STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315010	A. BUILDING **01** B. WING _____	**04/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	**225 W JERSEY STREET** **ELIZABETH, NJ 07202**

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
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 4/7/22 and 4/8/22, 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 Occupancy The facility is a 3-story building that was built in 90's, It is composed of Type II protected construction. The facility is divided into 9- smoke zones. The 350 KW diesel generator does 100 % of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		

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

Electronically Signed | 04/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 The facility has 200 certified beds. At the time of the survey the census was 182.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)	K 161		7/7/22

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K 161	Continued From page 2 Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide an acceptable construction type and construction standards in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through 19.1.6.7, 19.3.1 and 8.6. This deficient practice was evidenced by the following: 1. On 4/7/22 during the building tour from 9:50 AM to 3:00 PM, The Surveyor, Maintenance Director and Regional Plant Operations Director, observed on the ground floor where the FACP (Fire Alarm Control Panel) was located, that the above exposed ceiling area revealed a steel beam, metal box truss supporting corrugated steel decking that were all unprotected with no fire resistant rating provided. 2. On 4/7/22 during the building tour from 9:50 AM to 3:00 PM, The Surveyor, Maintenance Director and Regional Plant Operations Director, observed on the ground floor that the corridor closet revealed an exposed ceiling area, that a steel beam, metal box truss supporting corrugated steel decking were all unprotected with no fire resistant rating provided. An Interview was conducted on 4/8/22, at approximately 1:10 PM with the Maintenance Director and Regional Maintenance Director. The	K 161	K161 SS F Building Construction Type and Height CFR(s): NFPA 101 No residents were identified as having negative impact from this deficient practice. The deficient practice had the potential to affect all residents residing at this facility. The area observed on the ground floor where the Fire Alarm Control Panel (FACP) is located with the above exposed ceiling area will be provided with fire resistant rating in accordance with NFPA guidelines. Work completed. The observed corridor closet on the ground floor revealing an exposed ceiling area was protected with fire resistant rating in accordance with NFPA guidelines. The Director of Maintenance provided education to the Maintenance Department staff on the importance of providing acceptable construction type and construction standards in accordance with NFPA requirements. The Director of Maintenance/Designee will conduct monthly audits to ensure the fire-resistant rating remains in place and provides acceptable protection for construction type and standards in	

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K 161	Continued From page 3 surveyor asked for a set of building plans identifying the metal deck was restrained or unrestrained, UL assembly and fire resistance rating for the steel beams and composite metal deck, but at that time no documents and/or drawings were provided. The Administrator was informed of the findings at the Life Safety Code exit conference on 4/8/22. NJAC 8:39-31.2(e)	K 161	accordance with NFPA guidelines. Any areas identified as needing repair will be corrected immediately. The Director of Maintenance will present the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if any additional oversight of this area is required.	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/7/22, the facility failed to provide stair thread marking stripe (applied as a material that is integral with the nosing of each step, each floor's landing and handrails) with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3. The deficient practice was observed in 4 of 4 stairwells observed in the facility by the following: While touring the facility from approximately 9:40 AM, to 3:00 PM, the surveyor, Maintenance	K 225	K225 SS F □Stairways and Smokeproof Enclosures CFR(s): NFPA 101 No residents were identified as having negative impact from this deficient practice. The deficient practice had the potential to affect residents and staff utilizing the stairwells as exits. All four stairwells observed during survey identified as [redacted] and the old stairwell, have been provided with stair thread marking stripes (applied as a	5/4/22

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K 225	Continued From page 4 Director and Regional Plant Operations Director observed that the 4 egress stairwells identified as [redacted] and old stairwell's, revealed that marking stripes were not present on each step, floor landing, and handrails. The findings were verified by the Maintenance Director and Regional Plant Operations Director at the times of the observation. The Administrator was informed of this finding during the Life Safety Code survey exit conference on 4/8/22. NJAC 8:31.2(e) NFPA 101:2012 - 19.2.2.3, 7.2.2	K 225	material that is integral with the nosing of each step, each floor□s landing and hand rails) with solid and continuous marking stripes, in accordance with NFPA requirements. The Director of Maintenance provided education to Maintenance Department staff on the requirement for providing and maintaining stair thread markings. The Director of Maintenance/Designee will conduct monthly audits of each stairwell to ensure marking stripes are maintained in accordance with NFPA requirements. Any infractions observed during the monthly inspections will be repaired immediately. The Director of Maintenance will present the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if any additional oversight of this area is required.	
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/8/22, the facility failed to provide and maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire	K 271	K271 SS E □Discharge from Exits CFR(s): NFPA 101	7/7/22

