral panels throughout the building. The Maintenance Director will randomly audit electrical panels through ou the building weekly. This plan of correction will be monitored at the monthly Quality Assurance Performance Improvement meeting until such time consistent substantial compliance has been met.	Completion Date: **03/15/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0511 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to comply with NFPA 70, National Electric Code, for electrical wiring and equipment, affecting one of two floors in the facility. Findings include: Observation on January 21, 2025, between 9:36 a.m. and 9:45 a.m., revealed, storage within three feet of the electrical panels in the below locations. Per NFPA70 110.26(A)(1), a 3 ft. depth clearance is required in front of electrical equipment with a nominal voltage to ground of 0 to 150 volts. a. 9:36 a.m., on the first floor, Storage room across from Occupational Therapy; b. 9:45 a.m., on the first , Laundry Dryer Room. Exit interview with the Administrator and the Maintenance Director on January 21, 2025, at 10:15 a.m., confirmed the storage in fornt of the electrical panels.	K 0511		

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K 0511 SS=E	Continued from page 14	K 0511		
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.	K 0918	The weekly battery voltage tests and monthly battery conductance testing were completed. The Maintenance Director was in-serviced on ensuring that the weekly battery voltage testing and the monthly battery conductance testing are completed accurately. The Maintenance Director will audit the accuracy and completion of the voltage testing. This plan of correction will be monitored at the monthly Quality Assurance Performance Improvement meeting until such time consistent substantial compliance has been met.	Completion Date: **03/15/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0918 SS=F	Continued from page 15 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		

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K 0918 SS=F	Continued from page 16 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: 1. Document review on January 21, 2025, at 8:00 a.m., revealed the facility could not provide documentation of the following inspections: a. Weekly battery voltage testing; b. Monthly battery conductance testing. Exit interview with the Administrator and the Maintenance Director on January 21, 2025, at 10:15 a.m., confirmed the lack of documentation. 2. Observation on January 21, 2025, at 9:59 a.m., revealed, on the first floor, the remote generator annunciator panel at the Nurses' Station had a Low Fuel alarm. Exit interview with the Administrator and the	K 0918		

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K 0918 SS=F	Continued from page 17 Maintenance Director on January 21, 2025, at 10:15 a.m., confirmed the Low Fuel alarm.	K 0918		

Certified End Page

PROVIDENCE REHAB AND HEALTHCARE CENTER AT MERCY FITZGERALD

STATE LICENSE NUMBER: 074902

SURVEY EXIT DATE: 01/21/2025

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