STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __--_____ B. WING: _____	01/27/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER	**8601 STENTON AVE. WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **21610201**	

(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 27, 2025, it was determined that Wyndmoor Hills Rehabilitation And Nursing Center had deficiencies having the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0026 SS=C		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=C	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	1. Emergency preparedness plan was immediately updated with policy and procedures for 1135 waiver. 2. Emergency preparedness plan was audited to ensure proper compliance 3. Education provided to ensure proper compliance with this regulation.. 4. emergency preparedness plan will be audit to ensure proper compliance 2x a month for 2 months and 1x month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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E 0026 SS=C	Continued from page 2	E 0026		

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E 0026 SS=C	Continued from page 3 Based on document review and interview, it was determined the facility failed to develop policies and procedures to include the facility's role in providing alternate care at alternate care sites during emergencies, as part of their Emergency Preparedness (EP) plan, affecting the entire facility. Findings Include: Documentation reviewed on January 27, 2025, between 8:00 a.m. and 12:00 p.m., revealed the Emergency Preparedness plan did not include policies and procedures describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver, during a declared emergency. Exit Interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the EP plan did not include a policy for the facility's role identified by emergency management officials, in the event of an emergency.	E 0026		

Certified End Page

WYNDMOOR HILLS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 21610201

SURVEY EXIT DATE: 01/27/2025

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# 21610201 Component 01 Health Care & Rehab Building Based on a Medicare/Medicaid Recertification Survey completed on January 27, 2025, it was determined that Wyndmoor Hills Rehabilitation And Nursing Center 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 (222), fire resistive building, with a basement, that is fully sprinklered.	K 0000		

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

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

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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	1. The loading dock means of egress door was immediately salted again, and the ice melted. 2. Emergency exit doors audited to ensure egress remains free of all obstructions. 3. Education will be provided to ensure proper compliance with this regulation. 4. The loading dock means of egress door will be audited to ensure it remains free of all obstructions. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** 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 means of egress free of all obstructions, affecting one of four levels in the facility. Findings include: Observation on January 27, 2025, at 7:55 a.m., revealed the egress exit door out from emergency stairwell onto loading dock ramp, to dumpsters, including parking lot egress was encapsulated in ice due to an overnight interior building water damage that froze in below 32 degree weather. Exit interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed exterior egress walkway encased in ice.	K 0211		

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K 0291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	1. An audit of emergency lighting was conducted to ensure all units are in proper working order. 2. A log was created to document emergency lighting inspections and ensure compliance. 3. Education provided to ensure proper compliance with this regulation. 4. An audit of five emergency lights will be conducted to ensure they are in proper working order. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0291 SS=F	Continued from page 4 Based on document review and interview, it was determined the facility failed to maintain emergency lighting, affecting the entire facility. Findings include: Document review on January 27, 2025, between 8:00 a.m., and 12:00 p.m., revealed the facility could not produce documentation that emergency lighting had been tested for 30 seconds on a monthly basis and for 90 minutes on an annual basis. No record of last documented inspection provided. (This is a Repeat Deficiency from the March 13, 2024 annual survey). Exit Interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30 p.m, confirmed the lack of documentation.	K 0291		

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K 0291 SS=F	Continued from page 5	K 0291		
K 0293 SS=F	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	1. Exit sign inspections were conducted to ensure they are in proper working order. 2. A log was created to document exit sign inspections and ensure compliance. 3. Education provided to ensure proper compliance with this regulation. 4. An audit of five exit signs will be conducted to ensure they are in proper working order. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0293 SS=F	Continued from page 6 Based on document review, observation, and interview, it was determined the facility failed to maintain exit signs, affecting the entire facility. Findings include: Document review on January 27, 2025, between 8:00 a.m., and 12:00 p.m., revealed the facility failed to provide documentation of monthly exit sign inspections. No record of last documented inspection provided. (This is a Repeat Deficiency from the March 13, 2024 annual survey). Exit Interview with the Adminstrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the exit sign inspection deficiency existed.	K 0293		

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K 0293 SS=F	Continued from page 7	K 0293		
K 0342 SS=E	NFPA 101 Fire Alarm System - Initiation Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by:	K 0342	1. Items blocking the pull station inside the Activities Department were immediately removed. 2. Pull stations throughout the facility audited to ensure they remain readily accessible. 3. Education provided to ensure proper compliance with this regulation. 4. An audit of the pull station in the Activities Department will be conducted to ensure it remains readily accessible. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0342 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain initiation of the required fire alarm system, affecting one of four levels in the facility. Findings include: Observation on January 27, 2025, at 2:00 p.m., revealed that the pull station inside Activities Department was not readily accessible due to being blocked by miscellaneous storage items. Exit interview with Administrator and Maintenance Director on January 27, 2025 at 2:30 p.m., acknowledged that the fire alarm pull station was blocked by obstructions.	K 0342		
K 0345 SS=F		K 0345		

