STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395182	A. BLDG: __--_____ B. WING: _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ST. JOHN NEUMANN CENTER FOR REHABILITATION & HEALTHCARE STATE LICENSE NUMBER: **452202**	**10400 ROOSEVELT BOULEVARD PHILADELPHIA, PA 19116**

(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 23, 2025, it was determined that St. John Neumann Center For Rehabilitation & Healthcare, had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0007 SS=B	483.73(a)(3) EP Program Patient Population §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not	E 0007	1.Policy on person at risk was reviewed and education done with staff 2.Policy Available in Emergency Preparedness binder.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/21/2025**

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 0007 SS=B	Continued from page 1 limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by:	E 0007		

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E 0007 SS=B	Continued from page 2 Based on document review and interview, it was determined the facility failed to ensure policies and procedures were in place addressing patient population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans, affecting the entire facility. Findings include: Document review on January 23, 2025, at 8:30 a.m., revealed the Facility's Emergency Preparedness Plan did include policies and procedures that addressed persons at-risk. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 am, confirmed the lack of documentation.	E 0007		
E 0034 SS=B		E 0034		

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E 0034 SS=B	Continued from page 3 483.73(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E 0034	1.At risk resident list with mobility status was available as of 1-22-2025 and failed to give to inspector at inspection. 2. NHA will ensure the list is maintained in the emergency prepared book.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/21/2025**

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E 0034 SS=B	Continued from page 4 This REQUIREMENT is not met as evidenced by:	E 0034		

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E 0034 SS=B	Continued from page 5 Based on document review and interview, it was determined the facility's emergency preparedness communication plan did not include a means of providing information about the facility's needs and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee, affecting the entire facility. Findings include: Document review on January 23, 2025, at 8:30 a.m., revealed the facility's emergency preparedness communication plan did not include a means of providing information about the facility's needs and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the lack of documentation.	E 0034		

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E 0034 SS=B	Continued from page 6	E 0034		

Certified End Page

ST. JOHN NEUMANN CENTER FOR REHABILITATION & HEALTHCARE

STATE LICENSE NUMBER: 452202

SURVEY EXIT DATE: 01/23/2025

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# 452202 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on January 23, 2025, it was determined that St. John Neumann Center For Rehabilitation & Healthcare 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 two-story, Type II (000), unprotected noncombustible building, with three partial basements, that is fully sprinklered.	K 0000		

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

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K 0100 SS=C	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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. This REQUIREMENT is not met as evidenced by:	K 0100	1.The floor plans were accurately revised to include the following, but not limited to smoke barrier walls, fire barrier walls, horizontal exits, rated rooms, required exits, and shaft walls. 2.NHA/designee will educate maintenance on the requirements for having portable, accurate floor plans on site. NHA/designee will also conduct a house-wide education to ensure staff is aware of up-to-date floor plans. 3.NHA/ designee will audit accuracy of floor plans monthly x3. Results of the audit to be reported monthly QA.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0100 SS=C	Continued from page 2 Based on document review and interview, it was determined the facility failed to provide accurate, portable floor plans as required, affecting the entire facility. Findings Include: Document review on January 23, 2025, at 8:30 a.m., revealed the facility failed to provide a set of accurate, portable floor plans. The Division of Safety Inspection is requiring that all facilities under our jurisdiction have a portable, accurate floor plan on site to be used during the course of the Life Safety Code Survey. The Life Safety Code Floor Plans shall include the following: a. Smoke Barrier Walls (outside wall to outside wall); b. Fire Barrier Walls (2-hour walls); c. Horizontal Exits; d. Rated Rooms (Storage Rooms, Soiled Utility	K 0100		

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K 0100 SS=C	Continued from page 3 Rooms, designated Medical Gas Rooms) will be clearly designated. It is the facility's responsibility to have all Rated Rooms indicated on their Life Safety Code Floor Plan; e. Required Exits should be clearly noted and; f. Shafts Walls. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the lack of accurate floor plans.	K 0100		
K 0211 SS=E		K 0211		

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K 0211 SS=E	Continued from page 4 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 multi-purpose room furniture was immediately removed from area. The egress paths from the adult day care center and exit door, inside the entrance to the 400 wing were immediately shoveled. The exit door next to resident room 701 was repaired to ensure proper function. 2.NHA/Designee will complete a house-wide education on keeping egress doors free of obstruction. NHA/Designee will educate maintenance staff on keeping egress paths clear of snow. 3.NHA/ Designee will audit exit doors and egress paths throughout the facility to ensure they are free of obstruction. 4.NHA/ Designee will conduct a random audit of egress paths and exit doors weekly x4, monthly x2 to ensure they remain free of obstruction. Results of the audit will be reported at monthly QA.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0211 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain egress paths free of all obstructions, affecting two of three levels in the facility. Findings include: 1. Observation on January 23, 2025, at 10:28 a.m., revealed, on the first floor, both exits from the Multi-purpose Room were blocked by furniture. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the blocked exits. 2. Observations on January 23, 2025, between 10:30 a.m. and 11:00 a.m., revealed egress paths were not shoveled in the following locations: a. 10:30 a.m., Adult Daycare; b. 11:00 a.m., exit door inside the entrance to the 400 wing;	K 0211		

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K 0211 SS=E	Continued from page 6 c. This condition was noted for a majority of the egress paths from the facility. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the egress paths were not shoveled. 3. Observation on January 23, 2025, at 11:29 a.m., revealed on the first floor, the exit door next to resident room 701 required excessive force to open. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the door required excessive force to open.	K 0211		
K 0222 SS=E		K 0222		

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K 0222 SS=E	Continued from page 7 NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door	K 0222	1.The delayed egress door by laundry has been repaired to alarm and properly function. The proper signage was placed on the delayed egress door next to resident room 701. 2.NHA/Designee will educate the Maintenance Director on the requirements for maintaining delayed egress doors and ensuring they have the proper signage that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." 3.NHA/ Designee will audit the delayed egress doors in the facility to ensure proper function and signage. 4.NHA/Designee will conduct a random audit of delayed egress doors to ensure they are properly functioning and have the proper signage posted, weekly x4 monthly x3. 4.Results of the audit to be reported to monthly QA.	Completion Date: **03/07/2025** 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:
	395182	A. BLDG: __01_____ B. WING: _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ST. JOHN NEUMANN CENTER FOR REHABILITATION & HEALTHCARE STATE LICENSE NUMBER: **452202**	**10400 ROOSEVELT BOULEVARD PHILADELPHIA, PA 19116**

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K 0222 SS=E	Continued from page 8 assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 0222		

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K 0222 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain delayed egress doors, affecting one of three levels in the facility. Findings include: 1. Observation on January 23, 2025, at 10:52 a.m., revealed on the first floor, the delay egress door by Laundry, failed to alarm and open. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the door failed to alarm and open. 2. Observation on January 23, 2025, at 11:29 a.m., revealed on the first floor, the delayed egress door near resident room 701 lacked signage stating: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS "	K 0222		

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K 0222 SS=E	Continued from page 10 Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the lack of signage.	K 0222		
K 0293 SS=E	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.An inspection of all exit signage was completed on 1/27/2025 to ensure proper functioning. 2.NHA/Designee will in-service maintenance department on requirements for completing monthly exit sign inspection. 3.The Director of maintenance/ designee will continue to complete monthly inspections of the exit signage to ensure proper functioning. 4.NHA or designee will do audits of the monthly inspection x 3 months. 4.Results of the inspection to be reported at QA	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0293 SS=E	Continued from page 11 Based on documentation review and interview, it was determined the facility failed to maintain and inspect exit signage, affecting nine of twelve inspections. Findings include: Document review on January 23, 2025, at 8:30 a.m., revealed the facility could not provide documentation of monthly exit sign inspections prior to April of 2024. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the lack of documentation.	K 0293		
K 0324 SS=E		K 0324		

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K 0324 SS=E	Continued from page 12 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	1.Kitchen hood suppression inspection was completed on 1/29/2025. Monthly inspections have been scheduled for Maintenance. 2.NHA/Designee will in-service maintenance department on requirements for completing monthly Inspection of kitchen Hood suppression system. 3.Maintenance Director/designee will continue to complete monthly inspections of the kitchen hood suppression system to ensure proper functioning. 4. NHA/Designee will audit the monthly reports x 3. 5. Audit reports will be reported at QA.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0324 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain and inspect the kitchen hood suppression, affecting one of three levels in the facility. Findings include: Observation on January 23, 2025, at 10:47 a.m., revealed on the first floor, in the Kitchen, the hood suppression system lacked monthly inspections. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the lack of monthly inspections.	K 0324		
K 0341 SS=E		K 0341		

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K 0341 SS=E	Continued from page 14 NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by:	K 0341	1.The manual pull station in the kitchen is scheduled to be moved to be within 5 ft of exit door. 2.NHA/Designee will educate the maintenance director on the requirements of having pull stations within 5 feet of exit doors. 3.NHA/ Designee will conduct an audit of exit doors to ensure there is a pull station within 5 feet. 4.Audit report will be submitted to QA.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0341 SS=E	Continued from page 15 Based on observation and interview, it was determined the facility failed to properly install fire alarm initiating devices, affecting one of three levels in the facility. Findings include: Observation on January 23, 2025, at 10:45 a.m., revealed on the first floor, in the Kitchen, the manual pull station for the double exit doors was not mounted within 5 ft. of the exit doors. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the manual pull station was not mounted within 5 ft. of the exit doors.	K 0341		
K 0345 SS=F		K 0345		

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K 0345 SS=F	Continued from page 16 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.Failed batteries from the report dated 7-29-2024 have been ordered and replaced. The Clock in the chapel lobby is moved so the fire alarm strobe is not blocked. 2.NHA/Designee will educate the maintenance director in follow up regarding the requirement for failed reports and to assure furniture does not block the fire alarm strobe. 3.NHA/Designee will audit the fire alarm reports monthly x 3 to ensure all components are functioning. 4.NHA/Designee will audit fire alarm strobes weekly x4, monthly x2 to ensure they are not blocked. 5.Results of audits to be reported at monthly QA.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0345 SS=F	Continued from page 17 Based on document review, observation, and interview, it was determined the facility failed to maintain the fire alarm system, affecting the entire facility. Findings include: Document review on January 23, 2025, at 8:30 a.m., revealed the fire alarm inspection report dated July 29, 2024 noted the system had 4 failed batteries. The facility could not provide documentation that they were replaced. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the lack of documentation. 2. Observation on January 23, 2025, at 10:32 a.m., revealed on the first floor, the fire alarm strobe in the Chapel Lobby was blocked by a grandfather clock. Exit Interview with the Administrator and	K 0345		

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K 0345 SS=F	Continued from page 18 Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the blocked fire alarm strobe.	K 0345		
K 0355 SS=F		K 0355		

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K 0355 SS=F	Continued from page 19 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 certificate of the technician conducting the annual inspection has been obtained from the vendor. Blocked fire extinguisher in main dining room, across from 500-unit nurses' station and housekeeping storage in basement has been exposed and area cleared. Indicator lights for recessed portable fire extinguishers are maintained lit. Fire extinguisher monthly checks have been scheduled for maintenance. Basement elevator Machine room the fire extinguisher is mounted on the wall 2.NHA/Designee to in-service maintenance staff on requirement of maintenance and inspection of fire extinguishers monthly, ensuring they remain free from obstruction, and the indicator display is properly functioning. 3. The Maintenance director/ Designee has completed an inspection of fire extinguishers in the building to ensure they are stored, functioning, and the display indicator is properly visible. 4.The maintenance director/designee	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0355 SS=F	Continued from page 20	K 0355	will conduct a random audit (10 total) of the fire extinguishers monthly x 3 to ensure they are properly maintained, inspected, and the indicator display is properly functioning 5. Results of audits will be reported to QA.	

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K 0355 SS=F	Continued from page 21 Based on document review, observation, and interview, it was determined the facility failed to maintain and inspect portable fire extinguishers, affecting the entire facility. Findings include: 1. Document review on January 23, 2025, at 8:30 a.m., revealed the facility could not produce the certification for the technician conducting the annual portable fire extinguisher maintenance/inspection. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the lack of documentation. 2. Observations on January 23, 2025, between 10:41 a.m. and 11:36 a.m., revealed portable fire extinguishers were blocked by storage in the following locations: a. 10:41 a.m., on the first floor, Dining Room;	K 0355		

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K 0355 SS=F	Continued from page 22 b. 11:16 a.m., on the first floor, across from 500 wing Nurses' Station; c. 11:36 a.m., in the Basement, Housekeeping Storage to the left of the elevator. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the blocked portable fire extinguishers. 3. Observations on January 23, 2025, between 10:49 a.m. and 11:28 a.m., revealed the indicator lights for recessed mounted portable fire extinguishers were not lit in the following locations: a. 10:49 a.m., on the first floor, next to Laundry; b. 11:16 a.m., on the first floor, across from 500 wing Nurses' Station; c. 11:23 a.m., on the first floor, by 700 wing Nurses' Station; d. 11:26 a.m., on the first floor, behind 700 wing Nurses' Station;	K 0355		

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	395182	A. BLDG: 01 B. WING:	01/23/2025

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ST. JOHN NEUMANN CENTER FOR REHABILITATION & HEALTHCARE STATE LICENSE NUMBER: **452202**	**10400 ROOSEVELT BOULEVARD PHILADELPHIA, PA 19116**

(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 0355 SS=F	Continued from page 23 e. 11:28 a.m., on the first floor, next to resident room 701; f. 11:30 a.m., on the first floor, next to 700 wing Lounge; g. This condition was noted throughout the facility. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the portable fire extinguisher indicator lights were out. 4. Observations on January 23, 2025, between 10:50 a.m. and 11:35 a.m., revealed portable fire extinguishers were missing monthly inspections in the following locations: a. 10:50 a.m., on the first floor, Laundry washing machine room, not inspected since 10/2024; b. 10:58 a.m., on the first floor, by 400 wing fire barrier, not inspected since 11/2024; c. 11:30 a.m., on the first floor, by 700 wing Lounge, not inspected since 11/2024;	K 0355		

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ST. JOHN NEUMANN CENTER FOR REHABILITATION & HEALTHCARE STATE LICENSE NUMBER: 452202	10400 ROOSEVELT BOULEVARD PHILADELPHIA, PA 19116

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K 0355 SS=F	Continued from page 24 d. 11:34 a.m., in the Basement, Housekeeping Storage to the right of the elevator, not inspected since 11/2024; e. 11:35 am, in the Basement, Elevator Machine Room, not inspected since 7/2024. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the lack of monthly inspections. 5. Observation on January 23, 2025, at 11:35 a.m., revealed in the Basement Elevator Machine Room, the portable fire extinguisher was not mounted to the wall. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the portable fire extinguisher was not mounted to the wall.	K 0355		

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K 0371 SS=C	NFPA 101 Subdivision of Building Spaces - Smoke Compar Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by:	K 0371	1.It is the policy of the facility to ensure the smoke barriers are to provide at least two smoke compartments on every sleeping floor with a 30 or more -patient bed capacity. 2.Size of the compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any one point in the compartment to a door in the smoke carrier. 3.Smoke Compartment One (300 and 400 wings) 4.Smoke Compartment Two (500 and 600 wings) 5.Smoke Compartment Five (Chapel and Administration) 6.The facility request that the required FSES worksheet to be completed by the Department of Health in accordance with NAPA 101A.	Completion Date: **03/07/2025** 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:
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K 0371 SS=C	Continued from page 26 Based on document review and interview, it was determined the facility failed to maintain smoke compartments within required square footages, affecting three of nine smoke compartments. Findings Include: Document review on January 23, 2025, at 8:30 a.m., revealed smoke compartments one, two, and five exceed the maximum allowance of 22,500 square feet in total area. Smoke compartment one included Katharine, Drexel, and St. Anthony Avenue (300 & 400 Wings). Smoke compartment two included St. Elizabeth's Garden and All Saints Boulevard (500 & 600 Wings). Smoke compartment five contained the Chapel and Administration offices (Non-Patient Care Area). Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed smoke compartments exceeded the maximum allowance.	K 0371		

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 0372 SS=E	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	1.The smoke barriers doors have been adjusted to ensure they positively latch in the following areas: next to 400 wing, entrance of 500 & 600, and by resident room 605. 2.The Director of maintenance was educated on the requirement for smoke barrier doors to positively latch. 3.Maintenance Director/Designee completed an audit of smoke barrier doors in the facility to ensure they positively latch. 4.Maintenance Director/Designee will conduct a random audit of smoke barrier doors to ensure they positively latch. The audit will be completed weekly x4, then monthly x2. Report of audit will be reported at monthly QA.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0372 SS=E	Continued from page 28 Based on observation and interview, it was determined the facility failed to maintain the fire resistance of smoke barriers, affecting one of three levels in the facility. Findings include: Observations on January 23, 2025, between 10:59 a.m. and 11:21 a.m., revealed on the first floor, the smoke barrier doors failed to close together in the following locations: a. 10:59 a.m., next to 400 wing; b. 11:12 a.m., by the entrance to the 500 & 600 wing; c. 11:21 a.m., by resident room 605. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m., confirmed the doors failed to close together.	K 0372		

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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 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	1.The voltage battery of the generator was inspected and noted to be in proper function. The weekly inspection report has been revised to include the voltage battery check of generator. 2.Education was completed for maintenance director to ensure they inspect generator battery voltage weekly. 3.NHA/designee will audit weekly check report weekly x 4 and then monthly x3 to ensure compliance with generator battery check. Report on Audit will be reported in QA.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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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 and inspect the emergency generator, affecting the entire facility. Findings include: Document review on January 23, 2025, at 8:30 a.m., revealed the facility could not produce documentation of weekly battery voltage testing. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m, confirmed the lack of documentation.	K 0918		
K 0923 SS=E		K 0923		

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K 0923 SS=E	Continued from page 31 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	1.The door to the oxygen storage room next to resident room 729 has been repaired to ensure it positively latches. 2.NHA/Designee will educate the maintenance director on the requirement for the oxygen Storage room to positively latch and close. 3.The maintenance director/designee will audit the doors to the oxygen Storage rooms in the facility to ensure they close. 4.The NHA/Designee will audit oxygen storage rooms weekly x4, then monthly x2 to ensure they positively latch and close. Report of Audit will be reported in monthly QA meeting.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0923 SS=E	Continued from page 32 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 and interview, it was determined the facility failed to maintain the fire resistance of gas cylinder storage, affecting one of three levels in the facility. Findings include: Observation on January 23, 2025, at 11:27 a.m, revealed on the first floor, the door to the Oxygen Storage Room next to resident room 729, failed to close and positively latch. Exit Interview with the Administrator and Maintenance Director on January 23, 2025, at 11:45 a.m, confirmed the door failed to close and positively latch.	K 0923		

Certified End Page

ST. JOHN NEUMANN CENTER FOR REHABILITATION & HEALTHCARE

STATE LICENSE NUMBER: 452202

SURVEY EXIT DATE: 01/23/2025

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