STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 Survey: 12/8/2023 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		
F 000	INITIAL COMMENTS Survey Date: 12/8/2023 Survey Census: 87 Sample Size: 18 + 3 closed records A Recertification survey was conducted by the New Jersey Department of Health. The facility was found to be in substantial compliance with 42 CFR 483 subpart B for long term care facilities.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/11/2023

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
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 12/05/2023 and 12/06/2023 and Inglemoor R&CC was found to be in compliance 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 Inglemoor R&CC is a 1-story building that was built in 60's. It is composed of Type II unprotected construction. The facility is divided into 6 smoke zones. The facility has a 300 KW Diesel emergency generator that supplies electrical power to the entire building.	K 000		
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.	K 222		12/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/19/2023

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
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 222	Continued From page 1 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 by an approved, supervised automatic fire	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 222	Continued From page 2 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 facility provided documentation on 12/05/2023 and 12/06/2023, it was determined that the facility failed to provide 1 of 10 designated exit discharge (illuminated exit signs above door) doors and 2 designated exit access (illuminated exit signs above doors) doors with-in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 12/05/2023 (day one of survey), during the survey entrance, at approximately 8:55 AM, a request was made to the Administrator (Admin.) and Director of Building Services (DBS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with ten (10) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:19 AM on 12/05/2023 and continued on 12/06/2023, in the presence of the facility DBS, a tour of the building was conducted.	K 222	Element I –No residents were specifically identified as being affected Element II – All residents have the potential to be affected Element III – All 3 sets of doors had locks removed Element IV – The Director of Building Services or designee during daily rounds will ensure all doors of egress do not have a fastening device on the door that could restrict emergency use of the exit. Inspection and any findings will be reported at the quarterly QAPI safety meetings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING 01 B. WING ______	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 222	Continued From page 3 During the tour of the building, at approximately 10:10 AM, the surveyor observed the main entrance, one (1) set of (external) exit discharge doors and two (2) sets of (internal set of doors) revealed thumb turn lock on the egress side of the three sets of doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. A review of an emergency evacuation diagram posted in the corridor identify these three (3) sets of double doors are the primary exit doors to exit in the event of an emergency. The DBS confirmed the findings at the times of observations. The Administrator was informed of the deficiency during the survey exit on 12/06/2023, at approximately 12:50 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this	K 311		12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 311	Continued From page 4 box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 12/05/2023, in the presence of facility Management, it was determined that the facility failed to ensure that 2 of 4 exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 12/05/2023 (day one of survey), during the survey entrance, at approximately 8:55 AM, a request was made to the Administrator (Admin.) and Director of Building Services (DBS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with two (2) separate (Old and New) basements. There are two (2) interior stairwells that Staff could use in the event of an emergency. Starting at approximately 9:19 AM, on 12/05/2023, in the presence of the facility DBS, a tour of the building was conducted. During the tour, the surveyor inspected and conducted closure test of four (4) exit access doors leading into exit stairways with the following results, 1) At approximately 10:03 AM, during a closure test of the Old Basement, 2 (basement level and first floor level) exit access doors, when the doors were opened to a 90 degree opening to the door	K 311	Element I –No residents were specifically identified as being affected Element II – All residents have the potential to be affected Element III – Both doors have new positive latch, installed by engineering. Element IV – Monthly safety rounds will be conducted by the Director of Building Services or designee to inspect (or repair as needed) that doors have positive latch closure. Inspection and any findings will be reported at the quarterly QAPI safety meetings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ___	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 311	Continued From page 5 frame and allowed to self-close, both doors did not positive latch into its frame.This test was performed two additional times with the same results. The surveyor observed the door latching device was missing on the first floor stairwell door. The stairwell doors would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The DBS confirmed the finding at the time of observations. The Administrator was informed of the deficiency during the survey exit on 12/06/2023, at approximately 12:50 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 12/05/2023 and 12/06/2023 in the presence of	K 345	Element I –No residents were specifically identified as being affected	12/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 345	Continued From page 6 the facility management, it was determined that the facility failed to 1) Ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors and 2) Conduct semi-annual testing of the fire alarm and detection system, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficient practice was identified for 1of 1 fire alarm systems and was evidenced by the