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K 0345 SS=F	Continued from page 9 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	1. Discrepancies identified during the fire alarm panel's annual inspection were immediately scheduled for repair. 2. The fire alarm panel audited to ensure it is in proper working order. 3. Education will be provided to ensure proper compliance with this regulation. 4. An audit of fire alarm panel inspections will be conducted to ensure all repairs are scheduled and completed. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0345 SS=F	Continued from page 10 Based on documentation, observation and interview, it was determined the facility failed to maintain the fire alarm system in proper operating condition, affecting one of one fire alarm system in the facility. Findings Include: 1. Documentation review on January 27, 2025, between 8:00 a.m., and 12:00 p.m., revealed the facility fire alarm panel annual inspection dated 11/8/24 listed the following discrepancies: a) Indicating Bell -46079745 Basement by Fire Panel, Bells for Shield Building - Failed Operation 1-1 MB. b) Initiating Smoke Detector- 43577281 2nd Rm 234 - Failed Annunciation 1-2 D122. Exit Interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the listed fire alarm deficiencies remained uncorrected.	K 0345		

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K 0345 SS=F	Continued from page 11 2. Observation on January 27, 2025, at 12:15 p.m., revealed the facility fire alarm panel was in trouble mode at time of survey. Exit Interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the fire alarm panel trouble status.	K 0345		
K 0355 SS=E		K 0355		

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	396115	A. BLDG: __01_____ B. WING: _____	01/27/2025

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K 0355 SS=E	Continued from page 12 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	1. The area in front of the fire extinguisher across from resident Room 327 was immediately cleared. 2. Fire extinguishers were audited to ensure they remain free of obstructions. 3. Education will be provided to ensure proper compliance with this regulation. 4. An audit of the area in front of the fire extinguisher across from resident Room 327 will be conducted to ensure it remains clear of obstructions. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0355 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain portable fire extinguishers, affecting one of four levels in the facility. Findings include: Observation on January 27, 2025, at 2:20 p.m., revealed on the third floor, across from resident Room 327, several transport wheel chairs blocking a fire extinguisher. Exit Interview with the Administrator and Director of Maintenance on January 27, 2025, at 2:30 p.m., confirmed the blocked fire extinguisher.	K 0355		
K 0363 SS=E		K 0363		

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K 0363 SS=E	Continued from page 14 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	1. The doors for rooms 219 and 327 were immediately repaired to ensure they are in proper working order. 2. Resident room doors audited to ensure they remain in proper working order. 3. Education will be provided to ensure proper compliance with this regulation. 4. An audit of five resident room doors will be conducted to ensure they are in proper working order. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER	**8601 STENTON AVE. WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **21610201**	

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K 0363 SS=E	Continued from page 15 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363		

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K 0363 SS=E	Continued from page 16 Based on observation and interview, it was determined the facility failed to ensure corridor doors positively latched in the frames, affecting two of four levels in the facility. Findings include: Observation on January 27, 2025, between 12:00 p.m., and 2:30 p.m., revealed: a) Door to resident room 219 was binding in the frame and unable to close. b) Door to resident room 327 was difficult to open due to door handle not releasing latch. Exit Interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the above door deficiencies.	K 0363		

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K 0363 SS=E	Continued from page 17	K 0363		
K 0374 SS=E	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	1. The smoke doors near room 203 were immediately scheduled for maintenance to ensure they close smoke-tight. 2. Smoke doors throughout the facility audited to ensure they close smoke-tight. 3. Education will be provided to ensure proper compliance with this regulation. 4. An audit of three smoke doors will be conducted to ensure they are in proper working order. Audit will be done 2x a month for 2 months and 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0374 SS=E	Continued from page 18 Based on observation and interview, it was determined the facility failed to ensure doors in smoke barrier were maintained to resist the passage of smoke, affecting one of four levels. Findings include: Observation on January 27, 2025, at 1:20 p.m., revealed on the second floor, the smoke doors by room 203 failed to close smoke tight when tested. Exit Interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the doors failed to close smoke tight.	K 0374		
K 0541 SS=F		K 0541		

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K 0541 SS=F	Continued from page 19 NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by:	K 0541	1. The chute doors were immediately repaired to ensure they are in proper working order. 2. Chute doors were audited to ensure they remain in proper working order. 3. Education will be provided to ensure proper compliance with this regulation. 4. An audit of chute doors will be conducted to ensure they remain in proper working order. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0541 SS=F	Continued from page 20 Based on observation and interview, it was determined the facility failed to maintain the fire protection rating for linen chutes, affecting the entire facility. Findings include: Observations on January 27, 2025, between 12:00 p.m., and 2:30 p.m., revealed the soiled utility room chute doors (on the first floor, second floor, and the third floor) all failed to self-close and positively latch. Exit Interview with the Adminstrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the chute doors failed to latch.	K 0541		