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K 271	Continued From page 5 or other emergency in accordance with NFPA 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient condition was evidenced for 1 of 4 exit discharge's by the following finding: At 9:45 AM, the surveyor, Maintenance and Regional Plant Operations Directors observed that the [redacted] exit from the building required an approximately 6" step down from the door discharge, failing to maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency. The Maintenance and Regional Plant Operations Directors confirmed the finding's during the observations. The Administrator was informed of the finding at the Life Safety Code exit conference on 4/8/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.7, 19.2.7	K 271	No residents were identified as having negative impact from this deficient practice. The deficient practice had the potential to affect residents and staff exiting the [redacted] Floor [redacted] exit. The [redacted] exit was repaired with a landing area and new step to maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA guidelines. The Director of Maintenance provided education to the Maintenance Department staff on the importance of maintaining a level walking surface, free of obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA guidelines. The Director of Maintenance/Designee will conduct monthly audits of exit doors to ensure that exit door surfaces are maintained at level walking surfaces, free of all obstructions or impediments to full instant use in the case of fire or other emergency. The Director of Maintenance will present the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if additional oversight of this area is required.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and	K 281		5/4/22

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K 281	Continued From page 6 shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice was evidenced by the following: At 12:10 PM, the surveyor, Maintenance and Regional Plant Operations Directors observed by resident room [redacted], revealed switch controlling normal lighting supplied normal and emergency lighting for the means of egress and had no lighting when the switch was in the off position. The findings were verified by the Maintenance and Regional Plant Operations Directors at the time of the observation. The Administrator was informed of the finding at the Life Safety Code exit conference on 4/8/22. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	K281 SS F Illumination of Means of Egress CFR(s): NFPA 101 No residents were identified as having negative impact from this deficient practice. The deficient practice had the potential to affect residents and staff utilizing the means of egress near room [redacted]. An exit sign with dual lanterns was installed above the exit door near room [redacted] In the event of an emergency, the dual lanterns will operate automatically and illuminate the means of egress in accordance with NFPA guidelines. The Director of Maintenance conducted audits on all exit doors and found no other means of egress affected by this deficient practice. The Director of Maintenance provided education to the Maintenance Department staff on the importance of maintaining emergency illumination that would operate automatically along the means of egress in the event of an emergency. The Director of Maintenance/Designee will conduct monthly audits of emergency illumination along means of egress to assure compliance. Any infractions observed during the monthly inspections will be corrected immediately. The Director of Maintenance will present	

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K 281	Continued From page 7	K 281	the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if additional oversight of this area is required.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		5/4/22

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K 321	Continued From page 8 Based on observation and interview, the facility failed to provide fire barriers with one-hour fire resistance rating, wall-ceiling assembly and penetrations not properly fire stopped with a system or material that is capable of limiting the transfer of smoke from hazardous areas and provide and maintain self-closing devices and hardware on doors to hazardous areas , in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 8.3, 8.3.5.1, 8.5.6.2 and 8.7. This deficient practice has the potential to affect all residents and was determined by the following: 1. On 4/7/22 at 1:20 PM, the surveyor, Maintenance Director and Regional Plant Operations Director observed on the ground floor in the laundry room. The exposed area above the ceiling revealed wooden supports approximately 10' x 10' using 2" x 8"s that were supporting the metal unprotected corrugated decking above. 2. On 4/8/22 at 2:25 PM, the surveyor, Maintenance Director and Regional Plant Operations Director observed on the ground floor storage room, that when the surveyor attempted to enter the room, approximately 50 plus combustible cardboard boxes filled the room. The surveyor could not fully open the door to determine if it had an auto-closing device installed. The findings were verified by Maintenance Director and Regional Plant Operations Director at the times of the observation. The Administrator was informed of the findings at the Life Safety Code exit conference on 4/8/22.	K 321	K321 SS F □Hazardous Areas □ Enclosure CFR(s): NFPA 101 No residents were identified as having negative impact from this deficient practice. This deficient practice had the potential to affect residents residing in this facility. The wall-ceiling assembly and penetrations on the ground floor in the laundry room were properly fire stopped with material that is capable of limiting the transfer of smoke from hazardous areas. All combustible cardboard boxes were removed from the ground floor storage room that were blocking the door. The auto-closing mechanism on the door was tested once the boxes were removed and was found to be functioning properly. The Director of Maintenance provided education to the Maintenance Department staff on the importance of ensuring wall-ceiling assembly and penetrations are properly fire stopped with material that is capable of limiting the transfer of smoke from hazardous areas. The Director of Maintenance provided education to the Maintenance Department and Housekeeping staff on ensuring the ground floor storage room is maintained so the door can automatically close The Director of Maintenance/Designee will conduct monthly audits on all hazardous areas to ensure they are properly fire stopped. Any identified areas of concern will be corrected immediately. The Director of Maintenance/Designee will conduct monthly audits to ensure the	

