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 _____	**11/01/2021**

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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities. *It was noted that the building is in the process of being sold to new ownership, so the emergency preparedness manual (EP) must be updated to meet the requirements and policies of the new ownership.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/18/21 and 10/19/21,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 is a two-story building that was built in the 1980's. It is composed of Type V protected. The facility is divided into 20 smoke zones. The building has seven generators as per the Maintenance Director.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets	K 161		12/28/21

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

Electronically Signed | 12/06/2021

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K 161	Continued From page 1 Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on record review and interview on	K 161	K161	

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K 161	Continued From page 2 10/18/21 to 10/19/21, the facility failed to provide an acceptable construction type and wall-ceiling assembly in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1. This deficient practice was evidenced by the following: An interview was conducted on 10/18/21, at 09:15 AM, during the entrance conference with the (current) Administrator (LNHA) and Maintenance Director (MD) who were unable to confirm the building construction type. The LNHA and the MD were also unable to provide portable accurate floor plans identifying smoke barrier walls, fire walls, shafts, hazardous areas and exits for the life safety code survey. The findings were verified by the (current) Administrator and Maintenance Director at the time, the floor plans were provided to the surveyor. NJAC 8:39-31.2(e)	K 161	Element One □ Corrective Actions " The facility reached out to an architectural engineer on 11/30/21 to create site plans that include smoke barrier walls, fire walls, shafts, hazardous areas, and fire exits.The Plans have been developed by an Architect and forwarded to the facility. " The maintenance director was instructed to keep a portable set of facility floor plans that designate the location of smoke barrier walls, fire walls, shaft hazardous areas and exits readily available for reference at all times. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three □ Systemic Changes " The facility will have a set of portable facility floor plans designating the location of smoke barrier walls, fire walls, shafts hazardous areas and exits created. A copy of the plans will be stored in the maintenance director□s office for future reference. Element Four □ Quality Assurance The Maintenance Director will maintain a current portable copy of the facility floor plans with all require designations readily available to surveyors or other inspectors and available for use if needed by vendors or in the event of any repairs or emergencies. The maintenance director will report any changes or modifications to plans as appropriate to the QAPI	

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K 161	Continued From page 3	K 161	committee which currently meets weekly.	
K 211 SS=F	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 observations and interview on 10/22/21, in the presence of the Maintenance Director, it was determined that the facility failed to maintain exit access free from obstructions for full instant use. This deficient practice was evidenced by the following: At 11:00 AM, the surveyor observed and obtained photographs that the long term care (LTC) side of the egress/exit door were blocked by kitchen storage boxes on orange crates and a 4' x 18" chrome 4-shelf system filled with kitchen supplies. The 36" wide exit door was provided with a 18-inch square viewing window and the door had a paper sign stating "not an exit" from the LTC side. A separately licensed Dialysis Center was located on the other side of the door. An interview was conducted with the [Dialysis Center] Technician at the time of the observation and he stated that the means of egress on the Dialysis side to the LTC kitchen egress area had been blocked for 8-months.	K 211	K211 Element One – Corrective Actions • The storage boxes and chrome shelf blocking the means of egress by the kitchen were immediately removed. • The paper sign was removed from the exit door. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • Dialysis center staff were educated about using the doorway as a means of egress in the event of an emergency. • Emergency exit doors throughout the facility were checked to identify any objects that needed to be removed that might prevent safe egress from the facility in the event of an emergency. Element Four – Quality Assurance	12/28/21

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K 211	Continued From page 4 N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 101:2021 Sections 7 and 19.2.1	K 211	Root cause analysis was conducted, and a QAPI performance improvement project was implemented to assure exit doors are not blocked or obstructed preventing safe egress from the facility in the vent of an emergency. The maintenance director/designee will conduct rounds and assess the exit doors weekly for three months and then monthly thereafter. The results of the rounds shall be reported to the administrator weekly for three months. Quarterly the Maintenance Director will report audit findings and actions taken to the QAPI committee for review and further direction as appropriate.	
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 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	K 222		12/28/21

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K 222	Continued From page 5 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 by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222		

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K 222	Continued From page 6 Based on observations and interview on 10/19/21, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that the 15-second delayed egress feature on 1 of 5 exit discharge doors (with this feature) observed would activate when tested. This deficient practice was evidenced by the following: At 3:20 PM, the Surveyor and Maintenance Director observed the egress door by resident rooms 333 and 334. The surveyor observed the delayed 15-second egress feature which was labeled with a sign on the door that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door's egress feature did not function. The door was provided with a key pad that opened the door, and according to the Maintenance Director, the fire alarm would open the door when activated. These findings were verified by the Maintenance Director, during the observations and the testing of the doors. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222	K222 Element One – Corrective Actions • The door lock vendor was contacted on 12/1/21 to schedule a site visit to assess egress door by room number 334. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three – Systemic Changes • The vendor corrected the maglock function to ensure the door has a 15 second delayed egress as per code. • All exit doors on that unit were inspected and all had 15 second delayed egress and were working appropriately. Element Four – Quality Assurance Maintenance Director/designee will audit all exit doors weekly x6 months to ensure proper functioning and delayed egress. Any malfunction will be immediately corrected, and administrator notified. Maintenance Director will report to the QA Committee quarterly x3 quarters of findings.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, and interview on	K 291	K291	12/28/21

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K 291	Continued From page 7 10/19/21, it was determined that the facility failed provide a battery-backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 10/19/21 from 09:00 AM to 2:00 PM, the Surveyor toured with the Maintenance Director and observed the (1) main electrical room, where the seven (7) emergency generator transfer switches are located. The main electrical room was not equipped with emergency lighting independent of the building's electrical system and emergency generator. This finding was verified by the facility's Maintenance Director at the time of inspection. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	Element One □ Corrective Actions " Battery operated lights were ordered on 11/25/21 to be placed in the main electrical room above the emergence generators transfer switch and have been installed. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three □ Systemic Changes " Building wide audit was conducted to ensure no additional emergency generator panels were present and none were found. " Maintenance Director will be instructed to check the functioning of the backup lights once a month during his monthly generator full load test and to document on the test form. Element Four □ Quality Assurance Maintenance Director/designee, will check for proper functioning of backup light monthly and report any malfunction promptly to the administrator. Maintenance Director will report quarterly at the quarterly QA meeting of any findings x3 quarters.	
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	K 293		12/28/21

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K 293	Continued From page 8 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 interview on 10/21/21, the facility failed to properly identify doors, with a sign on a door, which is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall have a "No Exit" sign in accordance with NFPA 101, 2012 Edition, Section 7.10 and 7.10.8.3. This deficient practice was evidenced for 1 of 1 kitchen doors by the following: At 11:00 AM, the surveyor observed that the door in the Kitchen egress/exit corridor had a paper sign taped to the door indicating: "Not an exit." NFPA 101,2012 Edition, Section 7.10 and 7.10.8.3. states the sign shall indicate "NO EXIT". The findings were verified by the Maintenance Director (technician) at the time of the observation. NJAC 8:39-31.2(e)	K 293	K293 Element One – Corrective Actions • The 'Not an Exit' sign was immediately removed. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three – Systemic Changes • Facility wide audit was conducted to ensure no additional improper signs were being used throughout the building and 1 additional sign was removed. • Maintenance Director was informed of proper sign verbiage required per code. Element Four – Quality Assurance Maintenance Director/designee will immediately remove any improper exit signs and replace with appropriate signage. Maintenance Director will report to the QA Committee quarterly of any further instances of improper verbiage of exit signs x 6months.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		12/28/21

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K 321	Continued From page 9 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/18/21 in the presence of the Maintenance Director, it was determined that the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous area 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 practice was identified in 2 of 4 units (Atrium and Court 1) and was evidenced by the following:	K 321	K321 Element One – Corrective Actions • A self-closing door closure was installed in the Court 1 chemical storage room. • A self-closing door closure was installed in the Court 1 storage room. Element Two – Identification of at Risk Residents	

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K 321	Continued From page 10 1. The surveyor observed on 10/18/21 at 11:35 AM that the chemical storage room in (Silver Court-1 wing) across from resident room 119 exceeded 50 square feet, and contained more than 50 combustible boxes with chemicals and equipment. There was no self-closing device on the door. 2. The surveyor observed on 10/19/21 at 12:18 PM, the court-1 storage room across from the corridor fish tank, that more than 100 combustible boxes of adult diapers were being stored. The room exceeded 50 square feet and was not provided with a self-closing device on the door. An interview was conducted with the Maintenance Director at that time who acknowledged that hazardous storage areas that exceeded 50-square feet must have a door with a self-closing device. NJAC 8:39-31.2(e)	K 321	All residents have the potential to be affected by this deficient practice. Element Three – Systemic Changes • All storage rooms and chemical rooms were audited to ensure proper self closing door closures were installed. • Maintenance Director and maintenance techs will be educated on ensuring all hazardous areas have self-closing door closures. Element Four – Quality Assurance Maintenance Director/designee, will audit 4 hazardous areas per week x 8 weeks, then 2 hazardous areas per week x 4 months, to ensure all have appropriate self-closing door closures. And hazardous area missing a self-closing door closure will be immediately added. Maintenance Director will report to the QA Committee quarterly x3 quarters.	
K 341 SS=F	Fire Alarm System - Installation 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	K 341		12/28/21

