| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315303 | A. BUILDING **01**<br>B. WING _____ | **09/21/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **MORRIS VIEW HEALTHCARE CENTER** | **540 WEST HANOVER AVENUE**<br>**MORRISTOWN, NJ 07960** |

| (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<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/14/22, 9/15/22 and 9/16/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy<br><br>The building is a three-story building that was built in 90's, It is composed of Type II protected. The facility is divided into 45 smoke zones. The two facility generators do 100 % of the building.<br><br>1) Cummins 750 KW<br>2) Cat 600 KW<br><br>Currently the 3rd floor is unoccupied due to a renovation project. | K 000 | | |
| K 111 SS=F | Building Rehabilitation<br>CFR(s): NFPA 101<br><br>Building Rehabilitation<br>Repair, Renovation, Modification, or Reconstruction<br>Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following:<br>* Requirements of Chapter 18 and 19<br>* Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6<br>18.1.1.4.3, 19.1.1.4.3, 43.1.2.1<br>Change of Use or Change of Occupancy<br>Any building undergoing change of use or change of occupancy classification complies with the | K 111 | | 9/22/22 |

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

Electronically Signed | 10/14/2022

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| K 111 | Continued From page 1<br>requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2<br>18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7)<br>Additions<br>Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8.<br>18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview from 9/14/22 to 9/16/22, in the presence of the Regional Administrator and Maintenance Director, the facility failed to conduct daily inspection of construction repair, alterations or additions and means of egress are in place and continuously maintained in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.1.4.4, 4.6.10, 4.6.10.1 and 1135 waiver. The deficient practice was evidenced for 2 of 2 renovation projects observed by the following:<br><br>1) Documentation review and interview on 9/15/22, at approximately 2:15 PM, revealed daily inspection of the means of egress and construction areas for the new updated main entrance (currently in progress) were not | K 111 | K111 □ Building Rehabilitation<br><br>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:<br><br>9/16/2022 the Maintenance Director did round of the facility building construction areas and all were found to be hazard | |

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| K 111 | Continued From page 2<br>recorded.<br><br>2) Documentation review and interview on 9/15/22, at approximately 2:45 PM, revealed daily inspection of the renovation project conducted on the [redacted] floor currently (unoccupied) were not recorded.<br><br>The findings were verified by the Regional Administrator and Maintenance Director at the time of the observations, where they indicated no daily logs were completed for the current facility renovation projects.<br><br>The Administrator was notified of the findings at the Life Safety Code exit conference on 9/16/22.<br><br>NJAC 8:39-31.2(e) | K 111 | free.<br><br>2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:<br><br>-All residents have the potential to be affected by the deficient practices<br><br>-9/16/2022 the Maintenance Director created a daily log to document inspection of construction repair, alteration or additions and mean of egress in the construction area of the new updated main entrance and the renovation project on the 3rd floor.<br><br>3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:<br><br>-By 9/16/2022, the facility Maintenance Director was re-educated by the Regional Administrator on the components of this regulation with emphasis on ensuring the facility areas undergoing repair, renovation, modification, or reconstruction, has a change of use or change of occupancy is inspected and complies with this regulation.<br><br>-The daily log book will be in effect when there is active building rehabilitation in progress.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance | |

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| K 111 | Continued From page 3 | K 111 | program will be put into place:<br><br>-Administrator/Designee will review logs monthly and monitor for compliance. The findings will be reported at the monthly QAPI meeting x 90 days. | |
| K 291 SS=F | Emergency Lighting<br>CFR(s): NFPA 101<br><br>Emergency Lighting<br>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<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 9/15/22, in the presence of the Maintenance Director (MD) and Regional Administrator (RA), it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator's four (4) transfer switches, 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 identified for 4 of 4 transfer switches and was evidenced by the following:<br><br>On 9/15/22 at 12:05 PM, the surveyor observed at the ATS# 225, 600, B-3, and C panels, that the area was not equipped with battery back-up emergency lighting, independent of the building's electrical system and emergency generator.<br><br>The MD and RA both confirmed the findings at the time of the observations.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 9/16/22. | K 291 | K291 Emergency Lighting<br><br>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:<br><br>-On 10/05/22, The County Installed battery back-up emergency light above the emergency generator□s four transfer switches.<br><br>2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: | 10/14/22 |

