STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01** B. WING _____	**08/29/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	**1417 BRACE ROAD** **CHERRY HILL, NJ 08034**

(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 8/24/22, 08/25/22, and 08/29/2022, and Silver Healthcare 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 Occupancy Silver Healthcare Center is a two-story building that was built in the 1980's. It is composed of Type V protected. The facility is divided into 19 smoke zones.	K 000		
K 132 SS=E	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by:	K 132		11/25/22

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

Electronically Signed | 09/22/2022

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 132	Continued From page 1 Based on observation and interview on 08/24/22 and 08/25/22, the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.3.4. between the dialysis unit and the nursing facility. This deficient practice could affect all residents and was evidenced by the following: During the survey entrance on 08/24/22 at 8:50 AM, a request was made to the Interim Maintenance Director (IMD) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified there were three (3) buildings that were connected together, the Atrium, the Pavilion, and the Court buildings. The IMD further told the surveyor that there was a Dialysis Unit in the building. On 08/24/22 and 08/25/22, a tour of the building with the Corporate Vice President of Environmental Services (CVPES) and IMD was performed. Along the tour the surveyor observed the following: 1. On 08/25/22 at approximately 10:47 AM, the Surveyor, CVPES and IMD observed that the first floor dialysis unit and nursing facility fire door revealed the door had no 1-1/2 hour fire rating label. 2. On 08/25/22 at approximately 11:44 AM, the surveyor, CVPES and IMD observed that the second floor dialysis unit and nursing facility fire door revealed the door had no means to latch into its frame and no 1-1/2 hour fire rating label. The CVPES and IMD confirmed the findings at	K 132	1. Regarding inspection of fire door on first floor connecting to the dialysis center which revealed the door had no 1-1/2 hour fire rating label, and the second floor dialysis unit and nursing facility fire door revealed the door had no means to latch into its frame and no 1-1/2 hour fire rating label, maintenance reached out to vendor for repair, vendor came and installed new doors that latch properly and have 1-1/2 hour fire rating label. 2. All residents have the potential to be affected by this deficient practice. 3. All other doors were confirmed to be in compliance and checked by maintenance. 4. Weekly audits of all fire doors will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all fire doors are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	

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K 132	Continued From page 2 the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.1.3.4.	K 132		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 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: Based on interview and review of other facility documentation on 08/25/22, in the presence of the Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), it was determined that the facility failed to inspect the fire doors annually in accordance with S&C 17-38-LSC for 15 of 15 fire doors observed. This deficient practice was evidenced by the following: From approximately 10:00 AM to 2:00 PM, the surveyor reviewed all provided documentation from the IMD and CVPES. The annual fire door inspection documentation was not provided for	K 211	1. Regarding the facility□s failure to inspect the fire doors annually for 15 of 15 fire doors observed, fire door inspections were initiated by maintenance. 2. All residents have the potential to be affected by this deficient practice. 3. All fire doors were inspected. 4. Weekly audits of all fire doors will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all fire doors are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	10/3/22

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K 211	Continued From page 3 the facility's fire door assemblies. An interview was conducted with the CVPES during the document review. He stated that currently no further documentation could be provided on fire door inspections (Annual) for the last 12-months, as identified in the S&C 17-38-LSC documentation. The Administrator was informed of the finding's at the Life Safety Code exit conference on 08/29/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 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	K 222		11/25/22

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K 222	Continued From page 4 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 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	K 222		

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K 222	Continued From page 5 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: Based on observation and review of other facility documentation on 08/24/22, in the presence of facility management, it was determined that the facility failed to maintain exit discharge doors in proper working condition. The evidence includes the following: During the survey entrance at 8:50 AM, a request was made to the Interim Maintenance Director (IMD) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified there were three (3) buildings that were connected together, the Atrium, the Pavilion, and the Court buildings. On 08/24/22, starting at 9:43 AM, a tour of the building with the Corporate Vice President of Environmental Services (CVPES) and IMD was performed. At 10:02 AM, during an inspection in the Pavilion building, the surveyor observed in the sunroom located next to resident room 421 that the push bar on the exit discharge door was broken. This door did have a magnetic hold closed device that would release upon activation of the fire alarm system. A review of an emergency evacuation diagram posted in the area identified this door as the primary exit discharge door. The CVPES and IMD confirmed the findings at the time of observations.	K 222	1. Regarding the facility□s failure to maintain exit discharge doors in proper working condition, maintenance immediately inspected the door which the push bar was broken. Parts have been ordered and will be installed upon receipt.Vendor came and installed new push bar and it is in good working order. 2. All residents have the potential to be affected by this deficient practice. 3. All exit discharge doors were inspected and found to be in compliance. 4. Weekly audits of all exit discharge doors will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all exit discharge doors are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	