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K 341	Continued From page 11 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 10/19/21, the facility failed to provide notification by audible and visible signals in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. The deficient practice was evidenced in 2 of 2 courtyards observed by the following: At 10:10 AM, the surveyor observed in the presence of the Maintenance Director, that the (small and large) enclosed courtyard's did not have any occupant notification devices (horn/strobe tied into the fire alarm system). The findings were verified and confirmed by the Maintenance Director during the observations. NJAC 8:39-31.2(e) NFPA 70, 72	K 341	K341 Element One □ Corrective Actions " A horn strobe ensemble was installed in the resident smoking courtyard on 10/26/21. " Fire Panel vendor scheduled to come out 12/2/21 to provide a quote for a horn strobe ensemble for the courtyard. It has now been installed. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three □ Systemic Changes Facility has no additional courtyards. Element Four □ Quality Assurance Horn strobes are checked biannually by facility fire monitoring vendor for proper functioning. Maintenance Director will report to the QA Committee once horn strobe ensemble is installed.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		12/28/21

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SILVER HEALTHCARE CENTER	**1417 BRACE ROAD** **CHERRY HILL, NJ 08034**

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K 353	Continued From page 12 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Need observation times below: Based on observation and interview from 10/18/21 to 10/19/21, it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke-resistant and fire-rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. The deficient practice was identified for 5 of 5 resident units (Atrium, Court 1, Court 2, Pavilion and Ventilator Unit) and was evidenced by the following: During tour of the facility conducted on 10/18/21 from 10:30 AM, to 04:00 PM, and 10/19/21 from 08:30 AM, to 03:00 PM, the surveyor observed the following:	K 353	K353 Element One Corrective Actions " Escutcheon Plates were installed at the Court 1 Nurse station, Court 1 Server Room, corridor by rm 309, Housekeeping closet, Kitchen corridor, corridor by room 245, Electrical panel Room #64, respiratory supply closet, court 2 clean utility room, corridor by rm 210, ventilator unit stairwell, the kitchen and the green room. " The 4" x 4" hole in elevator #2 was repaired as well as pipe chase,ceiling tiles were replaced at the main entrance, the adult diaper storage room, supply room by boiler room, unit manager room, room 419, kitchen, kitchen corridor, boiler room, room 253, corridor by room 254, corner ceiling tile by elevator,hall spa south, and atrium housekeeping closet. " Atrium south nurse station ceiling was	

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K 353	Continued From page 13 The fire sprinkler escutcheon plates were missing or were not in the proper position in the following areas of the facility: 1. Court-1 nurse's station 2. Court-1 server room 3. Corridor by resident room 309 4. Housekeeping closet 5. Kitchen Corridor 6. Corridor by resident room 245 7. Electrical panel room #64 8. Respiratory supply closet 9. Court-2 clean utility closet 10. Corridor by resident room 210-211 11. Ventilator Unit stairwell 12. Kitchen 13. Green Room The surveyor also observed that there were ceiling tiles missing or holes in the ceiling tiles/sheetrock in the following areas of the facility: 1. The elevator #2, there was a 4"x 4" hole. 2. The elevator #2 pipe chase 3. The main entrance ceiling (2) tile's not in place (off track) high ceiling 4. The adult diaper storage room across from the fish tank 2' x 4' tile missing 5. The supply room by boiler room had a 2' x 4' tile missing 6. The unit manager room by the medication dispensing machine had a 2' x 2' tile missing. 7. The nurse's station 2' ceiling track was missing creating a 1" opening 8. The resident room 419 was missing a ceiling tile 9. The kitchen had two ceiling tiles missing by	K 353	fixed. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three □ Systemic Changes " New escutcheon plates were ordered and received on 11/11/21 for identified missing areas. An additional order was placed on 11/30/21 to correct the remaining identified missing escutcheon plates. " A facility wide audit was done of all missing ceiling tiles and all were replaced. " Facility Maintenance director resigned during survey. New Maintenance Director is scheduled to start 12/6/21 and will be informed of the requirements that all ceilings be smoke resistant. Element Four □ Quality Assurance Maintenance Director will audit 1 room a day x90 days then 3 rooms a week x6 months to ensure all escutcheon plates and ceiling tiles are present and in proper good condition. Any identified ceiling tile in need of replacement or escutcheon plates missing will be immediately corrected and the Administrator notified. Maintenance Director will report quarterly to the QA Committee meeting x4 quarters.	

