

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
STATE LICENSE NUMBER: 041402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT	E 0000		
E 0037	Based on an Emergency Preparedness Survey completed on January 22, 2025, it was determined that Monumental Post-Acute Care at Woodside Park had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0037		
SS=C				

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 0037 SS=C	Continued from page 1 483.73(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:	E 0037	MPAC has an Ep plan which includes education and training of Staff on Hire and annually. Maintenance Director and team will be re-in-serviced BY nha on MPAC Emergency Preparedness' Plan. The Maintenance Director or Designee will conduct random Drills/ quizzes monthly to ensure Staff or aware of and follow MPAC EP guidelines during emergencies. Results of Random Drills will be reported in Monthly QAPI	Completion Date: 03/28/2025 Status: APPROVED Date: 02/11/2025

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E 0037 SS=C	Continued from page 2 (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 0037		

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E 0037 SS=C	Continued from page 4 training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and	E 0037		

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E 0037 SS=C	Continued from page 5 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by:	E 0037		

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E 0037 SS=C	Continued from page 6 Based on document review and interview, it was determined the facility failed to develop an Emergency Preparedness Training program based on the emergency plan, risk assessment, policies and procedures, and communication plan, affecting the entire facility. Findings Include: Documentation reviewed on January 22, 2025, at 8:30 a.m., revealed the Emergency Preparedness plan did not include written policies and procedures identifying its training program for all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the Emergency Preparedness plan did not include a written emergency training program.	E 0037		

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E 0037 SS=C	Continued from page 7	E 0037			



Certified End Page

MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK

STATE LICENSE NUMBER: 041402

SURVEY EXIT DATE: 01/22/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 041402 Component 01 Building 01</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on January 22, 2025, it was determined that Monumental Post-Acute Care At Woodside Park 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)</p> <p>This is a two-story, Type III (200), unprotected ordinary building, with a basement, that is fully sprinklered.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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K 0161 SS=C		K 0161		

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K 0161 SS=C	Continued from page 2 NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small	K 0161	The facility was evaluated by an engineering firm in 2018. The evaluation determined that the building is permitted to be of Type II (000) construction, which means that the steel in the building is permitted to be non-rated and unprotected. An Analysis of the facility structure type was conducted by an engineer. The analysis provided concluded that the "construction type of the two-story, sprinkler protected, existing health care building is permitted to be Type II (000)." Type II(000) is an unprotected non-combustible construction. The facility has been classified as a Type III (200), unprotected ordinary construction. A request for a Time Limited Waiver was submitted to the Director of Safety Inspection 9/8/21, to last through 1/1/2025 The FSES worksheets will be reviewed and revised by an Engineer to identify if alternative corrections	Completion Date: 03/28/2025 Status: APPROVED Date: 02/11/2025

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K 0161 SS=C	Continued from page 3 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by:	K 0161	will be needed. The FSES worksheets (5.5) from the 2010 edition of the NFPA Guide on Alternative approaches to Life Safety will be included in the analysis.	

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K 0161 SS=C	Continued from page 4 Based on document review and interview, it was determined the facility failed to maintain building construction requirements, affecting the entire facility. Findings Include: Document review on January 22, 2025, between 8:30 a.m. and 2:00 p.m., revealed unprotected structural steel columns and beams above the suspended ceiling assemblies, and pan-style ceiling diffusers at the ceiling level, lacked full "blanket" protection, resulting in a classification of unprotected ordinary construction. The building has been classified as two stories. The story height exceeds the maximum height allowed for unprotected ordinary construction by one story. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the building construction.	K 0161		

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K 0222 SS=E	<p>NFPA 101 Egress Doors</p> <p>Egress Doors</p> <p>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:</p> <p>CLINICAL NEEDS OR SECURITY THREAT LOCKING</p> <p>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.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>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</p>	K 0222	<p>East doors near reception desk are now functioning appropriately (SLA part replaced)</p> <p>All other Egress doors in the facility were inspected and are functioning as designed.</p> <p>Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to 0222: EGRESS.</p> <p>Maintenance Director or Designee will conduct weekly inspections on all egress doors weekly x 3 weeks to ensure all are working as designed.</p> <p>Results will be reported in monthly qapi</p>	<p>Completion Date: 03/21/2025</p> <p>Status: APPROVED</p> <p>Date: 02/11/2025</p>

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K 0222 SS=E	Continued from page 6 (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, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK STATE LICENSE NUMBER: 041402	STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0222 SS=E	<p>Continued from page 7</p> <p>Based on observation and interview, it was determined the facility failed to ensure doors with Special Locking Arrangements (SLA's) were maintained in operable condition, affecting one of three levels.</p> <p>Findings include:</p> <p>Observation made on January 22, 2025, at 1:40 p.m., revealed, on the first floor, the East Annex double doors near the reception desk, one leaf failed to close when tested. The doors were equipped with a magnetic locking feature.</p> <p>Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the door deficiency.</p>	K 0222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK STATE LICENSE NUMBER: 041402	STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131
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K 0225 SS=E	<p>NFPA 101 Stairways and Smokeproof Enclosures</p> <p>Stairways and Smokeproof Enclosures</p> <p>Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.</p> <p>18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0225	<p>Storage cleaning cart has been removed from stairway #3.</p> <p>Maintenance conducted rounds and there were no other items stored under any stairs</p> <p>Maintenance Director or Designee will conduct in- service education for housekeeping staff on importance of adherence to 0225: Stairways and smoke proof enclosures</p> <p>The Maintenance team will conduct environmental rounds weekly x 4 weeks to ensure compliance with fire codes, and State, federal and local regulations)</p> <p>Results will be reported on monthly QAPI</p>	<p>Completion Date: 03/21/2025</p> <p>Status: APPROVED</p> <p>Date: 02/11/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
STATE LICENSE NUMBER: 041402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0225 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain the smokeproof enclosure of the stairwell, affecting one of three levels. Findings include: Observation on January 22, 2025, at 1:15 p.m., revealed basement Stairway number 3 had storage (cleaning cart) under the stairwell. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the storage under the stairwell.	K 0225		
K 0321 SS=F		K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK STATE LICENSE NUMBER: 041402		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0321 SS=F	Continued from page 11 This REQUIREMENT is not met as evidenced by:	K 0321	Results will be reported on monthly QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK STATE LICENSE NUMBER: 041402		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0321 SS=F	Continued from page 12 Based on observation and interview, it was determined the facility failed to ensure hazards were protected with smoke resistant separation in sprinklered locations, affecting three of three levels. Findings include: Observation on January 22, 2022, between 11:55 a.m. and 12:50 p.m., revealed deficiencies in the following locations: a. Maintenance and Housekeeping basement level Laundry Room door failed to close and latch; b. Maintenance and Housekeeping basement level Boiler Room door #2 failed to close and latch; c. There were soiled linen carts filled with linen stored in the second-floor corridors; d. On the first floor, the Annex Diaper Room had multiple unsealed penetrations in the entry door. Exit interview with the Facility Administrator and	K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0321 SS=F	Continued from page 13 Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed hazardous enclosures were not maintained.	K 0321		
K 0324 SS=E		K 0324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0324 SS=E	Continued from page 14 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	The Kitchen Suppression System will be repaired on 2/6/25 And inspected prior to 3/21/25 The Maintenance Director will in-service Maintenance staff on importance of adherence to : 0324- Cooking Facilities The maintenance Director or Designee will audit routine and periodic facility maintenance requirements monthly to ensure all are in compliance. Results will be reported in Monthly QA	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
STATE LICENSE NUMBER: 041402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0324 SS=E	Continued from page 15 Based on documentation review and interview, it was determined the facility failed to maintain the kitchen suppression system, affecting one of two inspections. Findings include: Document review on January 22, 2025, at 8:30 a.m., revealed the facility could not produce documentation the kitchen suppression system was inspected and serviced semi-annually. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the missing documentation.	K 0324		
K 0325 SS=E		K 0325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK STATE LICENSE NUMBER: 041402		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0325 SS=E	Continued from page 16 NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by:	K 0325	The ABHR Dispensers near rm 124 has been removed. Maintenance Staff inspected all other ABHR dispensers in the facility. None are too close to receptacles/outlets. All are in compliance with the code. Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to 0325: Alcohol Based Hand Rub Dispenser. (ABHR) The interdisciplinary team will conduct environmental rounds weekly x 4 weeks to ensure compliance with fire codes, and State, federal and local regulations) Results will be reported on monthly QAPI	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0325 SS=E	Continued from page 17 Based on observation and interview, it was determined the facility failed to maintain alcohol-based hand rub dispensers, affecting one of three levels. Findings Include: Observation on January 22, 2025, at 1:35 p.m., revealed, on the first floor, East, near room 124 had an alcohol-based hand rub dispenser mounted directly above an electrical outlet. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the ABHR dispenser mounted above the outlet.	K 0325		
K 0345 SS=F		K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0345 SS=F	Continued from page 18 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	Corrected on site. The generator company was in the facility at the same time of Life Safety Inspection. They were working n the generator, which caused the trouble codes. The Fire Alarm Panel at 2nd Floor Be Well nurses station does not have any further trouble codes. Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to 0345- Fire Alarm Testing and Maintenance: Maintenance team will inspect Fire Alarm Panel weekly x 4 weeks to ensure there are no trouble codes. Results will be reported on monthly QAPI	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0345 SS=F	Continued from page 19 Based on observation and interview, it was determined the facility failed to maintain the fire alarm system in proper operating condition, affecting the entire facility. Findings Include: Observation on January 22, 2025, at 1:05 p.m., revealed the facility fire alarm panel at 2 B Well Nurses Station displayed multiple trouble codes. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the fire alarm panel trouble codes.	K 0345		
K 0353 SS=E		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0353 SS=E	Continued from page 20 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 inspections are up to date and documentation is available. The Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to 0353- Sprinkler System Maintenance and Testing The maintenance Director or Designee will audit routine and periodic facility maintenance requirements monthly to ensure all are in compliance. Results will be reported in Monthly QA	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