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K 222	Continued From page 6 The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22. NJAC 8:39 -31.2 (e). NFPA 101 2012 7.2.1.6.1 (4).	K 222		
K 227 SS=E	Ramps and Other Exits CFR(s): NFPA 101 Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/25/22, in the presence of the Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), it was determined that the facility failed to comply with the requirements of NFPA 101:2012 sect. 7.2.5 pertaining to exit ramps. This deficient practice was identified for 1 of 1 exit/egress ramps and as evidenced by the following: At 1:18 PM, the surveyor observed that the exterior ramp outside of unoccupied resident rooms 326 and 327 were missing approximately five foot of guard railing on the right-side of the ramp decline leading to the public way.	K 227	1. Regarding the facility□s failure to comply with the requirements of NFPA 101:2012 sect. 7.2.5 pertaining to exit ramps, maintenance immediately inspected the railing. 2. All residents have the potential to be affected by this deficient practice. 3. All exit ramps were inspected and found to be in compliance. Maintenance immediately repaired the railing. 4. Weekly audits of all exit ramps will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all exit ramps are in compliance. Findings will be brought to the QAPI committee	10/22/22

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K 227	Continued From page 7 The IMD and CVPES confirmed the missing guard rail during the observations. The Administrator was informed of the finding's at the Life Safety Code exit conference on 08/29/22. 19.2.2.6 RAMPS: 7.2.5.3.2 -landings #(3) every landing shall have a width not less than the width of the ramp 19.2.3 Capacity of Means of Egress 19.2.3.4* 7.2.5.3 Ramp Details: 7.2.5.3.2 Landings (1) through (7) 7.2.5.3.3 Drop-Offs NJAC 8:39-31.1(c)	K 227	monthly for 3 months.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of other facility documentation on 08/24/22, in the presence of facility management, it was determined that the facility failed to ensure that an illuminated exit sign was in one (1) location to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following:	K 293	1. Regarding the facility□s failure to ensure that an illuminated exit sign was in one location to clearly identify the exit access path to reach an exit discharge door, maintenance immediately inspected the exit sign in question to determine repair needed. New illuminated exit sign was immediately installed. 2. All residents have the potential to be	10/22/22

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K 293	Continued From page 8 Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 During the survey entrance on 08/24/22 at 8:50 AM, a request was made to the Interim Maintenance Director (IMD) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there was one enclosed center court yard located in the Atrium building. During a tour of the building with the Corporate Vice President of Environmental Services (CVPES) and IMD at 12:11 PM an inspection of the outside enclosed center courtyard in the Atrium building was conducted. The surveyor observed no evidence of an illuminated exit sign above one (1) exit access door that leads you out of the enclosed center courtyard. This was a primary and/or secondary exit access route to reach an exit. The CVPES and IMD confirmed the findings at the time of observation. The Administrator was notified of the deficiency	K 293	affected by this deficient practice. 3. All illuminated exit signs were inspected and found to be in compliance. 4. Weekly audits of all illuminated exit signs will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all illuminated exit signs are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	

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K 293	Continued From page 9 at the Life Safety Code exit conference on 08/29/22.	K 293		
	Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101			
K 321 SS=E	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	K 321		10/26/22

