STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315054	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	**1100 CLEMATIS AVE** **PLEASANTVILLE, NJ 08232**

(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 DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/14/2023 and 11/15/2023 and Our Lady's Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Our Lady's Center is a single (1) story, Type II Protected building that was built in January 1963. The facility is divided into 12 smoke zones and has a Diesel Emergency Generator.	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 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: Based on observation and review of facility provided documentation on 11/14/2023 and 11/15/2023, in the presence of facility management, it was determined that the facility failed to provide four (4) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the	K 293	It is the practice of the facility to maintain illuminated exit signage in the courtyards. 1. Illuminated Exit sign have been installed in 3 enclosed courtyards for the residents or occupants to see exit path. 2. Facility wide exit sign inspection for December was completed on December 1st and all existing illuminated exit signs	1/12/24

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

Electronically Signed | 12/15/2023

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K 293	Continued From page 1 following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign."	K 293	functioning as per design. 3. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator an, Director of Maintenance an identified that, all resident could have the potential to be affected by this deficient practice. 4. Education on Exit Sign illumination has been completed with Maintenance staff to observe during rounds by Regional Maintenance Team. 5. Every month the Maintenance Director or designee will check a random location of the facility to ensure exit signs are functioning. This information will then be entered on a log and will be presented to monthly QAPI meeting.	

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K 293	Continued From page 2 On 11/14/2023 (day one of survey), during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with three (3) enclosed (surrounded by the building) outside courtyards that Resident, Staff and Visitors could use. Starting at approximately 9:40 AM on 11/14/2023 and continued on 11/15/2023, in the presence of the DOM, a tour of the building was conducted. During the two (2) day building tour the of the facility, the surveyor observed four (4) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, On 11/14/2023: 1) At approximately 11:56 AM, the surveyor observed in the enclosed outside courtyard #1(exit access door next to Resident room # [redacted], that the facility failed the have one (1) illuminated exit sign above the one (1) designated exit access door that clearly identifies the exit access route to reach an exit. 2) At approximately 12:15 PM, the surveyor observed in the enclosed outside Residents [redacted] courtyard #2 that the facility failed the have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly	K 293		

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K 293	Continued From page 3 identifies the exit access route to reach an exit. On 11/15/2023: 3) At approximately 11:42 AM, the surveyor observed in the enclosed outside courtyard (exit access door next to Resident room # H-11) #1, that the facility failed the have one (1) illuminated exit sign above the one (1) designated exit access door that clearly identifies the exit access route to reach an exit. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency during the survey exit on 11/15/2023 at approximately 1:51 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	K 353		1/12/24

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K 353	Continued From page 4 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: Based on observation, interview and record review on 11/14/2023 and 11/15/2023 in the presence of facility management, it was determined that the facility failed to comply with the inspection and testing requirements NFPA 25 as evidenced by the following: During the survey entrance on 11/14/2023 (day one of survey) at 9:17 AM, a request was made to the Administrator and Director of Maintenance (DOM) to provide all mandatory inspections from 01/01/2022 through 11/13/2023 for review later. Starting at approximately 9:40 AM on 11/14/2023, in the presence of the facility DOM a tour of the building was conducted. Along the tour at approximately 10:50 AM, an inspection in the basement, where the fire sprinkler control valves were located was performed. The surveyor observed on the inspection tag attached the the sprinkler control valves the following dates of quarterly (every 3 months) conducted, - 10/19/2023, 07/24/2023 and 04/25/2023. Later at approximately 12:40 PM during the documentation review of the mandatory inspections of the facility's quarterly (every 3	K 353	It is the practice of the facility to ensure proper Maintenance and Testing of Sprinkler System. 1. Sprinkler Inspections for 2023 have been completed quarterly. 2. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator an, Director of Maintenance an identified that, all resident could have the potential to be affected by this deficient practice. 3. The Sprinkler Company schedule has been adjusted to meet the needs of 4 inspections per calendar year and will be scheduled a year in advance to prevent further deficiencies. 4. Education has been completed with Maintenance staff regarding tags to confirm inspections are completed in timely fashion by Regional Maintenance Team. 5. Every quarter the Maintenance Director or designee will check sprinkler tags throughout the facility to ensure inspections are conducted. This information will then be entered in a log and will be presented to the monthly.	