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K 353	Continued From page 14 the large exhaust fan 10. The kitchen corridor had a missing 4' x 2' ceiling tile. 11. The boiler room had a missing 2' x 2' ceiling tile. 12. The resident room 253 had a ceiling tile missing. 13. The corridor by the nurse's station 254 had a hole in the ceiling 1" -2' x 4' ceiling tile was missing. 14. The corridor corner ceiling tile by the elevator was missing. 15. The nurse's station south there was approximately 2' x 8" sheetrock missing from a roof leak. 16. The hall spa south ceiling had an open 2' x 4' tile that was not in place 17. A housekeeping closet in the Atrium unit had two missing 2' x 4' ceiling tiles. The Maintenance Director confirmed the risks associated with displaced and missing escuchen plates and ceiling penetrations that would allow for the passage of heat to the space above which would delay the activation of the fire sprinkler system. This interview was conducted throughout the building tour on 10/18/21 and 10/19/21. No additional information was provided to the surveyor. NJAC 8:39-31.2(e) NFPA 13, 25	K 353		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	K 355		12/28/21

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K 355	Continued From page 15 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 interview, the facility failed to visually inspect fire extinguishers on a monthly basis (30 days) to ensure they were ready for use in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10, 2010 Edition, Sections 7.2, 7.2.1.2, 7.2.2, 7.2.4.3 and 7.2.4.4 and 7.2.4.5. This deficient practice was evidenced by the following: On 10/19/21 at 12:02 PM in kitchen cooking area, the surveyor observed that the two K-type fire extinguisher's were not inspected monthly. One fire extinguisher had a blank inspection tag and did not indicate that monthly inspection (date and initials) was completed. The second fire extinguisher had a inspection tag with a monthly inspection marked 09/10/21 and no current inspection as of the survey date of 10/19/21. An interview was conducted during the observations with the Maintenance Director where he stated and confirmed that the two K-type fire extinguishers in the kitchen were not signed off properly in accordance with NFPA 10. NJAC 8:39-31.2(e) NFPA 10	K 355	K355 Element One □ Corrective Actions " The 2 k type fire extinguishers in the kitchen have been visually inspected and noted on the attached tag Element Two □ Identification of at Risk Residents " All residents have the potential to be affected. An inspection of all fire extinguishers was conducted to ensure they have been visually inspected and noted on the attached monthly inspection tag. Element Three □ Systemic Changes " Maintenance staff have been re-educated about the necessity to document a monthly visual inspection all fire extinguishers and noted on the monthly inspection tag. " A monthly visual inspection will be conducted and documented on all fire extinguishers by the Maintenance Director/designee. Element Four □ Quality Assurance The Maintenance Director will submit the above monthly inspection report to the Administrator and will be included in the facility's QAPI Committee as well. The Maintenance Director will audit all fire extinguishers monthly to ensure they are	

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K 355	Continued From page 16	K 355	in proper working condition. Any identified as not meeting threshold will be immediately replaced and Administrator notified. Maintenance Director will report findings quarterly to the QA Committee meeting x4 quarters	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no	K 363		12/28/21

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K 363	Continued From page 17 restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/19/21, the facility failed to ensure that the corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. By not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was identified in 7 of 50 resident room doors and was evidenced by the following: On 10/19/21 during the building tour from 08:30 AM to 03:00 PM, the surveyor observed the following: 1. Resident room door 220 would not latch into its frame leaving approximately a 2" opening. 2. Resident room door 227 would not latch into its frame. 3. Resident room door 243 would not latch into its frame. 4. Resident room door 250 would not latch into its frame, due to a loose hinge preventing the door from closing properly.	K 363	K363 Element One – Corrective Actions • Door to rooms 220,227,243,250,405,412 and 415 were repaired so they close and latch properly. • Doors to resident's room were checked to ensure they close and latch. Several others were identified, and they have been repaired Element Two – Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three – Systemic Changes • A form was developed to track continued compliance with k-tags during facility rounds. • The maintenance director/designee will complete the tracing form during routine k-tag rounds weekly. • Doors were inspected, and any additional concerns identified were addressed to assure doors properly close and latch. • Staff were re-educated about the importance of reporting any doors that do not close and lacth properly to	

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K 363	Continued From page 18 5. Resident room door 405 would not close into its frame, the door was hitting the frame preventing the door from latching. 6. Resident room door 412 would not close into its frame, the door was rubbing on the floor preventing the door from latching. 7. Resident room door 415 would not close into its frame, the door was rubbing on the frame preventing the door from latching. An interview was conducted with the Maintenance Director during the observations, who stated and confirmed that resident room door's must close and latch into its frame. The surveyor asked for a door check log, but was not provided with one. NJAC 8:39-31.1(c), 31.2(e)	K 363	maintenance. Element Four – Quality Assurance The Maintenance Director/designee will conduct walking rounds weekly to check doors to assure doors close and latch correctly and will note any issues on the k-tag rounds report. Any identified issues will be immediately corrected, and the Administrator notified. The Maintenance Director will report findings quarterly at the quarterly QAPI Committee meeting x4 quarters.	
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	K 374		12/28/21

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K 374	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation from 10/18/21 to 10/19/21, it was determined that the facility failed to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. This deficient practice was observed for 6 of 10 sets of double smoke doors tested for closure and was evidenced by the following: 1. On 10/18/21 at 11:20 AM, the Surveyor and Maintenance Director observed the set of smoke-doors by resident 123. The surveyor observed that when the doors released from the magnetic hold-open device, 1 of 2 doors remained open due to the door rubbing onto the floor. Upon closer observation of the doors, it was revealed the lower door hinge was broken. At that time, the surveyor interviewed the Maintenance Director who acknowledged that the smoke door's must resist the passage of smoke to be compliant. 2. On 10/18/21 at 1:22 PM, the Surveyor and Maintenance Director observed the set of smoke-doors by resident rooms 222 and 223. The surveyor observed that when the doors released from the magnetic hold-open device and the two doors fully closed, there was a gap that was 1/4 to 1/2 inch in size. At that time, the surveyor interviewed the Maintenance Director who acknowledged that the smoke door's must resist the passage of smoke to be compliant.	K 374	K374 Element One Corrective Actions " The smoke door by room 123 has been repaired " The smoke doors by 222 were adjusted so there is no gap when it closes. " The smoke door by 412 has been repaired The smoke doors in Court 1 outside of elevator #2 were adjusted so there is no gap when it closes. " A quote has been received for the smoke door to the laundry room and it has been ordered. The laundry detergent drum was immediately removed from blocking the door. " The Laundry was staff in- serviced on the importance was of not blocking fire doors Element Two Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three Systemic Changes " Fire/smoke doors were inspected, and any additional concerns identified were addressed to assure all fire/smoke door are not blocked and properly close without gaps. " Staff were re-educated about the importance of not blocking fire doors. " A form was developed to track continued compliance with k-tags during facility rounds.	

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K 374	Continued From page 20 3. On 10/18/21 at 3:18 PM, the Surveyor and Maintenance Director observed the set of smoke-doors by resident 412. The surveyor observed that when the doors released from the magnetic hold-open device and the two doors fully closed, there was a gap 1/4 inch in size. Further, it was noted the wooden smoke doors were in ill-repair as the veneer/laminate was peeling off the doors. At that time, the surveyor interviewed the Maintenance Director who acknowledged that the smoke door's must resist the passage of smoke to be compliant. 4. On 10/19/21 at 10:28 AM, the Surveyor and Maintenance Director observed the set of smoke-doors in Court 1 outside of Elevator-2. The surveyor observed that when the doors released from the magnetic hold-open device and the two doors fully closed, there was a gap 1/4 inch in size. At that time, the surveyor interviewed the Maintenance Director who acknowledged that the smoke door's must resist the passage of smoke to be compliant. 5. On 10/19/21 at 10:55 AM, the Surveyor and Maintenance Director observed the fire/smoke-door to the laundry room would not close due to broken hinges making the entire door compromised from working order. At that time, the surveyor interviewed the Maintenance Director who acknowledged that the smoke door's must resist the passage of smoke to be compliant. 6. On 10/19/21 at 10:58 AM, the Surveyor and Maintenance Director observed the set of fire/smoke-double doors by the entrance to the laundry room. The surveyor observed that 1 of 2	K 374	" The maintenance director/designee will complete the tracing form during routine k-tag rounds weekly. Element Four □ Quality Assurance The Maintenance Director/designee will conduct walking rounds weekly to check doors to assure all fire/smoke doors are not blocked and close and latch correctly and will note any issues on the k-tag rounds report. Any identified issues will be immediately corrected, and the Administrator notified. The Maintenance Director will report findings quarterly at the quarterly QAPI Committee meeting x4 quarters.	

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K 374	Continued From page 21 doors were blocked from operation and testing due to a large drum of laundry detergent stored in front of the door. At that time, the surveyor interviewed the Maintenance Director who acknowledged that the smoke door's must resist the passage of smoke to be compliant. No additional information was provided to the surveyor by the Maintenance Director. On 10/19/21, the Licensed Nursing Home Administrator (LNHA) was unable to provide additional information regarding the surveyor's findings. NJAC 8:39-31.2(e)	K 374		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 10/18/21 to 10/19/21, in the presence of the facility Maintenance Director, it was determined that the facility failed to ensure: a.) resident bathroom ventilation systems for 90 of 100 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA)	K 521	K521 Element One □ Corrective Actions " Facility HVAC vendor did an initial assessment of facility rooftop HVAC units and bathroom exhaust system on 12/1/21. All rooftop units have been repaired on Court 1, Court 2, Vent and Pavilion where	12/28/21

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K 521	Continued From page 22 90 A, B., and b.) that HVAC (Heating, Ventilation, and Air Conditioning) rooftop units were maintained and functioning properly. This deficient practice affected 5 of 5 resident units (Atrium, Court 1, Court 2, Pavilion Unit and Ventilator Unit), and was evidenced by the following: On 10/18/21 from 10:30 AM, to 04:00 PM, and 10/19/21 from 08:30 AM, to 03:00 PM, the surveyor toured 5 of 5 resident units. The Surveyor and Maintenance Director observed that the ventilation in Court 1, Court 2, Atrium, Pavilion and Ventilator unit (10 bathrooms with ventilation) was not functioning. The surveyor requested that the Maintenance Director confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. On 10/18/21 at 02:00 PM, the surveyor interviewed the Maintenance Director, who confirmed that the approximately 6" x 6" exhaust vents in the above resident room bathrooms were not functioning when tested. He stated that the system has not been fully operational since he started approximately six months ago. The surveyor requested all logs and work orders at the time of the observations, but none were provided. The Maintenance Director stated that two large HVAC units on the Court-2 rooftop were not operating since he started six months ago. These non-functioning HVAC units would provide heat and A/C to the corridors of the majority of the	K 521	residents reside so hall temperatures are back to normal. There are 7 HVAC rooftop units on Atrium which is currently unoccupied. 2 have been repaired, 4 are waiting for parts to arrive which have been ordered, and 1 is being replaced. Regarding bathroom exhaust fans, 5 units are on Court 1, Court 2 and Vent. Out of the 5, 2 have been repaired, 1 has parts on order and the other 2 are being replaced. Out of 8 exhaust units on Pavilion, 2 have parts on order and 6 are being replaced. Out of 8 exhaust units on Atrium, 5 have parts on order and 3 are being replaced. Element Two Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three Systemic Changes " Facility HVAC vendor will be assessing and ordering all necessary parts and components to fix facility rooftop HVAC unit and bathroom exhaust system. Element Four Quality Assurance The Maintenance director will audit 1 room daily x90days, then 3 rooms weekly x6months. Any broken bathroom exhaust fans will be immediately reported to the administrator and HVAC vendor contacted to correct. The Maintenance director will check proper functioning daily x 90 days. If HVAC appears broken maintenance director will immediately inform	

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K 521	Continued From page 23 building. At this time, the heat and A/C would come from the PTAC (Packaged Terminal Air Conditioner) units in the individual resident rooms. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	Administrator and facility HVAC vendor will be notified. Maintenance director will report quarterly x3 quarters to the QA Committee of any disruptions or findings.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of the Maintenance Director, it was	K 531	K 531 Element One – Corrective Actions	12/28/21

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K 531	Continued From page 24 determined that the facility failed to ensure that 1 of 2 elevators in the facility complied with ASME A17.1, Safety Code for Elevators. This deficient practice was determined by the following: On 10/18/21 at 12:00 PM, the surveyor observed that the Passenger/Freight elevator was out of service. An interview was conducted during the observation where the Maintenance Director informed the Surveyor that the Passenger/Freight Elevator was out of service for approximately 1-week. At that time, the surveyor asked the Maintenance Director to provide a work-order or any documentation indicating the facility elevator company was notified. As of 10/19/21 at 3:00 PM, no further information or documentation was provided. NJAC 8:39-31.2(e)	K 531	• Facility elevator maintenance company was contacted and arrived on 11/1/21 and fixed the elevator and put it back in functioning and working order. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three – Systemic Changes • Facility elevator maintenance vendor is contracted with facility and is available 24hrs a day to fix any elevator related issue that arises. • Maintenance Director will be instructed to call vendor immediately upon being informed of any broken elevators. Element Four – Quality Assurance Maintenance Director will inform administrator immediately of any broken elevators and call vendor to fix. Maintenance Director will report to QA Committee of any planned elevator maintenance down time and any time elevator is not properly working x 6 months.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 911		12/28/21

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K 911	Continued From page 25 Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview from 10/18/21 to 10/19/21, it was determined that the facility did not maintain the required clearance around electrical panels, electrical equipment and controls in accordance with NFPA 101, 2012 LSC Edition, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26. This deficient practice of not ensuring 36" in-front of the electrical panels will prevent staff and emergency personnel from disconnecting the electrical power quickly in the event of an emergency. In addition, cardboard storage boxes and paper stored in front of electrical equipment may provide an ignition source and pose a potential fire risk. The deficient practice was observed in 4 of 6 electrical rooms observed, and was evidenced by the following: 1. On 10/18/21 at 10:08 AM, the surveyor observed in the laundry electrical panel room that personal laundry bins were blocking large electrical panels, potentially causing a delay in the shutoff of any electrical equipment in that room. 2. On 10/18/21 at 2:05 PM, the surveyor observed in the mechanical room by resident room 257 that the entrance to the room was compromised from entering due to a heavy amount of storage, which could delay the shutoff of any electrical equipment in that room. 3. On 10/19/21 at 1:18 PM, the surveyor observed in the electrical panel #1 room by the air compressor that a large picture frame was being	K 911	K911 Element One – Corrective Actions • All items blocking the 4 mentioned electrical panels were immediately removed to provide proper clearance in accordance with this regulation. • A 100% inspection of all electrical panel rooms was conducted to ensure proper clearance to the electrical panel. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three – Systemic Changes • All electrical rooms were inspected, and any additional concerns identified were addressed to assure proper clearance in compliance with regulations. • Staff were re-educated about the importance of not blocking access to the electrical panel or storing combustible materials in the electrical rooms. • A form was developed to track continued compliance with k-tags during facility rounds. • The maintenance director/designee will complete the tracing form during routine k-tag rounds weekly. Element Four – Quality Assurance The Maintenance Director/designee will conduct walking rounds weekly to check electrical rooms to assure proper clearance and will note any issues on the	

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K 911	Continued From page 26 stored in front of the electrical panel, blocking the ability to shut-off any breaker in the event of an emergency. 4. On 10/19/21 at 01:28 PM, the surveyor observed in the electrical panel closet marked EM-2 that eight white drums were stored in front of the panels, blocking the ability to quickly shut-off any breaker in the event of an emergency. The observations were confirmed by the Maintenance Director during the tour of the electrical rooms in the facility. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	k-tag rounds report. Any identified issues will be immediately corrected, and the Administrator notified. The Maintenance Director will report findings quarterly at the quarterly QAPI Committee meeting x4 quarters.	
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	K 918		12/28/21

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K 918	Continued From page 27 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 documentation review and interview from 10/18/21 to 10/19/21 in the presence of facility Maintenance Director, it was determined that the facility failed to provide documentation or logs indicating that the seven emergency electrical generator's were inspected weekly, tested 12 times each year under load, and exercised once every 36 months for four continuous hours in accordance with NFPA 99. This deficient practice was evidenced by the following: The surveyor requested the logs for the facility's seven generators on 10/18/21 and again on 10/19/21 from the Maintenance Director. The logs were not provided in accordance with NFPA 110. It was not known if the alternate power source was capable of supplying service within 10-seconds of activation. In an interview, on 10/18/21 at 2:30 PM, the	K 918	K918 Element One – Corrective Actions • Facility generator vendor is scheduled to come down to facility on 12/2/21 and provide instructions on how to run load testing of the generators. Element Two – Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three – Systemic Changes • Maintenance Director, or designee, will test all facility generators weekly per NFPA99 requirements and document. • Log form was created and will be filled out weekly when generator test is conducted. Element Four – Quality Assurance	

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K 918	Continued From page 28 facility's Maintenance Director indicated that the log books were destroyed by the previous Maintenance Director and he was not provided the instructions on how to perform these tests. NJAC 8:39-31.2(e) NFPA 99, 110	K 918	Generator logs will be reviewed by Administrator weekly x8 weeks then monthly x4 months to ensure proper testing is being completed. Maintenance director will report quarterly to the QA Committee x3 quarters of any concerns with generator testing.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/19/21, in the presence of the Maintenance Director,	K 920	K920 Element One □ Corrective Actions	12/28/21

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K 920	Continued From page 29 Dietary Director and the new facility Administrator as of 10/19/21, it was determined that the facility failed to maintain wiring, in accordance with NFPA 70 (National Electrical Code).This deficient practice was evidenced by the following: 1. On 10/19/21 at 1:10 PM, the surveyor observed outside the kitchen area by the dietary office and storage room that an orange extension cord was plugged into a duplex wall outlet, then installed through a hole into two sheetrock walls into the main kitchen and then plugged into a commercial high-draw electric toaster. An interview was conducted with the Maintenance Director, Dietary Director and (new) facility Chief Executive Officer and they stated that the orange extension cord should not be in the facility and they were not sure who installed it, but it appears from the installation that it's been there for awhile. 2. On 10/19/21 at 3:10 PM, the surveyor observed in the Director of Activities office that electronics were plugged into a multi-outlet power strip. The power strip was then plugged into another multi-outlet power strip, then plugged into the duplex wall outlet. At that time, an interview was conducted with the Maintenance Director during the observation and he stated the power strips cannot be plugged into each other. 3. On 10/19/21 at 3:35 PM, the surveyor observed in resident room 317, that the Packaged Terminal Air Conditioner (PTAC) unit power cord was spliced into another cord with a plug, then plugged into the duplex outlet. The spiced cords were exposed under the PTAC unit.	K 920	" The extension cord in dietary was removed. " The second power strip in the activity director office was removed. " Room 317 is closed and will not be occupied until this PTAC unit is replaced with an appropriate plug for the outlet. The unit has been unplugged. " The dietary and activity directors were in-serviced that the use of extension cords is not permitted. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three □ Systemic Changes " An audit was conducted throughout the facility to identify and remove any extensions cords or inappropriately used power strips. " Staff received re-education about the importance of not using extension cords on inappropriately using power strips. " All maintenance staff will be in serviced on not splicing cords on any PTAC unit or other devices " A form was developed to track continued compliance with k-tags during facility rounds. " The maintenance director/designee will complete the tracing form during routine k-tag rounds weekly. Element Four □ Quality Assurance The Maintenance Director/designee will conduct walking rounds weekly and do random checks for any improper use of	

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K 920	Continued From page 30 At that time, an interview was conducted during the observation and the Maintenance Director stated the cords were spliced to fit that outlet. NJAC 8:39-31.2(e) NJAC 8:39-31.7(g) NFPA 70, 99	K 920	power strips, any improper splicing of wires, and any use of extension cords and will note any issues on the k-tag rounds report. Any identified issues will be immediately corrected, and the Administrator notified. The Maintenance Director will report findings quarterly at the quarterly QAPI Committee meeting x4 quarters.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923		12/28/21

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K 923	Continued From page 31 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/19/21, in the presence of Maintenance Director, it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping and rupture in accordance with NFPA 99. This deficient practice was evidenced by the following: 1. On 10/19/21 at 10:32 AM, the surveyor along with the facility's Maintenance Director observed in the Court 1 ice-machine room that 16 portable oxygen cylinders, 10 full and 6 not completely empty(approximately 500 PSI) were next to combustible storage (foam cups and a box of plastic straws). A total of 2 of 16 portable oxygen cylinders were observed to be freestanding and not secured from tipping and rupture. The facility exceeded the maximum amount of portable oxygen cylinders (300 cubic feet/12 cylinders (tanks) permitted within 5-feet of combustibles). 2. On 10/19/21 a 11:28 AM, the surveyor along with the facility's Maintenance Director observed in the Director of Housekeeping/Laundry office	K 923	K923 Element One □ Corrective Actions " Freestanding Oxygen tanks were immediately removed from the Court 1 ice machine room floor and placed in appropriate holder. The facility removed oxygen tanks from the Court 1 ice machice area so that the area did not contain more than the 12 cylinders permitted for that space. " Freestanding oxygen tanks were immediately removed from the Housekeeping Director□s office and properly stored. Element Two □ Identification of at Risk Residents All residents have the potential of being affected by this deficient practice. Element Three □ Systemic Changes " Housekeeping Director is no longer employed by facility. " Nursing staff and new housekeeping director were re-educated about the proper storage of oxygen tanks.	

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K 923	Continued From page 32 that 6 of 6 portable oxygen cylinders were freestanding, unsecured from tipping and rupture. The cylinders were at approximately 500 PSI each, at the time of the observations. At that time, the surveyor interviewed the facility's Maintenance Director who stated that the cylinders must be individually secured from tipping and rupture at all times in the facility. NJAC 8:39-31.2(e) NFPA 99	K 923	Element Four □ Quality Assurance " Maintenance Director/designee will check oxygen tank storage during daily rounds to be sure they are properly stored. Any oxygen tank found unsecured will be immediately corrected. Maintenance Director will report to the QA Committee quarterly x 2 quarters of trends	

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{E 000}	Initial Comments Revisit to Survey Date: 11/01/21- No Deficiencies Cited This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	{E 000}		
{K 000}	INITIAL COMMENTS Revisit to Survey Date: 11/01/21- No Deficiencies Cited LIFE SAFETY CODE 101:2012 THIS FACILITY IS IN COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED USING CMS-2786R	{K 000}		

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

Electronically Signed | 01/24/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	R **01/06/2022**

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}	Continued From page 1	{K 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 2	{K 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 3	{K 000}		

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LIFE SAFETY CODE 101:2012

THIS FACILITY IS IN COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED USING CMS-2786R

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SILVER HEALTHCARE CENTER	**1417 BRACE ROAD** **CHERRY HILL, NJ 08034**

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{K 000}	Continued From page 4	{K 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 5	{K 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 6	{K 000}		

Revisit to Survey Date: 11/01/21- No Deficiencies Cited

LIFE SAFETY CODE 101:2012

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