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K 321	Continued From page 10 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of other facility documentation on 08/25/22, in the presence of the Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions 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, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 9 of 9, hazardous storage rooms and was evidenced by the following: During the survey entrance at 8:50 AM, a request was made to the IMD to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified there were three (3) buildings that are connected together, the Atrium, the Pavilion and the Court buildings. Later during the building tour, in the presence of the CVPES and IMD, the following hazardous areas were observed and utilized as hazardous storage areas that were not smoke resistant: 1) Unoccupied resident rooms: 127, 317, 335, 336, 337, 340, 342, and 344. 2) Court One, B Wing, shower room. 3) At 10:02 AM, during a closure test of the Central Supply room, 1-1/2 hour fire rated	K 321	1. Regarding the facility's failure to ensure that fire rated doors to hazardous areas (in unoccupied resident rooms 127, 317, 335, 336, 337, 340, 342, and 344, and Court One, B Wing, shower room, and Central Supply room) were self-closing, labeled, and were separated by smoke resistant partitions in accordance with NFPA guidelines. Maintenance immediately checked all doors to check what was needed to have all doors in compliance. 2. All residents have the potential to be affected by this deficient practice. 3. All doors needing doors closers were inspected and parts were ordered. Door closers have been installed in resident rooms 317, 335, 336, 337, 340, 342, and 344, and Court One, B Wing, shower room, and Central Supply room. Storage was removed from room 127. 4. Weekly audits of all doors needing closers will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all door closers are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	

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K 321	Continued From page 11 corridor door, was performed. The door did not self close and positive latch into its frame as required. The surveyor recorded the room was 44 feet by 20 feet (880 square feet), which is larger than 50 square feet. The room housed multiple combustible cardboard boxes. The IMD and CVPES confirmed the finding's during the observations. The Administrator was informed of the finding's at the Life Safety exit conference on 08/29/22. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 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.	K 324		10/22/22

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	315280	A. BUILDING **01** B. WING _____	**08/29/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	**1417 BRACE ROAD** **CHERRY HILL, NJ 08034**

(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 324	Continued From page 12 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: Based on observation and interview on 08/25/22, in the presence of the Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), it was determined that the facility failed to ensure that cooking equipment was protected in accordance with NFPA (National Fire Protection Association) 96. This deficient practice was evidenced for 1 of 1 working electric stoves and was evidenced by the following: At 12:20 PM, the surveyor observed in the activity center, across from unoccupied resident room 328, that an approximately one inch stack of white paper was being stored on the left-back heating element of the working electric stove. An interview was conducted with the IMD at the time of the observation, and he stated that nothing combustible should be stored on the stovetop at any time. The Administrator was informed of the observation at the Life Safety Code exit conference on 08/29/22. NFPA 96 NJAC 8:39-31.2(e) NFPA 101-2012 : 19.3.2.5	K 324	1.Regarding the facility's failure to ensure that cooking equipment was protected in accordance with NFPA 96, paper was immediately removed from the top of the heating element. 2.All residents have the potential to be affected by this deficient practice. 3.All heating elements were inspected to ensure that nothing combustible was stored on top of the element and found to be in compliance. Activities staff in-serviced on not placing any non-cooking equipment on a heating element. 4.Weekly audits of all heating elements will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all cooking equipment is in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	
K 341 SS=E	Fire Alarm System - Installation	K 341		10/22/22

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	315280	A. BUILDING **01** B. WING _____	**08/29/2022**

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K 341	Continued From page 13 CFR(s): NFPA 101 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: Based on observation and interview on 08/25/22, in the presence of facility management, it was determined that the facility failed to install supervised smoke/heat detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. This deficient practice was observed in 1 of 1 areas and was evidenced by the following: During the tour of the building, in the presence of the Corporate Vice President of Environmental Services (CVPES) and Interim Maintenance Director (IMD), the surveyor observed that the facility failed to provide supervised smoke/heat detection in the following location:	K 341	1. Regarding the facility's failure to install supervised smoke/heat detection in accordance with NFPA 101. Vendor installed a smoke/heat detector within 20 feet of the stove as required by code. 2. All residents have the potential to be affected by this deficient practice. 3. All areas in need of a smoke detector according to NFPA guidelines were found to be in compliance. 4. Weekly audits of all areas in need of smoke detectors will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all areas in need of smoke detectors have a smoke detector in place and are in compliance. Findings	

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K 341	Continued From page 14 1. At 10:13 AM, an inspection inside the main kitchen was performed. The surveyor observed no evidence of a smoke/heat detector within 20 feet of the stove as required by code. The CVPES and IMD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22. Fire Safety Hazard. NJAC 8:39 -31.2 (a).	K 341	will be brought to the QAPI committee monthly for 3 months.	
K 351 SS=F	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:	K 351		10/22/22

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K 351	Continued From page 15 Based on observation, interview, and review of other facility documentation on 08/24/22 and 08/25/22, it was determined that the facility failed to a.) provide proper fire sprinkler coverage to all areas of the facility, and b.) 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, Reference #2: Uniform Construction Code, Special detailed requirements based on use and occupancy section 407 group I-2, [F] 407.5 Automatic sprinkler system. Smoke compartments containing patient sleeping units shall be equipped throughout with an automatic fire sprinkler system in accordance with Section 903.3.1.1. The smoke compartment shall be equipped with approved quick-response or residential sprinklers in accordance with section 903.3.2. During the survey entrance on 08/24/22 at 8:50 AM, a request was made to the Interim Maintenance Director (IMD) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified there were three (3) buildings that were connected together, the Atrium, the Pavilion and the Court buildings. The IMD also told the surveyor that there was a	K 351	1. Regarding the facility□s failure to provide proper fire sprinkler coverage to all areas of the facility, and properly install sprinklers as required by CMS regulations and in accordance with the requirements of NFPA 101. Maintenance immediately replaced the escutcheon caps missing in Pavilion building sunroom next to rooms 421, and 416, in the Pavilion building main Dining/Activity room high ceiling escutcheon caps missing from two fire sprinkler heads, vendor contacted to repair. Maintenance also replaced missing escutcheon caps in resident rooms 308 closet, and 328 closet. Maintenance replaced the escutcheon cap in the Pantry area. Maintenance immediately removed the tape on all sprinkler heads in rooms on Court One, B Wing. Maintenance replaced missing escutcheon cap in resident room 239. Maintenance also replaced missing escutcheon cap in the Kitchen's dry storage room. Vendor was called to add fire sprinkler protection inside the HVAC closet in the kitchen. 2. All residents have the potential to be affected by this deficient practice. 3. All missing escutcheon caps were replaced, repair of hanging pipe will be scheduled with the vendor, and vendor was scheduled to add sprinkler coverage in the kitchen HVAC closet to be in compliance. 4. Weekly audits of all sprinkler heads will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all areas in need of sprinkler heads have them in place and are in compliance.	

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K 351	Continued From page 16 Dialysis Unit in the building. On 08/24/22 and 08/25/22 a tour of the building with the Corporate Vice President of Environmental Services (CVPES) and IMD was performed. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: On 8/24/22, 1) At 10:02 AM, in the Pavilion building sunroom (next to resident room #421) one fire sprinkler head had no escutcheon cap leaving a 1/4 of an inch gap in the ceiling tile. 2) At 10:05 AM, in the Pavilion building sunroom (next to Resident room #416) one fire sprinkler head had no escutcheon cap leaving a 3/8 of an inch gap in the ceiling tile. 3) At 10:06 AM, in the Pavilion building main Dining/Activity room high ceiling had two (2) fire sprinkler heads missing escutcheon caps leaving gaps in the ceiling tiles and one (1) fire sprinkler head hanging down three inches, leaving a 1/2 inch gap between the escutcheon cap and ceiling tile. 4) At 11:38 AM, resident room #308's closet had one (1) fire sprinkler head with no escutcheon cap leaving a 1/4 of an inch gap in the wall board ceiling. 5) At 12:27 PM, resident room #328's closet had one (1) fire sprinkler head with no escutcheon cap leaving a 3/4 of an inch gap in the wall board ceiling. 6) At 12:58 PM, the Pantry area fire sprinkler	K 351	Findings will be brought to the QAPI committee monthly for 3 months.	

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K 351	Continued From page 17 head had no escutcheon cap leaving a gap in the ceiling tile. On 8/25/22, 7) An inspection of Court One, B Wing, revealed 19 of 21 resident rooms had two (2) fire sprinkler heads in each room that had masking tape covering the frangible glass of the sprinkler heads. These sprinklers would not function properly in the event of a fire. 8) At 12:09 PM, inside resident room #239, the fire sprinkler head had no escutcheon cap leaving a 3/8 of an inch gap in the wallboard ceiling. 9) At 10:32 AM, inside the Kitchen's dry storage room, one (1) fire sprinkler head had no escutcheon cap leaving a 1/2 inch gap in the wallboard ceiling. 10) At 10:25 AM, inside the main Kitchen, the surveyor observed no evidence of a fire sprinkler protection inside the 27 inch deep by seven (7) feet long Heating, Ventilation and Air Conditioning closet. At this time, the surveyor asked the CVPES, do you see a fire sprinkler in the closet. The CVPES looked inside and said, "No." The CVPES and IMD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22. Fire Safety Hazard.	K 351		

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K 351	Continued From page 18 NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and review of other facility documentation on 08/24/22 and 08/25/22, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for 2 of 14 smoke barrier walls as evidenced by the following: During the survey entrance on 08/24/22 at 8:50 AM, a request was made to the Interim Maintenance Director (IMD) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified that there were 19 smoke zones in the facility. During a tour of the building on 08/24/22 and 08/25/22, in the presence of the Corporate Vice	K 372	1. Regarding the facility□s failure to maintain the integrity of smoke barrier partitions for 2 of 14 smoke barrier walls. The penetrations on Court One and Atrium area were sealed. 2. All residents have the potential to be affected by this deficient practice. 3. All smoke barrier walls were checked for penetrations to determine if any other areas were affected. 4. Weekly audits of smoke barriers will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all areas in need of smoke barriers have them in place and are in compliance. Findings will be brought to the QAPI	10/22/22

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K 372	Continued From page 19 President of Environmental Services (CVPES) and IMD, an inspection above the corridor ceiling tiles of 14 fire/smoke barrier walls was performed. The surveyor observed the following smoke barrier walls failed to maintain the 1/2 hour fire-rated construction as required by code in the following locations: 1. On 8/24/22 at 11:52 AM, during an inspection in the Atrium building (next to the nurses station where the generator C annunciator panel is located) the surveyor observed, above the ceiling tiles of the corridor double smoke doors, one 1-1/2 inch by 1-1/2 inch hole with two black wires running through the smoke barrier wall. 2. On 8/25/22 at 12:36 PM, an inspection of Court One, B Wing, identified above the corridor smoke doors, the surveyor observed one (1) approximately eight inch, one (1) approximately two inch, one (1) approximately three inch, and one (1) approximately six inch by approximately one inch penetrations with various BX cables and plastic coated wires running through the smoke barrier walls. These penetrations were observed on both sides through the smoke barrier walls, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The CVPES and IMD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22.	K 372	committee monthly for 3 months.	

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K 372	Continued From page 20 Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		
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 observation and review of other facility documentation on 08/24/22 and 08/25/22, in the presence of facility management, 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 14 sets of corridor double 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	K 374	1. Regarding the facility□s failure to maintain smoke barrier doors to resist the transfer of smoke. Maintenance adjusted the doors on Court 1 to ensure that there is no gap between the smoke doors. Vendor contacted to repair smoke doors on Court 2 to ensure that there is no gap between smoke doors. Vendor came out and repaired all smoke doors on court 2 to ensure that there is no gap between smoke doors. 2. All residents have the potential to be affected by this deficient practice. 3. All smoke barrier doors were checked for proper closing to determine if any other areas were affected.	11/17/22

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K 374	Continued From page 21 of an inch. During the survey entrance on 08/23/22 at 8:50 AM, a request was made to the Interim Maintenance Director (IMD) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified there were three (3) buildings that were connected together, the Atrium, the Pavilion and the Court buildings. The IMD also told the surveyor that there was a Dialysis Unit in the building. The facility had fourteen (14) sets of corridor double smoke barrier doors in the three buildings. Later, in the presence of the facility's Corporate Vice President of Environmental Services (CVPES) and IMD, a tour of the facility was performed. The surveyor performed closure tests of the fourteen (14) sets of double smoke barrier doors in the corridors with the following results: 1) On 8/25/22 at 10:58 AM, one set of double smoke doors on the second floor Court One, B Wing, when both doors were release from 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 a gap greater than 1/8 of an inch between the meeting edges. The surveyor measured and recorded a nine (9) inch gap between the meeting edges. This test was repeated two additional times with the same results. 2) On 8/25/22 at 11:35 AM, one set of double smoke doors next to resident room #223, when both doors were released from their magnetic hold-open devices and allowed to self close into	K 374	4. Weekly audits of smoke barrier doors will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all areas in need of smoke barrier doors have them in place and are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	

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K 374	Continued From page 22 their frame, this revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 1/8 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 CVPES and IMD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/2022.	K 374		
K 511 SS=E	N.J.A.C. 8:39-31.1(c), 31.2(e) Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced	K 511		10/28/22

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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 511	Continued From page 23 by: Based on observation and interview conducted on 08/25/22, in the presence of the Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), it was determined that the facility failed to install and maintain gas piping that complied with NFPA 54, National Electric Code. This deficient practice was evidenced for 1 of 1 observed gas line installations and was evidenced by the following: At approximately 10:39 AM, the surveyor observed in the facility laundry wing, that approximately 50' of exposed yellow flexline gas pipe, Corrugated Stainless Steel Tubing (CSST), was installed from the four (4) commercial dryers to the upper ceiling area through the supply/break room. The CSST was then installed to the floor above and was observed to not have the required sleeve for installation from one floor to another floor and was installed through the concrete floor unprotected. The IMD and CVPES confirmed the findings during the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 08/29/22. NJAC 8:39-31.2(e) NFPA 70	K 511	1. Regarding the facility's failure to install and maintain gas piping that complied with NFPA 54, National Electric Code. Maintenance staff installed Corrugated Stainless-Steel Tubing as required for the exposed flex line gas pipe in the laundry room area. 2. All residents have the potential to be affected by this deficient practice. 3. All other gas lines were checked to determine that they were in compliance and had the proper tubing. 4. Weekly audits of gas lines will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all gas lines have proper tubing on them and are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING	K 531		12/23/22

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	315280	A. BUILDING **01** B. WING _____	**08/29/2022**

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K 531	Continued From page 24 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 interview and review of other facility documentation on 08/25/22, in the presence of Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), it was determined that the facility failed to test and inspect the elevator annually with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division. This deficient practice was evidenced by the following: A review of the facility's elevator inspection certificate, revealed that 2 of 2 hydraulic elevator devices were marked: Certificate Occupancy/Compliance for both devices #1 and #2. The annual inspection date of 12/31/20 was good until 12/31/21 and the current date of 08/29/22 indicated that the annual	K 531	1. Regarding the facility□s failure to complete annual elevator inspection. The facility contacted the elevator vendor to schedule repairs and inspection. Elevator technician arrived onsite 10/28/22 to address the violations to allow the inspection to be scheduled. Inspector arrived on and Completed inspection on 11/21/22 and elevator passed inspection. Certificates were issued with a date of 12/23/22. 2. All residents have the potential to be affected by this deficient practice. 3. All elevators were checked and were in proper working condition at the time, repairs are in progress and inspections will be scheduled once repairs have been completed on the elevator in question. 4. Weekly audits of elevator inspection	

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K 531	Continued From page 25 inspection date was almost eight months past due. During an interview, at 11:30 AM, the CVPES stated he will communicate with their contracted elevator vendor and Department of Community Affairs to schedule an inspection as soon as possible. The Administrator was informed of this issue at the Life Safety Code exit conference on 08/29/22. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 9.4.6 Elevator Testing 9.4.6.3 (2)	K 531	records will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all elevators are up to date on inspections and are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation on 08/25/22, in the presence of the Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), it was	K 712	1. Regarding the fire alarm system failure to activate throughout the entire facility to indicate the transmission of a fire alarm signal. The facility immediately contacted the fire alarm vendor to troubleshoot the	9/9/22

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K 712	Continued From page 26 determined that the facility fire alarm vendor, failed to indicate that the transmission of a fire alarm signal was not activated throughout the facility in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. The deficient practice could affect all residents and was evidenced by the following: On 08/25/22, the surveyor reviewed the facility fire drill monthly reports which revealed that in the Atrium, Courts One and Two and the Pavilion, that the transmission of the fire alarm was checked off on the fire alarm vendor document "throughout the facility." The system was tested by the CVPES and it was confirmed that the facility had three separate fire alarm panels and they currently do not communicate with each other. This was confirmed with a system activation performed by the CVPES. The systems and locations are as follows: 1. Honeywell panel- location Court Kitchen 2. Hochiki panel- location Boiler room 3. Simplex panel- location Boiler room The findings were verified by the IMD and CVPES at the times of the observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712	issue. The facility initiated fire watch immediately until the repairs could be made to connect all fire alarm panels. The fire alarm panels were connected by the vendor and confirmed to be communicating properly between the 3 panels by activating the fire alarm in all 3 areas of the different panels. 2. All residents have the potential to be affected by this deficient practice. 3. All individual fire alarm panels were checked and were in proper working condition in each area, and fire watch was initiated immediately until the fire alarm panels could be linked together. 4. Weekly audits of fire alarm panel communication will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that all fire alarm panels are communicating properly and are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	
K 741 SS=E	Smoking Regulations	K 741		10/22/22