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K 353	Continued From page 5 months) fire sprinkler system system inspections for the previous 22 months identified the system had the following quarterly sprinkler system inspection reports, 01/26/2022, 04/27/2022, 09/09/2022, and 01/26/2023. At approximately 1:47 PM on day one (1) of survey, the surveyor made a request to the Administrator and DOM if there were any other quarterly (every 3 months) sprinkler system inspections and to provide the reports to the surveyor on 11/15/2023 (day two of survey) for review. On 11/15/2023 at approximately 9:30 AM the DOM provided the following fire sprinkler system quarterly inspection reports for review, - 04/25/2023, 07/24/2023 and 10/19/2023. The facility did not conduct a quarterly fire sprinkler system inspection between 04/27/2022 and 09/09/2023. The facility failed to conducted four (4) quarterly sprinkler inspection for the year 2022 as required per NFPA 25. The Administrator was informed of the deficiency during the survey exit on 11/15/2023 at approximately 1:51 PM. NJAC 8:39-31.2(e) NFPA 25	K 353		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire	K 355		1/12/24

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K 355	Continued From page 6 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 11/14/2023 and 11/15/2023, in the presence of facility management, it was determined that the facility failed to: 1) Perform an annual inspection for 1 of 35 portable fire extinguishers, and 2) Replace 2 of 35 portable fire extinguishers when discharged, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or	K 355	It is the practice of the facility to ensure Fire Extinguishers are properly charged. 1. All Fire Extinguishers mentioned in 2567 have been reinspected and are ready for use. 2. All Fire Extinguishers in the facility have been reinspected and are ready for use and the staff inspect the extinguisher weekly to prevent this from happening in the future. 3. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator an, Director of Maintenance an identified that, all resident could have the potential to be affected by this deficient practice. 4. Education has been completed with Maintenance staff regarding monitoring Fire Extinguishers by Regional Maintenance Staff. 5. Every month the Maintenance Director or designee will check Fire Extinguishers throughout the facility to ensure they are ready for use. This information will then be entered on a log and will be presented to the monthly	

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K 355	Continued From page 7 electronic notification. The findings include the following; On 11/14/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting at approximately 9:40 AM on 11/14/2023 and continued on 11/15/2023, in the presence of the facility's DOM, a tour of the facility was conducted. During the two day building tour the surveyor observed and inspected thirty-five (35) portable fire extinguishers in various locations. The surveyor observed 34 of the 35 portable fire extinguishers were last annually inspected in January 2023 with the surveyor observing the following issues that were identified: On 11/14/2023: 1) At approximately 9:43 AM, the surveyor observed one (1) "ABC-Type" fire extinguisher to the left of Resident room # [redacted] A further inspection identified that the pressure indicating needle was in the "RED" discharge zone of the pressure indicating gauge. This fire extinguisher would not function properly in the event of a fire. At that time a request was made to the DOM to replace the fire extinguisher. The DOM complied with the request. 2) At approximately 11:56 AM, the surveyor observed one ABC Type fire extinguisher in the outside enclosed courtyard next to Resident room	K 355		

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K 355	Continued From page 8 NJ EX Ord had no evidence of an annual inspection tag. On 11/15/2023: 3) At approximately 11:50 AM, the surveyor observed one (1) "ABC-Type" fire extinguisher to the left of Resident room # NJ EX Ord. A further inspection identified that the pressure indicating needle was in the "RED" discharge zone of the pressure indicating gauge. This fire extinguisher would not function properly in the event of a fire. At that time a request was made to the DOM to replace the fire extinguisher. The DOM complied with the request. The facility's DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency during the survey exit on 11/15/2023 at approximately 1:51 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 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)	K 372		1/12/24