following: On 12/05/2023 (day one of survey) during the survey entrance, at approximately 8:55 AM, a request was made to the Administrator and Director of Building Services (DBS) to provide all mandatory inspections that had been conducted from 01/01/2022 through 12/04/2023 for review later. The surveyor also requested the facility to provide a copy of the last smoke detectors sensitivity testing. On 12/05/2023, at approximately 11:59 AM, during the documentation review of the mandatory inspections of the facility's Fire Alarm and Detection system semi-annual (every 6 months) inspections for the previous 22 months, identified the system had the following semi-annual fire alarm and detection system inspection reports: The surveyor reviewed the following Fire Alarm and Detection system inspections: - 05/04/2022 semi-annual inspection. - 04/18/2023 semi-annual inspection. This review of the testing reports revealed no reference to a smoke detection sensitivity testing.	K 345	Element II – All residents have the potential to be affected Element III – Director of Building Services contracted with fire alarm vendor to begin to conduct smoke sensitivity testing every 2 years and semi - annual fire alarm system inspection, effective 12/27/2023. Element IV – Director of Building Services or designee will enter these inspections on a tracking software to ensure inspections are completed at proper intervals. Director of Building Services will report at the quarterly QAPI safety committee results and dates of when inspection are performed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 345	Continued From page 7 The facility conducted one semi-annual inspection for 2022. At approximately 12:55 PM on 12/05/2023, the surveyor asked the facility Administrator and DBS that they may have to call the fire alarm and detection vendor and ask for a copy of the last smoke detector sensitivity testing, ask for any other semi-annual inspections for 2022, and to provide the copy of the smoke detector sensitivity testing and semi-annual inspection to the surveyor by 12/06/2023 (day two of survey) for review. On 12/06/2023 the DBS provide a semi-annual inspection dated 3/10/2023. The smoke detector sensitivity testing of the fire alarm and detection system had not been done and the facility conducted one semi-annual inspection of the fire alarm and detection system for the year 2022. The Administrator was informed of the deficiency during the survey exit on 12/06/2023 at approximately 12:50 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 353 SS=E	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 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		12/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 353	Continued From page 8 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: Based on interview and record review on 12/05/2023 and 12/06/2023 in the presence of facility management, it was determined that the facility failed to comply with the inspection and testing requirements NFPA 25 as evidenced by the following: On 12/05/2023 (day one of survey) during the survey entrance, at approximately 8:55 AM, a request was made to the Administrator and Director of Building Services (DBS) to provide all mandatory inspections that had been conducted from 01/01/2022 through 12/05/2023 for review later. On 12/05/2023, at approximately 11:59 AM, during the documentation review of the mandatory inspections of the facility's quarterly (every 3 months) fire sprinkler system system inspections for the previous 22 months, identified the system had the following quarterly sprinkler system inspection reports: -12/15/2022. - 3/10/2023 and 8/31/2023.	K 353	Element I No residents were specifically identified as being affected Element II All residents have the potential to be affected Element III Director of Building Services contacted and confirmed schedule with sprinkler company for quarterly inspection. Element IV Director of Building Services or designee will enter these inspections on a tracking software to ensure inspections are completed at proper intervals. Director of Building Services will report at the quarterly QAPI safety committee results and dates of when inspection were performed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 353	Continued From page 9 At approximately 12:55 PM on 12/05/2023, the surveyor asked the facility Administrator and DBS if there were any other quarterly (every 3 months) sprinkler system inspections and could they provide them to the surveyor on 12/06/2023 (day two of survey) for review. On 12/06/2023 at approximately 9:04 AM, the Administrator and DBS provided the following quarterly sprinkler inspections: - 1/28/2022, 5/04/2022 and 9/19/2022. The facility did not conduct a quarterly fire sprinkler system inspection between 03/10/2023 and 8/31/2023. The facility failed to conducted quarterly (every three months) sprinkler inspections for the year 2023 as required per NFPA 25. The Administrator was informed of the deficiency during the survey exit on 12/06/2023 at approximately 12:50 PM. NJAC 8:39-31.2(e) NFPA 25	K 353		
K 911 SS=D	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. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced	K 911		12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ____	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 911	Continued From page 10 by: Based on observation on 12/05/2023 and 12/06/2023, 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 (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 12/05/2023 (day one of survey) during the survey entrance, at approximately 8:55 AM, a request was made to the Administrator (Admin.)	K 911	Element I –No residents were specifically identified as being affected Element II – Potential residents are one or more Element III – GFCI was repaired Element IV – Director of Building Services or designee will conduct quarterly GFCI inspection using a commercial GFCI outlet tester for GFCI outlets and repair or replace as needed and annually by a certified electrician. Director of Building Services will report inspection and any finding at the quarterly QAPI safety committee results and dates of when inspection were performed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ___	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(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 911	Continued From page 11	K 911		

and Director of Building Services (DBS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

The surveyor also asked "How many Resident sleeping rooms are in the facility?" The DBS told the surveyor that there are 65 Resident sleeping rooms in the facility.

A review of the facility provided lay-out identified the facility is a single-story building that has six (6) smoke compartments.

Starting at approximately 9:19 AM on 12/05/2023 and continued on 12/06/2023 in the presence of the facility DBS, a tour of the building was conducted.

During the two (2) day tour of the facility, the surveyor observed and tested seven (7) electrical outlets in wet (with-in 6 feet of a sink) locations with one (1) electrical outlet that failed to de-energize when tested in the following location:

On 12/05/2023:
1. At approximately 10:24 AM, inside Resident room #119, one GFCI electrical outlet, located to the right of the bathroom hand washing sink, when tested with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code.

The DBS confirmed the finding at the time of observations.

The Administrator was informed of the deficiency during the survey exit on 12/06/2023 at approximately 12:50 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING 01 B. WING	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	311 S LIVINGSTON AVE LIVINGSTON, NJ 07039

(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 911	Continued From page 12 NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	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 installations.	K 918		12/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 13 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/05/2023 and 12/06/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 12/05/2023 (day one of survey) during the survey entrance, at approximately 8:55 AM, a request was made to the Administrator and Director of Building Services (DBS) if the facility had an Emergency Generator. The DBS told the surveyor, yes we have one 300 KW Diesel Emergency Generator. On 12/05/2023, during a tour of the building, with the DBS at approximately 9:50 AM, an inspection outside of the building, where the 300 KW Diesel emergency generator was located, was performed. The surveyor observed the emergency stop button was located inside the generator metal housing on the control panel on the generator. At this time, the surveyor asked the DBS, "Do you have a remote emergency stop button for the generator?" The DBS said, "no." The DBS confirmed the finding at the time of inspection.	K 918	Element I –No residents were specifically identified as being affected Element II – All residents have the potential to be affected Element III – Emergency Stop will be installed at the proper location by a certified electrician by 12/27/23 Element IV –Emergency Stop is scheduled to be installed by electrician by 12/27/2023. Director of Building Services or designee will inspect it is operational on monthly basis during load test. Director of Building Services will report at the quarterly QAPI safety committee monthly test results and dates of when inspection were performed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING ______	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 14 The Administrator was informed of the deficiency during the survey exit on 12/06/2023 at approximately 12:50 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315322	A. Building 01 - MAIN BUILDING 01 B. Wing	12/28/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	311 S LIVINGSTON AVE LIVINGSTON, NJ 07039

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 Reg. # NFPA 101 LSC K0222	Correction Completed 12/11/2023	ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 12/11/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 12/27/2023
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 12/13/2023	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 12/11/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 12/27/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
12/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO