STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396090	A. BLDG: __--_____ B. WING: _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PRESTON RESIDENCE STATE LICENSE NUMBER: **15700201**	**200 SYCAMORE DRIVE WEST GROVE, PA 19390**

(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 25, 2025, it was determined that Preston Residence had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0030 SS=C	483.73(c)(1) Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians	E 0030	1.The name/contact list was located in the original EOP binder. 2. The EOP phone list will be updated as needed or should personnel change. 3. The EOP is reviewed on an annual basis and the contact list will be verified as current. 4. The Facilities Director will verify monthly that the list remains current and document on the audit sheet. This will be maintained in the EOP and reported to the Safety Committee on a monthly basis. 5. The completion date is 9/25/25.	Completion Date: **09/25/2025** Status: **APPROVED** Date: **07/08/2025**

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 0030 SS=C	Continued from page 1 (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan	E 0030		

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E 0030 SS=C	Continued from page 2 must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by:	E 0030		

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E 0030 SS=C	Continued from page 3 Based on document review and interview, it was determined the facility failed to include names and contact information of staff within the physical copy of the emergency preparedness plan, which serves the entire component. Findings include: 1. Review of documentation on June 25, 2025, at 10:48 AM, revealed the names and contact information for staff were not within the physical copy of the emergency preparedness plan. Interview with the Director of Maintenance on June 25, 2025, at 10:48 AM, confirmed the names and contact information for staff were not within the physical copy of the emergency preparedness plan.	E 0030		

Certified End Page

PRESTON RESIDENCE

STATE LICENSE NUMBER: 15700201

SURVEY EXIT DATE: 06/25/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0000	INITIAL COMMENT Facility ID #15700201 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on June 25, 2025, it was determined that Preston Residence was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type V (111), protected wood frame structure, with a small Mechanical Room at basement level, which is fully sprinklered.	K 0000		
K 0325 SS=E		K 0325		

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

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K 0325 SS=E	Continued from page 1 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	1. The wall mounted hand sanitizer dispenser cited was moved on 6/25/25 to a non-outlet, non-switch wall. 2.All dispenser locations were verified to be appropriately mounted on a non-outlet, non-switch wall. 3.All current and new dispensers' locations will be audited 1 x weekly x's 1 month, and bi-weekly for 2 months. This will be added to the Quarterly PM. 4. All results will be reported to QAPI on a Quarterly basis for until satisfied the cited deficient practice has been rectified. 5. The completion date is 8/24/25.	Completion Date: **08/24/2025** Status: **APPROVED** Date: **07/08/2025**

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K 0325 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to monitor the placement of alcohol based hand rub dispensers within the facility, affecting one of three smoke compartments within the component. Findings include: 1. Observation on June 25, 2025, at 11:33 AM, revealed an alcohol based hand rub dispenser was located directly above a light switch, within Resident Room 336. Interview with the Director of Maintenance on June 25, 2025, at 11:33 AM, confirmed the alcohol based hand rub dispenser was located directly above an ignition source.	K 0325		
K 0761 SS=C		K 0761		

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K 0761 SS=C	Continued from page 3 NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 0761	1. The Fire Door inspection documentation was verified to exist and to have occurred in the last 12 months for the date of 11/12/24. 2. The Fire Door inspections will be conducted annually 3. Annual inspections will be scheduled through the work order system and maintain NFPA compliance. A notification will be generated through this work order system (TELS) 4. Inspections will be monitored through the work order system for completion and documentation reported to QAPI as completed. An audit of the Life Safety Book will be completed annually to ensure compliance. 5. The completion date is 8/24/25.	Completion Date: **08/24/2025** Status: **APPROVED** Date: **07/10/2025**

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K 0761 SS=C	Continued from page 4 Based on document review and interview, it was determined the facility failed to provide documentation verifying fire doors within the facility had been inspected within the previous 12 months, affecting the entire component. Findings include: 1. Observation on June 25, 2025, at 9:45 AM, revealed the facility failed to provide documentation verifying fire doors within the facility had been inspected, within the previous 12 months. Interview with the Director of Maintenance on June 25, 2025, at 9:45 AM, confirmed the facility failed to provide documentation verifying fire doors within the facility had been inspected, within the previous 12 months.	K 0761		
K 0918 SS=C		K 0918		

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K 0918 SS=C	Continued from page 5 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	K 0918	1. The 4 hour generator load test has been completed as of 7/2/25. 2. The 4 hour generator load test will be conducted every 36 months. 3. The 4 hour generator load test will be scheduled through the work order system to maintain compliance. 4. The scheduled load tests will be monitored through the work order system for compliance and reported to QAPI as completed. An annual audit will be completed and filed in the Life Safety Book to ensure compliance. 5. The completion date is 8/24/25.	Completion Date: **08/24/2025** Status: **APPROVED** Date: **07/10/2025**

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K 0918 SS=C	Continued from page 6 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

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K 0918 SS=C	Continued from page 7 Based on document review and interview, it was determined the facility failed to provide documentation verifying a continuous 4-hour exercise of the emergency generator had occurred within the previous 36 months, affecting the entire component. Findings include: 1. Review of documentation on June 25, 2025, at 9:15 AM, revealed the facility failed to provide documentation verifying a continuous 4-hour exercise of the emergency generator had occurred within the previous 36 months. Interview with the Director of Maintenance on June 25, 2025, at 9:15 AM, confirmed the lack of documentation verifying a continuous 4-hour exercise of the emergency generator had occurred within the previous 36 months.	K 0918		
K 0920 SS=E		K 0920		

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K 0920 SS=E	Continued from page 8 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	1. The surge protector was removed on 6/25/25. 2. A facility wide inspection was conducted to ensure no other surge protectors were inappropriately used on 7/1/25. 3. An audit will be conducted 1 x weekly for 1 month and bi-weekly for 2 months. 4. The audits will be reported to QAPI quarterly or until the deficient practice has been rectified. Education regarding surge protectors will be completed by 7/18 and provided at new employee orientation and annually thereafter. 5. The completion date is 8/24/25.	Completion Date: **08/24/2025** Status: **APPROVED** Date: **07/10/2025**

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K 0920 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to monitor the use of surge suppressors, affecting one of three smoke compartments within the component. Findings include: 1. Observation on June 25, 2025, at 10:54 AM, revealed a surge suppressor, supplying electrical power to a coffee machine, within the Break Room. Interview with the Director of Maintenance on June 25, 2025, at 10:54 AM, confirmed the high draw appliance was plugged into a surge suppressor.	K 0920		

Certified End Page

PRESTON RESIDENCE

STATE LICENSE NUMBER: 15700201

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