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K 372	Continued From page 9 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations, interview and review of facility provided documentation on 11/14/2023 and 11/15/2023, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for five (5) of eight (8) smoke barrier walls inspected as evidenced by the following: On 11/14/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1)building with thirteen (13) smoke barrier walls in the facility. Starting at approximately 9:40 AM on 11/14/2023 and continued on 11/15/2023, in the presence of the facility's DOM, an inspection of the above the corridor ceiling tiles of eight (8) smoke barrier walls was performed. The surveyor observed the following smoke barrier wall failed to maintain the 1/2 hour fire rated construction as required by code in the following locations; On 11/14/2023: 1. At approximately 10:40 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors (next to the snack room) had two (2) approximately 1" penetrations with wires running through the barrier wall. These penetrations were observed on both sides	K 372	It is the practice of the facility to ensure Smoke barriers are free from penetration. 1. All Penetrations mentioned in 2567 have been sealed using Fire Barrier Caulk as per the UL Listing. 2. All Smoke and Fire Barriers throughout the building have been inspected for penetrations and any found have been corrected using Fire Barrier Caulk as per the UL Listing for opening size to maintain proper barrier for resident safety. 3. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator an, Director of Maintenance an identified that, all resident could have the potential to be affected by this deficient practice. 4. Education has been completed with Maintenance staff regarding monitoring Smoke and Fire barrier doors above the ceiling to ensure they are properly sealed by Regional Maintenance Staff. 5. Every month the Maintenance Director or designee will check random areas above ceiling for penetrations throughout the facility. This information will then be entered on a log and will be presented to the monthly QAPI meeting.	

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K 372	Continued From page 10 through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. 2. At approximately 10:50 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors (next to Resident room # [redacted] had one (1) approximately 2" penetration with wires running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. 3. At approximately 11:03 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors (next to Resident room # [redacted] had two (2) approximately 1" penetrations with wires running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. 4. At approximately 11:11 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors (next to Resident room # [redacted] had one (1) approximately 1" penetration with wires running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The facility DOM confirmed the findings at the	K 372		

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K 372	Continued From page 11 times of observations. On 11/15/2023, during the building tour in the presence of the Corporate Vice President of Construction and Facilities and DOM the surveyor observed the following; 5. At approximately 10:18 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors (next to Resident room # [redacted] had one (1) approximately 2-1/2" penetration with 7 blue wires, 4 white wires and an approximately 2" pipe running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The facility Corporate Vice President of Construction and Facilities and DOM confirmed the finding at the time of observation. The Administrator was informed of the deficiency during the survey exit on 11/15/2023 at approximately 1:51 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 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.	K 911		1/12/24

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	315054	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	**1100 CLEMATIS AVE** **PLEASANTVILLE, NJ 08232**

(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 DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 12 Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 11/14/2023 and 11/15/2023, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 11 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 11/14/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a	K 911	It is the practice of the facility to ensure electrical systems are functioning as per design. 1. All missing GFCI Outlets mentioned in 2567 have been replaced. 2. All GFCI Outlets in the entire building have been inspected and are functioning as designed to maintain the safety of residents and will be inspected Monthly. 3. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator an, Director of Maintenance an identified that, all resident could have the potential to be affected by this deficient practice. 4. Education completed with Maintenance staff regarding monitoring GFCI Outlets withing 6 feet of water source and to ensure they are functioning as designed by Regional Maintenance Staff. 5. Every month the Maintenance Director or designee will check random areas throughout the facility to ensure GFCI outlets are functioning. This information will then be entered on a log and will be presented to the monthly QAPI meeting.	

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K 911	Continued From page 13 request was made to the Administrator (Admin.) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building. There are eight (8) Resident wings, common areas and an Administrative wing in the facility. Starting at approximately 9:40 AM on 11/14/2023 and continued on 11/15/2023, in the presence of the facility DOM, a tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested eleven (11) electrical outlets in wet (with-in 6 feet of a sink) locations with two (2) electrical outlets that failed to de-energize when tested in the following locations; On 11/14/2023: 1. At approximately 11:01 AM, inside the Activities room, one Duplex electrical outlet located five feet four inches (5'-4") to the right of the hand washing sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. On 11/15/2023: 2. At approximately 11:14 AM, inside the Physical Therapy room, one Duplex electrical outlet located three feet three inches (3'-3") to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code.	K 911		

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K 911	Continued From page 14 The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency during the survey exit on 11/15/2023 at approximately 1:51 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 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	K 918		1/12/24