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| K 291 | Continued From page 4<br><br>NJAC 8:39-31.2(e)<br>NFPA 101:2012 - 19.2.9.1, 7.9 | K 291 | -On 10/14/22 The County Fire Marshal□s Office conducted a review of the installed battery back-up emergency light above the emergency generator□s four transfer switches and confirmed they were functioning properly. No concerns were identified at this time.<br><br>-All residents have the potential to be affected by this deficient practice.<br><br>3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:<br><br>-On 9/16/2022 the Administrator verbally educated the Maintenance Director of the findings and the components of this regulation as it pertains to battery back-up emergency light above the emergency generator□s four transfer switches.<br><br>-The functionality of the battery back-up emergency light above the emergency generator□s four transfer switch will be tested monthly and documented findings will be tracked by facility Maintenance Director.<br><br>-Any newly hired Maintenance staff will be educated on these components during orientation.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: | |

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| K 291 | Continued From page 5 | K 291 | -The Maintenance Director will conduct a test of the battery back-up emergency light above the emergency generator□s four transfer switches to ensure it is functioning and document weekly x 4 weeks and then every month in accordance with the New Jersey Uniform Fire Code requirements.<br><br>-Findings of these audits will be provided to the Administrator by the Maintenance Director and reported at the monthly QAPI meeting x 3 months | |
| K 321 SS=E | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler<br>Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops | K 321 | | 12/7/22 |

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| K 321 | Continued From page 6<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review on 9/16/22, in the presence of the Maintenance Director (MD) and Regional Administrator (RA), the facility failed to provide a fire barrier with two hour fire resistance rating in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1 and 8.7.1. The deficient practice was evidenced for 2 of 9 hazardous areas observed.<br><br>1. On 9/16/22 at 10:10 AM, the surveyor observed in the boiler room that approximately 2' of the steel I-beam was not encased fully in fire-rated material.<br><br>2. On that same date at 10:38 AM, the surveyor observed in the storage room marked [redacted] that above the drop ceiling, the exposed I-beam was not fully encased in fire-rated material.<br><br>The findings were verified by the RA and MD at the time of the observations.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 9/16/22.<br><br>NJAC 8:39-31.2(e) | K 321 | K321 Hazardous Areas - Enclosure<br><br>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:<br><br>-The boiler room's steel beam was encased fully in fire-rated material by a contracted vendor.<br><br>-The storage room marked [redacted] had the exposed beam encased in fire-rated material by a contracted vendor.<br><br>2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:<br><br>All residents have the potential to be affected by this deficient practice. | |

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| K 321 | Continued From page 7 | K 321 | At the completion of the contracted work the Administrator/designee will conduct an observational audit of the boiler room steel beam that it has been encased fully in fire-rated material and the storage room marked [redacted] has the exposed beam encased in fire-rated material and report any findings to the Maintenance and the Fire Marshal.<br><br>The Maintenance Director will monitor the spray on fire proofing quarterly.<br><br>3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:<br><br>On 9/16/2022 the Regional Administrator verbally re-educated the facility Maintenance Director on the components of this regulation with emphasis on ensuring a fire barrier is provided with two-hour fire resistance rating for exposed beams.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:<br><br>The Maintenance Director will monitor for compliance monthly and report findings at the monthly QAPI meeting x 3 months. | |
| K 341 SS=F | Fire Alarm System - Installation<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and | K 341 | | 9/28/22 |

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| K 341 | Continued From page 8<br>components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview from 9/14/22 to 9/16/22, in the presence of the Regional Administrator (RA) and Maintenance Director (MD), it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 2 of 2 enclosed courtyards 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<br><br>The deficient practice was evidenced by the following:<br><br>During the building tour on 9/15/22, an inspection of (2) outside area enclosed courtyards were performed. The surveyor observed no evidence of a fire alarm notification (horn/strobe) in the fountain courtyard and the enclosed courtyard next to the fountain courtyard. | K 341 | K 341 Alarm System - Installation<br><br>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.<br><br>1. What corrective action(s) will be accomplished for those residents/Staff found to have been affected by the practice:<br><br>- On 09/28/22 one exterior fire alarm notification device (horn/strobe units) was installed in each of the enclosed courtyard areas.<br><br>2. How you will identify other residents | |

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| K 341 | Continued From page 9<br>An interview was conducted during the observations and the surveyor asked the MD, if there was a horn/strobe, tied into the fire alarm system within the (2) above enclosed courtyards. The MD confirmed that currently there are no horn/strobe tied into the fire alarm system that was observed in the 2-enclosed courtyards.<br><br>The Administrator was notified of the findings at the Life Safety Code exit conference on 9/16/2022.<br><br>NJAC 8:39-31.2(a)<br>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 | K 341 | having potential to be affected by the same practice and what corrective action will be taken:<br><br>- All residents have the potential to be affected by this deficient practice.<br><br>- On 9/19/2022 an observation audit of the courtyard areas was completed and no required additional concerns noted.<br><br>3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:<br><br>- On 9/16/2022, the Regional Administrator re-educated the Maintenance Director on the components of this regulation with emphasis on providing horn/strobes in any enclosed courtyard<br><br>- County of Morris conducts quarterly testing of the system and the Maintenance Director will verify compliance to this standard during monthly inspections. Any adjustments identified will be addressed immediately.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:<br><br>-The monitoring of this tag will be conducted by the Maintenance Director. The Maintenance Director will visually inspect the courtyards weekly x 4 weeks and monthly x 2 months. The testing of | |

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| K 341 | Continued From page 10 | K 341 | the system will be conducted by the county and verified by the Maintenance Director at the end of the quarter.<br><br>-A report of the Maintenance Directors findings will be reported at the monthly QAPI meeting x 90 days. | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 9/14/22, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72.<br><br>This deficient practice had the potential to affect all residents in the facility and was evidenced by the findings below:<br><br>On 9/14/22 at approximately 9:40 AM, in the presence of the facility's Maintenance Director (MD) and Regional Administrator (RA), the surveyor observed that the main fire alarm annunciator panel indicated, "Trouble." The surveyor observed that the amber trouble light was activated in 3 of 3 panels that were | K 345 | K345 Fire Alarm Systems<br><br>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:<br><br>The ground wire that assists in the functionality of the fire alarm annunciator panels were repaired by a contracted | 11/21/22 |

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|---|---|---|---|
| | 315303 | A. BUILDING **01**<br>B. WING _____ | **09/21/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **MORRIS VIEW HEALTHCARE CENTER** | **540 WEST HANOVER AVENUE**<br>**MORRISTOWN, NJ 07960** |

| (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 |
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| K 345 | Continued From page 11<br>observed. The panels indicated trouble "Ground Fault."<br><br>On that same date, the surveyor interviewed the MD and RA, who stated that the trouble issue with the fire alarm annunciator panels were a problem with a ground wire and the 3rd floor renovation. The MD stated that the fire alarm system currently operated normally, but the grounding issue still remained.<br><br>The Administrator was informed of the findings at the Life Safety Code Exit Conference on 9/16/22.<br><br>NFPA 70<br>NFPA 72<br>NJAC 8:39-31.2(e) | K 345 | vendor.<br><br>Work for the ground wire was inspected by EX. Order 26.(4) B1 Fire Marshal.<br><br>2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:<br><br>All residents have the potential to be affected by this deficient practice.<br><br>3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:<br><br>By 09/19/2022, the Chief Compliance Officer re-educated the Maintenance Director on the components of this regulation with emphasis on ensuring the fire annunciator panels are reporting and activated correctly.<br><br>The EX. Order 26.(4) B1 Fire Marshal will report defective equipment and corrective actions taken with their quarterly inspections.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:<br><br>The Administrator/designee will monitor for compliance through EX. Order 26.(4) B1 Fire Marshal inspection reports and discuss findings at the monthly QAPI meeting x 3 months. | |

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| K 363 SS=E | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>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 restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. | K 363 | | 9/22/22 |