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K 321	Continued From page 9 NJAC 8:39-31.2(e)	K 321	storage room on the ground floor is maintained so that the door can automatically close. The Director of Maintenance will present the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if additional oversight of this area is required.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations on 4/7/22 in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to provide automatic fire sprinkler system protection to all areas in accordance with NFPA 13. This deficient practice was evidenced	K 351	K351 SS E□ Sprinkler System - Installation No residents were identified to have had any negative impact from this deficient practice.	7/7/22

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K 351	Continued From page 10 in 5 of 50 observations by the following: 1. At 10:50 AM, the surveyor observed in the [redacted] floor solarium room that the outer area (approximately 2-foot wide x 50-foot long) of the exterior ceiling was not provided with any fire sprinkler coverage. The approximately 2-foot wide x 2-foot high section was observed to have angled glass panels that in the event of a fire would offer no fire sprinkler protection. 2. At 11:15 AM, the surveyor observed at the maintenance exit, that the exterior wooden overhang was more than 4-foot wide x approximately 15-foot long and not provided with any fire sprinkler coverage. 3. At 11:25 AM, the surveyor observed that the [redacted] stairwell was not provided with any fire sprinkler coverage. 4. At 1:10 PM, the surveyor observed in the central supply/maintenance director office that the closet approximately 5-foot x 4-foot containing wooden shelves was observed to not have any fire sprinkler coverage. 5. At 1:58 PM, the surveyor observed in hydraulic elevator #3 that the lower level pit area was (dirty with combustible paper and straw wrappers) and not provided with any fire sprinkler coverage. The Maintenance Director confirmed that the top of the elevator did not have any fire sprinkler coverage. An interview was conducted with the Maintenance Director during the observation's where he stated and confirmed that the above findings did not have any fire sprinkler coverage.	K 351	This deficient practice had the potential to affect residents residing in this facility. The elevator pit was cleaned by the Maintenance Department to ensure cleanliness and to remove all combustible materials. Automatic fire sprinklers were installed to all areas identified during survey including the [redacted] Floor Solarium, the exterior wooden overhang at the maintenance exit, the east lower-level stairwell, the central supply/Maintenance Director office, and hydraulic elevator #3. The Director of Maintenance provided education to the Maintenance Department staff on the importance of maintaining a clean elevator pit to ensure no combustible materials are present. Elevator pit cleaning will be done monthly by the Maintenance Department. The Director of Maintenance/Designee will conduct monthly elevator pit inspections to ensure cleanliness. Any untoward findings will be addressed immediately by the Maintenance Department. The Director of Maintenance/Designee will conduct monthly audits of the sprinkler system ensuring there is no dust and nothing blocking the sprinkler heads. A quarterly, semi-annual, and annual inspection is conducted by the facility fire sprinkler vendor to ensure the function and maintenance of the fire automatic fire sprinkler system. The Director of Maintenance will present the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if additional oversight of	

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(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 351	Continued From page 11 The Administrator was informed of the observation at the life safety code exit conference on 4/8/22. NJAC 8:39-31.2(e) NFPA 13, 25 NFPA 101- 2012 edition Life Safety Code 9.7.1 Automatic Sprinklers 9.7.1.1*(1)	K 351	this area is required.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 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	K 363		5/4/22

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	315010	A. BUILDING **01** B. WING _____	**04/08/2022**

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K 363	Continued From page 12 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. 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: Based on observation and interview on 4/7/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 2 of 50 resident room door's and was evidenced by the following: On 3/7/22, during the building tour from 9:00 AM to 3:30 PM, the surveyor, Maintenance and Regional Plant Operations Directors observed that the doors to resident rooms, did not latch into the door frame in the following room numbers: [redacted] - hardware malfunction. - chair blocking door from closing An interview was conducted with the Maintenance	K 363	K363 SS D —Corridor Doors CFR(s): NFPA 101 No residents were identified having negative impact from this deficient practice. This deficient practice had the potential to affect residents residing in room [redacted] and [redacted] (documented in error as #147 on the 2567). Corridor doors identified during survey as #241 and #247 were evaluated to ensure the doors latched into the door frames. A chair blocking door [redacted] was removed. The door to this room latched without any issues. The hardware to door [redacted] was realigned by Maintenance and was able to catch the latch appropriately. The Director of Maintenance/Designee conducted audits on all resident room doors to ensure that they were closing and latching to properly confine fire and smoke products and to properly defend occupants in place. No other areas of concern were identified.	

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K 363	Continued From page 13 Director, who stated and confirmed that the above findings were observed. The Administrator was informed of the finding at the Life Safety Code exit conference on 4/8/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	The Director of Maintenance/Designee provided education to facility staff on the importance of not blocking fire-rated doors with any items in the event of a fire/smoke emergency. The Director of Maintenance provided education to the Maintenance Department staff on the importance of ensuring that room doors will close and latch to properly confine fire and smoke products and to properly defend occupants in place in the event of an emergency. The Director of Maintenance/Designee will conduct monthly audits on the closing and latching of resident room doors to ensure that the corridor doors properly confine fire and smoke products and properly defend occupants in place per NFPA requirements. The Director of Maintenance will present the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if additional oversight of this area is required.	
K 372 SS=F	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.	K 372		5/4/22

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K 372	Continued From page 14 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: Based on observations on 4/7/2022, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for 1 of 2 sections of smoke barrier walls. This deficient practice was evidenced by the following: On 4/7/2022 at 10:28 AM, the surveyor, Maintenance Director and Regional Plant Operations Director observed on floor [redacted] at the old to new section bridge where the fire doors were located, when the Maintenance Director removed the ceiling tiles, it was observed that penetrations were observed on both sides through the smoke barrier walls approximately 6-inches above to the corrugated steel decking, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The findings were verified and confirmed by the Maintenance Director and Regional Plant Operations Director during the observations. The surveyor informed the Administrator of the finding's at the Life Safety Code exit conference on 4/8/2022. NFPA 101 2012 edition Life Safety Code 19.3.7.3, 8.6.7.1(1) NJAC 8:39-31.2(e)	K 372	K372 SS F □Subdivision of Building Spaces □ Smoke Barrier CFR(s): NFPA 101 No residents were identified as having negative impact from this deficient practice. This deficient practice had the potential to affect residents residing in this facility. Penetrations on both sides of the smoke barrier wall on floor [redacted] at the old to new section bridge where the fire doors are located were sealed closed to prevent smoke, fumes and fire from passing through to the other compartment. No other penetrations were noted upon further inspection by the Maintenance Department. The Director of Maintenance provided education to the Maintenance Department staff on the importance of maintaining the integrity of smoke barrier partitions. The Director of Maintenance/Designee will conduct monthly audits on smoke barrier partitions throughout the facility to ensure the integrity of the smoke barrier partition is maintained. Any untoward findings will be corrected immediately by the Maintenance Department. The Director of Maintenance will present the findings from monthly audits at the next quarterly QAA meeting for follow-up and to determine if additional oversight of this area is required.	

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K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 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: Based on observations on 4/7/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 2 of 6 smoke barrier doors and was evidenced by the following: At 10:32 AM, the surveyor, Maintenance Director and Regional Plant Operations Director observed the set of double smoke doors by resident room [redacted], that when fully closed the foam draft seal did not meet properly leaving a gap approximately 1/4 inch. 1 of 2 doors revealed that the bottom of the door was under cut approximately 1-1/2 inches. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a	K 374	K374 SS E □Subdivision of Building Spaces □ Smoke Barrier Doors CFR(s): NFPA 101 No residents were identified having any negative impact from this deficient practice. This deficient practice had the potential to affect residents residing in this facility. The smoke barrier doors identified during survey near resident room [redacted] have been replaced with metal doors. During further inspection of existing smoke barrier doors, it was determined that two other sets of doors would also be replaced to ensure the transfer of smoke, fire and poisonous gases do not pass from one smoke compartment to another in the event of a fire. The repairs have been completed.	7/7/22