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K 741	Continued From page 27 CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/25/22, in the presence of the Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), the facility failed to maintain smoking areas in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. The practice of dumping cigarette buts and ash into trashcans with other	K 741	1. Regarding the facility's failure to maintain smoking areas in accordance with the requirement of NFPA 101. The practice of dumping cigarette butts and ash into trashcans with other combustibles, increased the risk of fire to facility occupants. The facility checked on the placement of approved ashtrays in the	

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K 741	Continued From page 28 combustibles, increased the risk of fire to facility occupants. This deficient practice was evidenced for 1 of 1 smoking areas observed and was evidenced by the following: At 11:48 AM, the surveyor, IMD and CVPES observed, in the smoking courtyard by the beauty salon atrium, a trash/garbage container with cups, gloves, cigarette butts and ash mixed together. The container was not an approved astray for disposal of cigarette butts. There were no approved self-closing covered metal containers for the disposal of cigarette butts and ashes. The finding was verified by the IMD and CVPES at the time of the observation. The Administrator was informed of the finding at the Life Safety Code exit conference on 08/29/22.	K 741	smoking area in the Atrium, and Activities staff who conduct supervised smoking were re-educated about proper disposal of cigarette butts, and use of ashtrays. 2. All residents have the potential to be affected by this deficient practice. 3. The placement of the ashtray was checked for the smoking area to ensure that the proper disposal of cigarette butts would be completed. 4. Weekly audits of the smoking area will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that ashtrays are in place and cigarette disposal is done in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	
K 912 SS=E	NJAC 8:39-31.2(e) Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 912		10/22/22

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K 912	Continued From page 29 Based on observation and review of other facility documentation on 08/24/22 and 08/25/22, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 7 electrical outlets located next to a water source was equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: During the survey entrance on 08/24/22 at 8:50 AM, a request was made to the Interim Maintenance Director (IMD) to provide a copy of the facility layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified there were three (3) buildings that were connected together, the Atrium, the Pavilion and the Court buildings. On 08/24/22 starting at 9:43 AM, a tour of the building with the IMD and Corporate Vice President of Environmental Services (CVPES) was performed. During the two-day tour of the facility, the surveyor observed and tested seven (7) electrical outlets (within four feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. On 8/24/22 at 12:11 PM, inside the Atrium Beauty Salon, when the surveyor tested one duplex electrical outlet located 42 inches to the left of a hair washing sink with a GFCI tester to de-energize, the outlet did not de-energize as required by code. The IMD and CVPES confirmed the findings at the time of observations. The Administrator was notified of the deficiency at	K 912	1. Regarding the facility's failure to ensure that 1 of 7 electrical outlets located next to a water source was equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. The outlet was replaced with a GFCI outlet immediately as required. 2. All residents have the potential to be affected by this deficient practice. 3. All other GFCI outlets were checked and were confirmed to be in proper working condition. 4. Weekly audits of GFCI outlets will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that GFCI outlets are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	

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K 912	Continued From page 30 the Life Safety Code exit conference on 08/29/22. NJAC 8:39 -31.2 (e) NFPA 99	K 912		
K 915 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation on 08/25/22, in the presence of the Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), it was determined that the facility failed to provide a Type 1 Essential Electrical System in accordance with NFPA 99. This deficient practice was evidenced by the following:	K 915	1. Regarding the facility's failure to provide a Type 1 Essential Electrical System in accordance with NFPA 99. Generator company identified Type 1 ESS transfer switch and it has been clearly labeled and is in compliance with TYPE 1 ESS (NFPA Essential Electrical System Classification Type). 2. All residents have the potential to be	10/27/22

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K 915	Continued From page 31 At approximately 11:00 AM, the surveyor observed all documents provided by the facility for record review. The provided electrical annual inspection dated 04/29/22 did not provide any information on "Essential Electrical System Design Standards." The facility currently had a Ventilator (vent) unit that required a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. At approximately 12:15 PM, the surveyor interviewed the CVPES who indicated that he was not sure if the current electrical system for the vent unit was a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. At approximately 1:15 PM, while touring the facility, the surveyor, IMD and CVPES could not locate the required three branch panels that are divided as follows: 1) Life Safety 2) Critical 3) Equipment (Each branch is required to have at least 1-transfer switch) The Administrator was informed of the findings at the Life Safety Code exit conference on 08/29/22. *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 ESS. NJAC 8:39-31.2(e)	K 915	affected by this deficient practice. 3. All other transfer systems have been checked by the generator company to ensure that they are in compliance with the TYPE 1 ESS (NFPA Essential Electrical System Classification Type). 4. Weekly audits of all electrical systems will be completed for TYPE 1 ESS (NFPA Essential Electrical System Classification Type) by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that the electrical systems are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	

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K 915	Continued From page 32 NFPA 99- 6.7.5.1.1 6.7.5.1.3* Critical Branch 6.7.5.1.4 Equipment Branch 6.7.5.1.2 Life Safety Branch	K 915		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and 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	K 918		11/17/22

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K 918	Continued From page 33 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, interview, and review of other facility documentation on 08/25/22, in the presence of the Interim Maintenance Director (IMD) and Corporate Vice President of Environmental Services (CVPES), it was determined that the facility failed to a.) certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems, b.) ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1., and c.) failed to conduct the required load bank test for 1 of 4 generators, once every 36 months for 4 continuous hours. This deficient practice was evidenced for 4 of 4 generator logs provided by the Corporate Vice President of Environmental Services (CVPES) by the following: 1). On 08/25/22, a review of the facility's generator records for the previous twelve months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the IMD was performing a monthly load test, but he was not recording the required transfer times on the current testing log provided on four of four generators. An interview was conducted with the CVPES at the time of record review, who confirmed no	K 918	1. Regarding the facility□s failure to a.) certify the time needed by their generator to transfer power to the building was within the required 10- second time frame, in accordance with NFPA 99 for emergency electrical generator systems, b.) ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, and c.) failed to conduct the required load bank test for 1 of 4 generators, once every 36 months for 4 continuous hours. Generator log updated to note the time of the transfer. Generator company contacted and they installed remote manual stop station. 4 hour load bank test documentation located, test was completed. 2. All residents have the potential to be affected by this deficient practice. 3. All other generators were inspected to ensure that the time frame for transfer power is within the acceptable time frame. Generator log updated to note the time of the transfer. Generator company installed remote manual stop stations for all generators. 4-hour load bank test was conducted for all generators by vendor. 4. Weekly audits of all generators will be completed by Maintenance Director or Designee to ensure the transfer time, remote manual stop station, and load bank tests are completed and in place for four weeks, and monthly thereafter for 3	

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K 918	Continued From page 34 transfer times were currently on the facility logs provided for four of four generators. 2). On 08/25/22 at 12:40 PM, the surveyor, IMD and CVPES observed that the facility's exterior four generators did have an exterior remote shutoff. An interview was conducted during the observation with the IMD. He stated that he was unaware that the four exterior generators did not have a remote manual stop station to prevent inadvertent or unintentional operation located (remote) of the enclosure housing the prime mover. 3.) At 12:15 PM, record review indicated that the Genset 80 KW Unit A generator did not have the required load-bank test. The CVPES, in an interview, indicated that he was not sure why the Genset 80 KW generator did not have the required load-bank test. The Administrator was informed of the findings at the Life Safety Code exit conference on 08/29/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918	months to ensure that the generator/ systems are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315280 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/23/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0132	11/25/2022	LSC K0211	10/03/2022	LSC K0222	11/25/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0227	10/22/2022	LSC K0293	10/22/2022	LSC K0321	10/26/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	10/22/2022	LSC K0341	10/22/2022	LSC K0351	10/22/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	10/22/2022	LSC K0374	11/17/2022	LSC K0511	10/28/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	12/23/2022	LSC K0712	09/09/2022	LSC K0741	10/22/2022

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0912	10/22/2022	LSC K0915	10/27/2022	LSC K0918	11/17/2022

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/29/2022	☐ YES ☐ NO