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| K 363 | Continued From page 13<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 9/15/22, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.<br><br>This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place.<br><br>This deficient practice was further identified in 7 of 50 residents' room doors observed and was evidenced by the following:<br><br>During the building tour from 9:15 AM to 2:00 PM, the surveyor, Maintenance Director (MD) and Regional Administrator (RA), toured the facility and observed:<br><br>Resident Room # 1409 the door rubbed on the door frame.<br>Resident Room # 1410 the door would not latch into its frame.<br>Resident Room # 1411 The door hardware did not latch into the frame.<br>Resident Room # 1427 The door hardware did not latch into the frame as the door hardware was loose.<br>Resident Room # 2125 The door hardware did not latch into the frame.<br>Resident Room # 2128 The door hardware did not latch into the frame.<br>Resident Room # 2411 The door hardware did not latch into the frame. | K 363 | K363 Corridor Doors<br><br>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:<br><br>By 9/21/2022, 7 resident room doors were repaired to ensure the door didn□t rub on the frame, door hardware latched to the frame, and the door hardware was secure.<br><br>2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:<br><br>All residents have the potential to be affected by the deficient practices.<br><br>09/19/2022, the Maintenance Director and conducted an audit of facility resident doors to ensure that doors didn□t rub on the frame, door hardware latched to the frame, and the door hardware was secure.<br><br>3. What measures will be put into place or what systematic changes you will make | |

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| K 363 | Continued From page 14<br>At the time of observations, the surveyor interviewed the Assistant Maintenance Director and RA, who both confirmed the above findings.<br><br>The Administrator was informed of the findings at the Life Safety Code Exit Conference on 9/16/22.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. | K 363 | to ensure that the practice does not recur:<br><br>09/19/2022, the Maintenance Director was verbally re-educated by the Regional Administrator on the components of this regulation with emphasis on ensuring that facility resident doors to don□t rub on the frame, door hardware latches to the frame, and the door hardware is secure.<br><br>The facility implemented a monthly preventative maintenance system for the resident door testing and subsequent corrective actions.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:<br><br>Administrator/designee will review preventative maintenance logs monthly and monitor for compliance. The findings will be reported at the monthly QAPI meeting x 90 days. | |
| K 374<br>SS=F | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>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 | K 374 | | 12/8/22 |

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| K 374 | Continued From page 15<br>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.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of facility provided documentation from 9/14/22 to 9/16/22, 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.<br><br>This deficient practice was observed for 4 of 12 sets of double smoke doors tested for closure and was evidenced by the following:<br><br>1. On 9/15/22 at 10:28 AM, the surveyor, Maintenance Director (MD) and Assistant Administrator (AA) 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 MD who acknowledged that the smoke doors must resist the passage of smoke to be compliant.<br><br>2. On 9/15/22 at 12:45 PM, the surveyor, MD, and AA observed the set of smoke-doors by resident room number 1401. 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. | K 374 | K374 Subdivision of Building Space<br>-Smoke Barrier<br><br>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:<br><br>-By 9/19/2022 an audit was completed by the Morris County Fire Marshal and Maintenance Director noting that 4 sets of double smoke doors were deficient.<br><br>-12/08/2022 - 4 sets of double smoke doors repaired and inspected by the Morris County Fire Marshal.<br><br>2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:<br><br>-All residents have the potential to be affected by this deficient practice. | |

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| K 374 | Continued From page 16<br><br>3. On 9/15/22 at 1:00 PM, the surveyor, MD, and AA observed the set of smoke-doors by resident room number 1413. The surveyor observed that when the doors released from the magnetic hold-open device and the two doors fully closed, but it was observed that the vertical door astragal was missing on the lower edge approximately 8" from the floor, leaving a gap from 1/4" to 1/2."<br><br>4. On 9/15/22 at 1:48 PM, the surveyor, MD, and AA observed the set of smoke-doors by resident room number 1216. 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. The door remained open approximately 1" from fully closing.<br><br>An interview was conducted with the MD during the observations, MD confirmed and stated that the smoke doors must fully close to resist the passage of smoke, flames, or gases during a fire.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 9/16/22.<br><br>NJAC 8:39-31.2(e) | K 374 | -The Fire Marshal and Maintenance Director conducted an audit of facility smoke barrier doors to ensure that doors create a smoke barrier that when released from the electro-magnet hold, the doors close with no air gap.<br><br>3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:<br><br>10/14/2022, the Administrator educated the facility leadership staff on the components of this regulation with emphasis on ensuring that double smoke doors when released from the electro-magnet hold the door are closed with no air gap and will not rub on the floor.<br><br>-The monthly routine documentation system for the smoke barrier door inspection will be conducted by the Maintenance Director. Identified deficiencies will be reported to and subsequent corrective actions will be initiated by the Morris County Fire Marshal/designee and reviewed by the Administrator.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:<br><br>-The Maintenance Director will inspect all smoke doors each month x 90 days. The findings will be presented to the QAPI committee on a monthly x 3 months. | |

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| K 521 SS=E | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 9/15/22, it was determined that the facility failed to ensure residents' bathroom ventilation systems for eight (8) of 40 units observed, were adequately maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B.<br><br>This deficient practice was evidenced by the following:<br><br>The surveyor in the presence of another surveyor, Regional Administrator (RA) and Maintenance Director (MD) observed that the ventilation in the following residents' bathrooms did not function: 1-D high-side 1424, 1425, 1426, 1427, and 1428.<br><br>The surveyor requested that the MD confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills. When tested, the tissue did not hold in place to confirm apppropriate ventilation. The residents' bathrooms were not provided with a window and required reliance on mechanical ventilation. | K 521 | K521 - HVAC<br><br>1.How the corrective action will be accomplished for those residents found to have been affected by the practice:<br><br>-On 9/16/2022 General Manager Engineer inspected the resident bathroom ventilation systems with no additional findings.<br><br>-On 09/16/2022 General Manager Engineer repaired the connection to the existing ventilation units for rooms, 1424, 1425, 1426, 1427, and 1428.<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>-On 9/16/2022 The General Manager Engineer inspected all rooms requiring ventilation and determined that there were no additional residents that were affected by this practice. | 9/22/22 |

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| K 521 | Continued From page 18<br><br>At that time, the surveyor interviewed the MD and RA who confirmed that the exhaust vents in the above residents' bathrooms were not functioning properly when tested.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 9/16/22.<br><br>NFPA 90 A<br>NFPA 101-2012 -19.5.2.1 section 9.2.2<br>NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1<br>NJAC 8:39-31.2(e) | K 521 | 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur<br><br>-On 9/16/2022 Chief Compliance Officer verbally re-educated the Maintenance Director on the components of this regulation with emphasis on ensuring exhaust ventilation is in working order and reporting deficient vents to the General Manager Engineer.<br><br>4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br><br>-Maintenance Director to monitor 5 resident bathroom ventilation systems weekly x 4 weeks and monthly x 4 months with findings reported at monthly QAPI meeting x 3 months or until team feels results of the monitoring are sufficient. | |
| K 531<br>SS=F | Elevators<br>CFR(s): NFPA 101<br><br>Elevators<br>2012 EXISTING<br>Elevators comply with the provision of 9.4.<br>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.<br>Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and | K 531 | | 11/15/22 |

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| K 531 | Continued From page 19<br>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.)<br>19.5.3, 9.4.2, 9.4.3<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review on 9/14/22, it was determined that the facility failed to ensure that elevators' firefighter's service was operated monthly with a written record for 7 (seven) of 7 (seven) elevator devices, in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.<br><br>This deficient practice was evidenced by the following:<br><br>During record review with the surveyor, Maintenance Director (MD), and Regional Administrator (RA), there was no documented evidence that 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 conformed 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.19.5.3, 9.4.2, 9.4.3).<br><br>An interview was conducted with the MD and RA during the record review and they confirmed | K 531 | K531 Elevators<br><br>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.<br><br>1. How the corrective action will be accomplished for those residents found to have been affected by the practice:<br><br>-By 11/15/2022, 7 of 7 elevator will be inspected with firefighter□s written service records in accordance with NFPA 101, 2012, Edition, Section 19.5.3, 9.4.2, 9.4.3.<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>-All residents have the potential to be affected by this practice. | |

