STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING **01** B. WING _____	**10/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE** **TRENTON, NJ 08638**

(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 10/06, 07/2022 and Avant Rehabilitation and Care 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. Avant Rehabilitation and Care Center s a three story, Type I Fire Resistant building that was built in January 1998. The facility is divided into 7 smoke zones.	K 000		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations on 10/06/2022 in the presence of facility Management it was determined that the facility failed to ensure that 1 of [redacted] exit access stairwell doors tested were	K 311	1. Corrective Action: Fire rated exit access door next to room [redacted], it was immediately fixed on [redacted]. Audit was completed of fire rated exit	12/5/22

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

Electronically Signed | 11/11/2022

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K 311	Continued From page 1 capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 10/06/2022 starting at 9:42 AM, a tour of the building in the presence of the Maintenance Director (MD) was performed. Along the tour the surveyor performed a closure test of the six (6) 1-1/2 hour fire rated exit access doors leading into the stairwells. At 10:20 AM, during a closure test of one (1) fire rated exit access door next to Resident room [redacted] when the door was opened to a 90 degree opening to the doors frame and allowed to self-close the door did not positive latch into their frame as required by code to maintain the fire rated construction. This test was repeated two additional times with the same results. The stairwell door would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The MD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311	access doors to assure that they positively latched. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Monthly audits will be completed by the maintenance director and/or designee to assure that fire rated exit access doors positively latch. 4. How Will These Actions Be Measured: The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101	K 351		12/5/22

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K 351	Continued From page 2 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 observation and review of facility provided documentation on 10/06/2022 , it was determined that the facility failed to properly install sprinklers as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 10/06/2022 during the survey entrance at 09:13 AM, a request was made to the	K 351	1. Corrective Action: Escheon caps were installed on the sprinkler heads located on the [redacted] floor [redacted] Unit oxygen storage room, [redacted] floor clean utility room and third floor clean utility room on 10/7/22. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Audit was completed of sprinkler heads escheon caps to assure sprinkler heads proper placement of escheon caps. Monthly audits will be completed by the maintenance director and/or designee to assure that sprinkler heads have proper	

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K 351	Continued From page 3 Maintenance Director (MD) 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 layout identified there were three (3) floors in the facility. Starting at 9:40 AM, in the presence of the facility MD a tour of the facility was conducted. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1) At 9:52 AM, the surveyor observed inside the [redacted] floor [redacted] Unit [redacted] storage room one fire sprinkler head. This fire sprinkler had no evidence of an escheon cap leaving a 1/2 of an inch gap around the sprinkler head. 2) At 10:00 AM, the surveyor observed inside the [redacted] floor Clean Utility room one sprinkler head had no evidence of an escheon cap leaving a 1/2 of an inch gap around the sprinkler head. 3) At 12:38 PM, the surveyor observed inside the [redacted] floor Clean Utility room one sprinkler head had no evidence of an escheon cap leaving a 1/2 of gap around the sprinkler head. With the opening's in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the room and not activate the fire sprinkler system. The MD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on	K 351	placement of escheon caps. 4. How Will These Actions Be Measured: Results of monthly audit will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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K 351	Continued From page 4 10/07/2022 at approximately 12:50 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=D	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 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 10/06/2022 in the presence of facility management, it was determined that the facility failed to: 1) Perform and document on the tag attached to the fire extinguisher a monthly visual examination for 1 of 16 fire extinguishers, 2) Install portable fire extinguishers with-in the required height for 1 of 16 fire extinguishers 3) Maintain one (1) portable fire extinguishers in proper working condition, in accordance with the requirements of 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, - 7.3 Maintenance. - 7.3.1.1 All 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	K 355	1. Corrective Action: On 10/7/22, the fire extinguisher located near the exit doors leading to the outside resident s[redacted] area was mounted to the proper height and visual inspection completed and documented on the tag attached to the extinguisher. On 10/7/22 fire extinguisher was replaced next to the resident room [redacted]. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Audit was completed of Fire extinguishers and their attached tags to ensure compliance. Monthly audits will be completed by the maintenance director and/or designee to assure that Fire extinguishers and their attached tags to ensure compliance.	12/5/22

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K 355	Continued From page 5 specifically indicated by an inspection or electronic notification. According to NFPA 10- 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. Reference #2 NFPA 10 - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. During the building tour on 10/06/2022 in the presence of the facility Maintenance Director (MD) the surveyor observed and inspected sixteen (16) portable fire extinguishers in various locations with the following, 1) At 12:18 PM, the surveyor observed one "ABC- type" fire extinguisher near the exit doors leading to the outside Resident smoking area that appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the to the center of the pressure indicating needle of the extinguisher 5 feet 8 inches. The surveyor also observed that the fire extinguisher was last annually inspected June 2022 with no evidence of a monthly visual inspection being performed and documented on the tag attached to the extinguisher for July 2022,	K 355	4. How Will These Actions Be Measured: Results of monthly audit will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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K 355	Continued From page 6 August 2022 and September 2022. 2) At 12:27 PM, One "ABC- type" fire extinguisher next to Resident room #115 pressure indicating needle was in the "RED" discharge zone on the gauge. The surveyor also observed on the tag attached to the extinguisher had a monthly visual examination documented for 10/01/2022. The MD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 374 SS=F	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:	K 374		12/5/22