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K 374	Continued From page 16 fire. The findings were verified and confirmed by the Maintenance Director and Regional Plant Operations Director during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code survey exit on 4/8/22. NFPA 101- 2012 edition Life Safety Code 19.3.7.6, 19.3.7.8, 19.3.7.9 NJAC 8:39-31.1(c), 31.2(e)	K 374	The Director of Maintenance educated the Maintenance Department staff on the importance of maintaining smoke barrier doors that will resist the transfer of smoke when completely closed for fire protection. The Director of Maintenance/Designee will conduct monthly audits on smoke barrier doors to ensure there are no gaps when closed that would permit the transfer of smoke, fire and poisonous gases to pass from one smoke compartment to another in the event of a fire. The Director of Maintenance will present the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if additional oversight of this area is required.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key	K 531		5/4/22

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K 531	Continued From page 17 operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 4/8/22, it was determined that the facility failed to ensure that elevators were inspected and tested monthly for 3 of 3 elevators, in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. The deficient practice could affect all residents and was evidenced by the following: At 12:50 PM, the surveyor and Maintenance Director observed no evidence that the Fire Fighters Emergency Operations Inspection and Test was performed and a written record of Phase I recall by use of the key switch, and a minimum of one floor operation, including findings documented monthly. Maintenance Director only recorded elevator #1 and elevator #2 on a monthly checklist. The finding was verified by the Maintenance Director at the time of the observations. The Administrator was informed of the finding at the Life Safety Code exit conference on 4/8/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531	K531 SS F Elevators CFR(s): NFPA 101 No residents were identified having any negative impact from this deficient practice. This deficient practice had the potential to affect all residents residing in this facility. All three facility elevators have been inspected. The Fire Fighters Emergency Operations Inspection and Test was performed and a written record of Phase I recall by use of the key switch and a minimum of one floor operation was documented for elevators #1 and #2. Elevator #3 does not have the Fire Fighters Emergency Operations capability. The Director of Maintenance provided education to the Maintenance Department staff that the Fire Fighters Emergency Operations Inspection and Test must be performed monthly and include manual operation, key switch and bell, phone and whether it was a pass or fail. The Director of Maintenance updated the log for the Fire Fighters Service Monthly Test Log to include the elevator number, date, key switch, bell, phone and whether it was a pass or fail. The Director of Maintenance/Designee will continue to conduct monthly inspections and tests for the Fire Fighters Emergency Operations Inspection and	

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K 531	Continued From page 18	K 531	Test utilizing the updated Fire Fighters Service □ Monthly Test Log. Any untoward findings will be reported to the facility elevator vendor for immediate attention to rectify the situation. The Director of Maintenance will present the findings from the monthly inspections and tests at the next quarterly QAA meeting for follow-up and to determine if additional oversight of this area is required.	
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	K 918		6/14/22

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K 918	Continued From page 19 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: Based on observation and interview on 4/8/22, the facility did not ensure a remote manual stop station for 1 of 1 generators. that was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: On 4/8/22, the surveyor, Maintenance and Regional Plant Operations Director observed that the 350 KW diesel generator was outside and encased. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. An interview was conducted during the observation with the Maintenance and Regional Plant Operations Directors, where they stated that at the time of observation, the area was observed not to have a remote manual stop station. The Administrator was informed of the finding at the Life Safety Code exit conference on 4/8/22. 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	K918 SS F □Electrical Systems □ Essential Electric System CFR(s): NFPA 101 No residents were identified having any negative impact from this deficient practice. This deficient practice had the potential to affect all residents residing in this facility. A remote manual stop station for the generator was installed on the outside patio to prevent inadvertent or unintentional operations of the 350 KW diesel generator which is located outside and encased. The Director of Maintenance provided education to the Maintenance Department staff and facility administration on how and when to utilize the remote manual stop in the event of an inadvertent or unintentional operation of the 350KW diesel generator. Maintenance will test semi-annually. The Director of Maintenance will present the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if additional oversight of	

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K 918	Continued From page 20	K 918	this area is required.	