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| K 531 | Continued From page 20<br>currently there is no firefighter's monthly service log.<br><br>It was noted that 2 (two) of 7 (seven) elevators were out of service at the time of the building survey.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 9/16/22.<br><br>NJAC 8:39-31.2(e)<br>NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. | K 531 | 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur<br><br>-On 9/16/2022 Chief Compliance Officer verbally re-educated the Maintenance Director on the components of this regulation with emphasis ensuring that 7 of the 7, elevator firefighter□s written service records are visible and available for elevator inspection.<br><br>-Written firefighter□s service records will be posted, visible and available for elevator inspection.<br><br>4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br><br>-Maintenance Director to monitor elevators 2 x per month x 3 months to confirm that written firefighter□s service records are posted, visible and available for elevator inspection. All findings will be reported to monthly QAPI meeting x 3 months. | |
| K 918<br>SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second | K 918 | | 9/30/22 |

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|---|---|---|---|
| | 315303 | A. BUILDING **01**<br>B. WING _____ | **09/21/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **MORRIS VIEW HEALTHCARE CENTER** | **540 WEST HANOVER AVENUE**<br>**MORRISTOWN, NJ 07960** |

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| K 918 | Continued From page 21<br>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.<br>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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview, and review of facility documents on 9/16/22, in the presence of the Maintenance Director (MD) and Regional Administrator (RA), it was determined that the facility failed to a.) certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency | K 918 | K918 Electrical Systems- Essential Electrical Systems<br><br>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan | |

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| K 918 | Continued From page 22<br>electrical generator systems and b.) ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.<br><br>This deficient practice was evidenced for 2 (two) of 2 (two) generator logs provided by the MD by the following:<br><br>1. On 9/15/22, a review of the generator records for the previous twelve months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the county owned building's boiler operator was performing the monthly load tests, but he was not recording the required transfer times on the current testing log provided on 2 (two) of 2 (two) generators for 12 of 12 load tests observed on the 2 (two) logs provided by the Boiler Operator.<br><br>An interview was conducted with the MD, RA, and Boiler operator at the time of record review, who confirmed no transfer times were currently on the facility log's provided for 2 (two) of 2 (two) generators.<br><br>2. On 9/15/22 at 12:40 PM, the surveyor, MD, and RA observed that the facility's two (2) generators did have a remote shutoff.<br><br>An interview was conducted during the observation with the MD and RA who stated that they were aware that the two generators did not have a remote manual stop station to prevent inadvertent or unintentional operation located (remote) of the enclosure housing the prime mover. The RA indicated that a work order was | K 918 | of correction is prepared and/or executed solely because required.<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:<br><br>-9/30/2022, the Manager Engineer coordinated the required transfer load test to ensure 2 of 2 the generators were functioning as designed and transferred power to the building and was within the required 10-second time frame and documented as such.<br><br>-Manager Engineer was verbally educated on the requirement of documenting generators transferred power to the building.<br><br>-Morris County Electrician installed a 2 manual stop stations outside the building.<br><br>2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:<br><br>-All residents have the potential to be affected by this deficient practice.<br><br>-9/30/2022, the Manager Engineer coordinated the required transfer load test to ensure the generators were functioning as designed and transferred power to the building and was within the required 10-second time frame and documented as such. | |

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| K 918 | Continued From page 23<br>generated for the installation of the remote shut-off devices.<br><br>Locations : outside Cummins 750 KW<br>interior Cat 600 KW<br><br>The Administrator was informed of the findings at the Life Safety Code Exit Conference on 9/16/22.<br><br>NJAC 8:39-31.2(e), 31.2(g)<br>NFPA 99<br>NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.<br>NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems | K 918 | Added time within the comments section of the existing Emergency Generator Run Log.<br><br>3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:<br><br>-09/16/2022, the Regional Administrator verbally re-educated the Manager Engineer and the facility Maintenance Director on the components of this regulation with emphasis on ensuring required maintenance testing of the facility generator is conducted per guidelines and documented as such.<br><br>-09/16/2022, the Regional Administrator verbally re-educated the Manager Engineer and the facility Maintenance Director on the need for two manual stop stations.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:<br><br>-The Administrator/designee will audit the generator test log form monthly x 90 days and the findings will be reported at the monthly QAPI meeting monthly x 3 months.<br><br>-Morris County Manager Engineer will inspect the manual stop station during monthly maintenance and report any discrepancies to the Administrator. | |

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| K 918 | Continued From page 24 | K 918 | Administrator will bring findings to the QAPI meetings. | |