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K 374	Continued From page 7 Based on observations and review of facility provided documentation on 10/06/2022, 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 3 of 7 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 10/06/2022 during the survey entrance at 09:13 AM, a request was made to the Maintenance Director (MD) 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 that there are two (2) sets of corridor double smoke doors on the [redacted] floor, are two (2) sets of corridor double smoke doors on the [redacted]. floor and three (3) corridor smoke doors on the [redacted] floor. Starting at 9:40 AM, in the presence of the facility MD a tour of the facility was conducted. The surveyor performed closure tests of the seven (7) sets of smoke barrier doors in the corridors with the following results, 1) At 9:54 AM, one set of double smoke doors between the [redacted] floor [redacted] room and Resident room [redacted] when both doors were release from	K 374	1. Corrective Action: On 10/7/22 the double smoke doors located between the [redacted]-floor day room and resident room #[redacted] resident room [redacted], Resident room [redacted] were fixed to assure that the smoke barrier doors close leaving only the minimum clearance necessary for proper operation. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put Into Place: Audit was completed of smoke barrier doors to assure all close to resist the transfer of smoke. Monthly audits will be completed by the maintenance director and/or designee to assure that smoke barrier doors close to resist the transfer of smoke. 4. How Will These Actions Be Measured: Results of monthly audit will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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K 374	Continued From page 8 their magnetic hold open devices and allowed to self close into their frame, this revealed one door did not close into its frame, it was not resistant to the transfer of smoke. The surveyor observed an approximately 34 inch opening between the two doors. This test was repeated two additional times with the same results. 2) At 11:07 AM, one set of double smoke doors next to Resident room when [redacted] when both doors were release from their magnetic hold open devices and allowed to self close into their frame, this revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 1/2 of an inch between the meeting edges. The surveyor measure and recorded a 1/2 of an inch gap between the meeting edges. This test was repeated two additional times with the same results. 3) At 12:25 PM, one set of double smoke doors next to Resident room when [redacted] when both doors were release from their magnetic hold open devices and allowed to self close into their frame, this revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 3/8 of an inch between the meeting edges. The surveyor measure and recorded a 3/8 of an inch gap between the meeting edges near the bottom of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The MD confirmed the findings at the time of	K 374		

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K 374	Continued From page 9 observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 PM. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 531 SS=E	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 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 observations and interview on 10/06, 07/2021, in the presence of facility management it was determined that the facility failed to maintain elevator emergency communications for 2 of 3 elevators tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the	K 531	1. Corrective Action: Upon identification that elevator #1 and #2 emergency telephones were not working properly, the elevator company was immediately called and repaired both telephones. 2. Identification of other residents or	12/5/22

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K 531	Continued From page 10 following: During the survey entrance at 9:13 AM, a request was made to the Maintenance Director (MD), how many elevators are in the building. The MD told the surveyor that there are three (3) elevators. On 10/06/2022 starting at 9:40 AM, during a tour of the building in the presence of the facility Administrator and MD at 9:42 AM a test of elevator #1 emergency telephone was performed. When the surveyor tested the emergency phone it did not function properly. On 10/07/2022 during a tour of the building with the Corporate Regional Maintenance (CRM) at 11:57 AM a test of elevator #1 emergency telephone was performed. When the surveyor tested the phone it did not function properly. At 12:12 PM a test of elevator #2 emergency telephone was performed. When the surveyor tested the phone it did not function properly. An interview was conducted during the two observations with the CRM. He acknowledged and confirmed that the emergency communication telephones in elevators #1 and #2 did not function. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Monthly audits will be completed by the maintenance director and/or designee to assure that Emergency telephones in elevators #1, #2 and #3 work properly. 4. How Will These Actions Be Measured: Results of monthly audit will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		12/5/22

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AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE** **TRENTON, NJ 08638**

(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 918	Continued From page 11 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: Based on observation and interview on 10/06/2022 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for	K 918	K918 SS=E Electrical Systems □ Essential Electric Systems 1. Corrective Action:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING **01** B. WING _____	**10/12/2022**

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K 918	Continued From page 12 1 of 1 emergency generator 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 could affect all residents and was evidenced by the following: On 10/06/2022 during the survey entrance at 09:13 AM, a request was made to the Maintenance Director (MD) if the facility had an emergency generator. The MD said, yes we have one. During the building tour with the facility MD at 12:38 PM an inspection of the emergency generator was performed. At this time the surveyor asked the MD, where is the remote emergency shut off for the generator. The MD told the surveyor, There is no remote emergency shut off. The surveyor observed that the emergency shut off was located on the generator's control panel. The MD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 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	Upon identification that the Emergency Generator System was not equipped with a remote manual stop station, 2 quotes were obtained to purchase and installed on 11/10/22. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Education will be provided to management/supervisors on the generator emergency stop procedure upon installation of the stop button on 11/10/22. Education completed on 11/11/22. 4. How Will These Actions Be Measured: Monthly audit in conjunction with monthly generator checks will be completed to assure integrity of Emergency Generator System will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Safety and Quality Assurance and Process Improvement Committee monthly Meeting for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued	

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K 918	Continued From page 13	K 918	submission and reporting.	