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K 0741 SS=F	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by:	K 0741	1. Cigarette butts outside the entrance door to the lobby were immediately cleaned up, and a metal cigarette container was ordered. 2. Smoking areas were audited to ensure they have a metal cigarette container. 3. Education will be provided to ensure proper compliance with this regulation. 4. An audit of smoking areas will be conducted to ensure they have a metal cigarette container. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0741 SS=F	Continued from page 22 Based on observation and interview, it was determined the facility failed to follow smoking regulations at one of one designated smoking area. Findings include: Observation on January 27, 2025, at 8:00 a.m., revealed the facility had an accumulation of cigarette butts on the ground outside the entrance door to the lobby, which is also the designated smoking area. A Metal container with a self-closing cover device into which ashtrays can be emptied was not available. Exit Interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the above deficiency.	K 0741		
K 0761 SS=F		K 0761		

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K 0761 SS=F	Continued from page 23 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 annual fire door inspection was completed immediately. 2. A log was created to ensure proper documentation of the annual fire door inspection. 3. Education will be provided to ensure proper compliance with this regulation. 4. An audit of annual fire door inspections will be conducted to ensure proper documentation and compliance. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0761 SS=F	Continued from page 24 Based on document review and interview, it was determined the facility failed to maintain fire door inspections, affecting the entire facility. Findings include: Document review on January 27, 2025, between 8 a.m. and 12:00 p.m., revealed the facility could not produce documentation showing an annual fire door inspection was conducted within the past 12 months. No record of last documented inspection provided. (This is a Repeat Deficiency from the March 13, 2024 annual survey). Exit Interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the documentation was not available at time of survey.	K 0761		

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K 0761 SS=F	Continued from page 25	K 0761		
K 0911 SS=E		K 0911		

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K 0911 SS=E	Continued from page 26 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	1. The open junction box in the basement boiler room was immediately secured. Appropriate screws were installed on the second floor, above the smoke doors to the left of the nurses' station, to secure a junction box. The heater inside the Activities Department was repaired to ensure compliance. 2. Electrical equipment throughout the facility audited to ensure compliance. 3. Education will be provided to ensure proper compliance with this regulation. 4. An audit of the junction box in the boiler room and the heater in the Activities Department will be conducted to ensure compliance. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/21/2025**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0911 SS=E	Continued from page 27 Based on observation and interview, it was determined the facility failed to maintain electrical equipment, affecting two of four levels of the facility. Findings include: Observation on January 27, 2025, between 12:00 p.m. and 2:30 p.m., revealed the following electrical deficiencies: a) The basement Boiler room had an open unsecured junction box resting on top of the middle boiler; b) The second floor, above the smoke doors, left of the nurses station, Electrical tape was used to secure a junction box cover in lieu of appropriate screws. c) Inside the Activities Department, there was an Electric baseboard heater laying on top of an abandoned heating register, with exposed Romex wiring. There was combustible storage, including cardboard surrounding the heater. Reference: NFPA 70-314.17, NFPA 70-314.28 (C), and NFPA 300.11 Exit interview with the Administrator and Maintenance Director on January 27, 2025, at 2:30	K 0911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __01_____ B. WING: _____	01/27/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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STATE LICENSE NUMBER: **21610201**	

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K 0911 SS=E	Continued from page 28 p.m., confirmed the above electrical system deficiencies.	K 0911		
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	K 0918	1. All required tests and inspections were immediately scheduled. 2. A log was created to ensure proper documentation of all tests and inspections. 3. Education will be provided to ensure proper compliance with this regulation. 4. An audit of tests and inspections will be conducted to ensure proper documentation and compliance. Audit will be done 2x a month for 2 months and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/10/2025** 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:
	396115	A. BLDG: __01_____ B. WING: _____	01/27/2025

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K 0918 SS=F	Continued from page 29 and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __01_____ B. WING: _____	01/27/2025

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K 0918 SS=F	Continued from page 30 Based on document review and interview, it was determined the facility failed to maintain one of one generator, affecting the entire facility. Findings include: Document review on January 27, 2025, between 8:00 a.m., and 12:00 p.m., revealed the facility failed to provide documentation for the following tests/inspections: a) Weekly battery voltage or electrolyte levels testing; (This is a Repeat Deficiency from the March 13, 2024 annual survey) b) Monthly specific gravity or conductance testing; (This is a Repeat Deficiency from the March 13, 2024 annual survey) c) Monthly 30 minutes under load; d) Monthly operation of transfer switches; e) Weekly visual inspection.	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0918 SS=F	Continued from page 31 Interview with the Adminstrator and Maintenance Director on January 27, 2025, at 2:30 p.m., confirmed the tests had not been completed with documentation logged in the past 12 months.	K 0918		

Certified End Page

WYNDMOOR HILLS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 21610201

SURVEY EXIT DATE: 01/27/2025

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