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K 918	Continued From page 15 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: Based on observation and interview on 11/14/2023 and 11/15/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 11/14/2023 (day one of survey) during the survey entrance at approximately 9:17 AM, a request was made to the facility Administrator and Director of Maintenance (DOM) if the facility had an Emergency Generator. The DOM told the surveyor, yes we have one Diesel Emergency Generator. On 11/15/2023 (day two of survey) during the building tour at approximately 11:20 AM, an inspection outside of the building where the Diesel emergency generator was located was performed. The surveyor observed the emergency stop button was located on the control panel on the generator. At that time the surveyor asked the DOM, Do you have a remote emergency stop button for the generator. The DOM said, no.	K 918	1. The Facility Generator manual stop has been installed outside of the room's enclosure by Commander Power Systems on December 26th 2024. 2. Engineering staff have been educated in inspecting and maintaining the generator manual stop by Regional Maintenance Staff on December 26th 2024. 3. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator an, Director of Maintenance an identified that, all resident could have the potential to be affected by this deficient practice. 4. A facility inspection has been conducted and has been found to comply. 5. Audit will be conducted monthly by Engineering Director/ designee. Findings of the audit will be submitted to QAPI for review and recommendations.	

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K 918	Continued From page 16 The DOM confirmed the finding at the time of inspection. The Administrator was informed of the deficiency during the survey exit on 11/15/2023 at approximately 1:51 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 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)	K 923		1/12/24

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K 923	Continued From page 17 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 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: Based on observation on 11/14/2023 in the presence of facility management it was determined that the facility failed to provide wall-ceiling assembly with one-hour fire resistance rating in accordance with NPFA 99, 2012 Edition Sections 11.3.1, 11.3.2, 11.3.3 and 11.3.4. This deficient practice was evidenced by the following: Reference: National Fire protection Association (NFPA) Standards 99 Health Care Facilities, Definitions, - One "E-size cylinder" = 24.96 cu ft. - Twelve "E-size cylinder" = 299.52 cu ft. - H Cylinder = approximately 250 cu ft. NFPA 99 2012 edition 5.1.3.3.2 and 5.1.3.3.3 Storage of Oxygen Greater that 3000 cu ft., Construction assembly, One hour FFR enclosure with 45-minute fire doors, Secured. During the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various	K 923	It is the practice of the facility to ensure proper oxygen storage throughout the building. 1. Signage has been installed in oxygen storage room limiting storage of oxygen to less the 3,000 Cubic Feet and removal of excess oxygen has been completed . 2. All other oxygen storage rooms have been checked and have minimal storage and this was done to prevent any future excess storage. 3. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator an, Director of Maintenance an identified that, all resident could have the potential to be affected by this deficient practice. 4. Education has been completed with Maintenance staff regarding monitoring oxygen storage limits and to ensure they are not exceeding limits as designed by Regional Maintenance Team on December 26th 2023. 5. Every month the Maintenance Director or designee will check oxygen	

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K 923	Continued From page 18 rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with eight (8) Resident Wings and common areas. Starting at approximately 9:40 AM, in the presence of the facility DOM a tour of the building was conducted. Along the building tour at approximately 11:50 AM, an inspection inside an Oxygen storage room (located between the [redacted]-Wing and [redacted]-Wing) was performed. During this inspection the surveyor observed and measured above the rooms ceiling tiles a 2-1/2 by 17 inches penetration through the fire rated wall leading to the exit corridor The surveyor observed inside the room, - One hundred and seven (107) full E-Type oxygen cylinders (2,670.72 cu ft.) - Six (6) Full H-Type oxygen cylinders (1500 cu ft.) This is 4,170.72 cu ft. of stored oxygen inside the room. The facility failed to maintain the rooms one (1) hour fire rated construction. The DOM confirmed the finding at the time of observation. The Administrator was informed of the deficiency during the survey exit on 11/15/2023 at approximately 1:51 PM. Fire Safety Hazard. NJAC - 31.2 (e) NFPA 99	K 923	storage areas throughout the facility to ensure storage limits. This information will then be entered on a log and will be presented to the monthly QAPI meeting.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315054 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	01/12/2024	LSC K0353	01/12/2024	LSC K0355	01/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	01/12/2024	LSC K0911	01/12/2024	LSC K0918	01/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	01/12/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO