STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396113	A. BLDG: __--_____ B. WING: _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CENTER AT THE HILL AT WHITEMARSH, THE STATE LICENSE NUMBER: **17900201**	**4000 FOX HOUND DRIVE LAFAYETTE HILL, PA 19444**

(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 December 17, 2024, at The Health Center at The Hill at Whitemarsh, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

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

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

Certified End Page

HEALTH CENTER AT THE HILL AT WHITEMARSH, THE

STATE LICENSE NUMBER: 17900201

SURVEY EXIT DATE: 12/17/2024

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:
	396113	A. BLDG: 01 B. WING:	12/17/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CENTER AT THE HILL AT WHITEMARSH, THE STATE LICENSE NUMBER: **17900201**	**4000 FOX HOUND DRIVE** **LAFAYETTE HILL, PA 19444**

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K 0000	INITIAL COMMENT Facility ID# 17900201 Component 01 Long-Term Skilled Unit (Village D) Based on a Medicare/Medicaid Recertification Survey completed on December 17, 2024, it was determined that The Health Center at The Hill at Whitemarsh 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 three-story, Type II (111), protected non-combustible building, with a basement, that is fully sprinklered.	K 0000		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CENTER AT THE HILL AT WHITEMARSH, THE STATE LICENSE NUMBER: **17900201**	**4000 FOX HOUND DRIVE LAFAYETTE HILL, PA 19444**

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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	Egress should be free of impediments. Items stored directly in front of the 2 North kitchen fire exit have been removed. Audits will be conducted once week for 4 weeks, bi-weekly for month to ensure compliance. Staff education completed on 12-30-2024. The Facilities Director or designee will bring such audits to the QA meeting monthly x3 in order for the QA team to verify compliance and egress is free from any obstruction	Completion Date: **01/03/2025** Status: **APPROVED** Date: **01/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CENTER AT THE HILL AT WHITEMARSH, THE	**4000 FOX HOUND DRIVE LAFAYETTE HILL, PA 19444**
STATE LICENSE NUMBER: **17900201**	

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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 the means of egress free of impediments to egress, affecting one of four levels. Findings Include: Observation on December 17, 2024, at 12:20 p.m., revealed items were stored directly in the front of 2 North Kitchen fire exit to café. Exit Interview with the Administrator and Maintenance Director on December 17, 2024, at 1:00 p.m., confirmed the obstructions in the means of egress.	K 0211		
K 0321 SS=E		K 0321		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HEALTH CENTER AT THE HILL AT WHITEMARSH, THE STATE LICENSE NUMBER: **17900201**	**4000 FOX HOUND DRIVE** **LAFAYETTE HILL, PA 19444**

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K 0321 SS=E	Continued from page 3 NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 0321	The facility should maintain the fire resistance rating of hazardous areas in sprinklered locations in all levels of facility. Per fire safety guidelines, fire caulk: 3M Fire Barrier Sealant CP 25WB+ was installed on the third-floor South resident storage room D3091 for unsealed penetration around copper pipe. The second-floor electrical transformer room door self-closer has been installed. The combustible boxes laying on top of electrical transformer in the second-floor kitchen dry storage have been removed. Staff education has been provided to ensure compliance. Audits will be conducted once week for 4 weeks, bi-weekly for month to ensure compliance. Staff education completed on 12-30-2024. The Facilities Director or designee will bring such audits to the QA meeting monthly x3 in order for the QA team to verify compliance.	Completion Date: **01/03/2025** Status: **APPROVED** Date: **01/06/2025**

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K 0321 SS=E	Continued from page 4 This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain the fire resistance rating of hazardous areas, in sprinklered locations, affecting two of four levels. Findings include: Observation on December 17, 2024, revealed the following deficiencies of hazardous area enclosures: a. 12:00 p.m., on the third floor, the resident storage room D3091, unsealed penetration around a copper pipe. b. 12:10 p.m., on the third floor, the electrical transformer room door lacked a self-closer. c. 12:30 p.m., on the second floor, the kitchen dry storage, combustible boxes laying atop electrical transformer. Exit Interview with the Administrator and Maintenance Director on December 17, 2024, at 1:00 p.m., confirmed the hazardous area deficiencies.	K 0321		

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K 0321 SS=E	Continued from page 6	K 0321		
K 0351 SS=E	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:	K 0351	The facility will maintain automatic sprinkler protection in all levels of care. The second floor JCI room sprinkler protection has been installed. Audits will be conducted once week for 4 weeks, bi-weekly for month to ensure compliance. The Facilities Director or designee will bring such audits to the QA meeting monthly x3 in order for the QA team to verify compliance.	Completion Date: **01/03/2025** Status: **APPROVED** Date: **01/06/2025**

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K 0351 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain complete automatic sprinkler protection, affecting one of four levels. Findings Include: Observation on December 17, 2024, at 12:15 p.m., revealed, on the second floor, South JCI room lacked sprinkler protection. Exit Interview with the Administrator and Maintenance Director on December 17, 2024, at 1:00 p.m., confirmed the incomplete sprinkler coverage.	K 0351		
K 0372 SS=E		K 0372		

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K 0372 SS=E	Continued from page 8 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 facility will maintain smoke barrier walls of unsealed penetration. Per fire safety guidelines, fire caulk: 3M Fire Barrier Sealant CP 25WB+ was installed on the second-floor South penetration around the plastic pipe above the smoke doors by reception area. Audits will be conducted once week for 4 weeks, bi-weekly for month to ensure compliance. The Facilities Director or designee will bring such audits to the QA meeting monthly x3 in order for the QA team to verify compliance.	Completion Date: **01/03/2025** Status: **APPROVED** Date: **01/06/2025**

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K 0372 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls free of unsealed penetrations, affecting one of four levels. Findings include: Observation on December 17, 2024, at 12:20 p.m., revealed an unsealed penetration around a plastic pipe, on the second floor, South, above smoke doors by reception. Exit Interview with the Administrator and Maintenance Director on December 17, 2024, at 1:00 p.m., confirmed the penetration.	K 0372		
K 0911 SS=E		K 0911		

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K 0911 SS=E	Continued from page 10 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	The facility will maintain protection of electrical wiring at all levels of care. The duplex switch cover in the 2-South electrical transformer room has been installed. Audits will be conducted once week for 4 weeks, bi-weekly for month to ensure compliance. The Facilities Director or designee will bring such audits to the QA meeting monthly x3 in order for the QA team to verify compliance.	Completion Date: **01/03/2025** Status: **APPROVED** Date: **01/06/2025**

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K 0911 SS=E	Continued from page 11 Based on observation and interview, it was determined facility failed to maintain protection of electrical wiring, affecting one of four levels. Findings include: Observation on December 17, 2024, at 12:15 p.m., revealed a duplex switch was missing its protective cover, exposing the inner wiring, 2-South electrical transformer room. Exit Interview with the Administrator and Maintenance Director on December 17, 2024, at 1:00 p.m., confirmed the exposed wiring.	K 0911		

Certified End Page

HEALTH CENTER AT THE HILL AT WHITEMARSH, THE

STATE LICENSE NUMBER: 17900201

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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

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Deputy Secretary for Quality Assurance

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PLEASE DO NOT DETACH

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