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K 0353 SS=E	Continued from page 21 Based on document review and interview, it was determined the facility failed to maintain the sprinkler system, affecting two of four inspections. Findings include: Document review on January 22, 2025, at 8:30 a.m., revealed the facility could not produce documentation showing First and Third Quarter sprinkler inspections had been conducted during the prior 12 months. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the missing documentation.	K 0353		
K 0355 SS=C		K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0355 SS=C	Continued from page 22 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	Information Regarding the qualifications of the Tech/s conducting annual fire extinguisher inspections are available on site in the facility Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to 0355- Portable Fire Extinguishers The maintenance Director or Designee will audit routine and periodic facility maintenance requirements monthly to ensure all are in compliance Results will be reported in Monthly QA	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0355 SS=C	Continued from page 23 Based on document review and interview, it was determined the facility failed to maintain and inspect the portable fire extinguishers, affecting the entire facility. Findings include: Document review on January 22, 2025, at 8:30 a.m., revealed the facility could not produce an appropriate certificate for the technician conducting the annual fire extinguisher inspections. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the missing documentation.	K 0355		
K 0372 SS=E		K 0372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
STATE LICENSE NUMBER: 041402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0372 SS=E	Continued from page 24 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	The unsealed penetrations near 253 have been sealed with an approved through- penetration fire sealant. Environmental rounds have been conducted through the facility. There were no further penetrations Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to 0372 Subdivision of Building spaces- Smoke Barrier The interdisciplinary team will conduct environmental rounds weekly x 4 weeks to ensure compliance with fire codes, and State, federal and local regulations) Results will be reported on monthly QAPI	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0372 SS=E	Continued from page 25 Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls free of unsealed penetrations, affecting two of four smoke compartments. Findings include: Observation on January 22, 2025, at 12:55 p.m., revealed, on the second floor, above smoke doors near resident room 253, unsealed penetrations around data wires. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the unsealed penetrations.	K 0372		
K 0374 SS=E		K 0374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0374 SS=E	Continued from page 26 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	Double smoke door near rm 227 is working as designed. It only closes if the fire alarm is activated. Environmental rounds have been conducted through the facility. There were no malfunctioning doors. Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to: 0374 Subdivision of Building spaces- smoke barriers The Maintenance team will conduct environmental rounds weekly x 4 weeks to ensure compliance with fire codes, and State, federal and local regulations) Results will be reported in monthly QAPI	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK STATE LICENSE NUMBER: 041402		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0374 SS=E	Continued from page 27 Based on observation and interview, it was determined the facility failed to ensure smoke barrier doors were maintained with smoke tight resistance, affecting two of three levels. Findings include: Observations on January 22, 2025, at 12:30 p.m., revealed, on the second floor, West, next to resident room 227, the double smoke doors failed to close. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the door deficiencies.	K 0374		
K 0521 SS=E		K 0521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0521 SS=E	Continued from page 28 NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	Portable air conditioning unit removed from boiler rm #2 Maintenance Director conducted rounds in the facility and there were no other air conditioners installed out of compliance. Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to: 0521- HVAC The interdisciplinary team will conduct environmental rounds weekly x 4 weeks to ensure compliance with fire codes, and State, federal and local regulations) Results will be reported in monthly QAPI	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

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K 0521 SS=E	Continued from page 29 Based on document review and interview, it was determined the facility failed to maintain HVAC (heating, ventilating, and air conditioning) systems, affecting one of three levels. Findings include: Observation on January 22, 2025, at 12:05 p.m., revealed the Maintenance and Housekeeping basement corridor, next to Boiler Room #2 had a portable air conditioning unit ducted into the ceiling. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the portable AC unit was used as a permanent part of the HVAC system.	K 0521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0522 SS=E	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by:	K 0522	Combustible materials removed from HVACs in 108 and 240 Maintenance Director conducted facility rounds and there were no other HVACs covered with combustible materials Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to: 0522- HVAs- Any Heating Device The Maintenance team will conduct environmental rounds weekly x 4 weeks to ensure compliance with fire codes, and State, federal and local regulations) Results will be reported in monthly QAPI	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK STATE LICENSE NUMBER: 041402		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
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K 0522 SS=E	Continued from page 31 Based on observation and interview, it was determined the facility failed to maintain heating units free of combustible materials, affecting two of three levels. Findings include: Observations made on January 22, 2025, between 12:30 p.m. and 1:15 p.m., revealed combustible materials were placed on top of a heating unit in resident rooms 240 and 108. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the placement of combustible materials on top of a heater.	K 0522		
K 0912 SS=E		K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0912 SS=E	Continued from page 32 NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0912	The outlet near the kitchen hand wash sink has been replaced with an appropriate GFCI outlet Maintenance Director conducted facility rounds and there were no other NON- GFCI outlets located withing 6 inches of a sink. Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to: 0912- Electrical Systems – Receptacles The Maintenance team will conduct environmental rounds weekly x 4 weeks to ensure compliance with fire codes, and State, federal and local regulations) Results will be reported in monthly QAPI	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

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K 0912 SS=E	Continued from page 33 Based on observation and interview, it was determined the facility failed to maintain electric systems, in wet locations, affecting one of three levels. Findings include: Observation on January 22, 2025, at 2:05 p.m., revealed at Kitchen hand wash sink area, a non-GFCI outlet located within 6 feet of the sink. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the non-GFCI outlet.	K 0912		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0918 SS=F	Continued from page 34 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	The following inspections have been scheduled/ conducted for the Generator: a. Weekly Visual inspection b. Battery electrolyte levels/ or battery voltage c. Battery Electrolyte specific gravity or conductance d. Monthly 30-minute load test e. Evidence of Wet Stacking f. 3 yrs., 4 hrs. load test g. Annual 90 min. Load Bank h. Monthly Load Test i. Annual Fuel Quality test j. Monthly testing and recording of battery specific gravity or conductance testing Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to 0918 Electrical Systems- Essential Electric Systems The maintenance Director or Designee will audit routine and periodic facility maintenance	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

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NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK STATE LICENSE NUMBER: 041402	STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131
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K 0918 SS=F	Continued from page 35 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	requirements monthly to ensure all are in compliance. Results will be reported in monthly QAPI	

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K 0918 SS=F	Continued from page 36 Based on observation, 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 22, 2025, at 8:30 a.m., revealed the facility could not produce documentation of the following tests and inspections: a. Weekly inspection of battery electrolyte levels or battery voltage; b. December 2024 test of battery electrolyte specific gravity or conductance testing; c. Monthly 30 minute under load test; d. No evidence of wet-stacking; e. Annual 90-minute load bank test; f. 3-year, 4 hour load test; g. Annual fuel quality test. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
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K 0918 SS=F	Continued from page 37 p.m., confirmed the missing documentation. 2. Observation on January 22, 2025, at 1:10 p.m., revealed the emergency generator annunciator panel, on the second floor, at 2 B Well Nurses Station, warning lamp had multiple trouble lights illuminated when tested. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the trouble lights on the annunciator panel. 3. Observation made on January 22, 2025, at 1:14 p.m., revealed the following inside the emergency generator set location (transformer room) on the second floor: a. the room lacked battery back-up emergency lighting; b. the manual stop station was located inside this room and is kept locked.	K 0918		

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K 0918 SS=F	Continued from page 38 Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the lack of back-up lighting and the obstruction to access emergency equipment.	K 0918		
K 0923 SS=E		K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
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K 0923 SS=E	Continued from page 39 NFPA 101 Gas Equipment - Cylinder and Container Storage 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	Cautionary, (NO SMOKING), Empty, and Full signs have been placed in 2 west nsg station medical room. Maintenance Director conducted facility rounds and all other oxygen storage areas had appropriate signage Maintenance Director or Designee will conduct in servicing for maintenance staff on importance of adherence to: 0923- Storage The Maintenance team will conduct environmental rounds weekly x 4 weeks to ensure compliance with fire codes, and State, federal and local regulations) Results will be reported in monthly QAPI	Completion Date: 03/21/2025 Status: APPROVED Date: 02/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0923 SS=E	Continued from page 40 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK STATE LICENSE NUMBER: 041402		STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0923 SS=E	Continued from page 41 Based on observation and interview, it was determined the facility failed to maintain oxygen storage requirements, affecting one of three levels. Findings include: Observation on January 22, 2025, at 12:50 p.m., revealed on the second floor west nursing station medical room had the following deficiencies: a. Missing cautionary signage on the entry door. The precautionary sign shall include the wording "CAUTION: OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING;" b. Missing "Empty" and "Full" signage for oxygen storage inside the room. Exit interview with the Facility Administrator and Maintenance Director on January 22, 2025, at 2:00 p.m., confirmed the missing signage.	K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u> 01 </u> B. WING: <u> </u>		(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE: 4001 FORD ROAD PHILADELPHIA, PA 19131		
STATE LICENSE NUMBER: 041402					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
K 0923 SS=E	Continued from page 42	K 0923			



Certified End Page

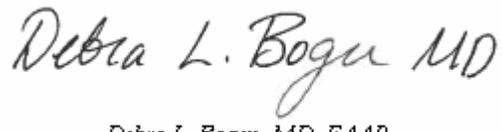
MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK

STATE LICENSE NUMBER: 041402

SURVEY EXIT DATE: 01/22/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY