STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING _____	**03/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

(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 The nursing home building construction was stated to be 1990's with no current major renovations or noted additions. It is a one story building Type II (111) construction and is fully sprinklered. The outside 175 KW diesel generator does approximately 40% of the building. The building utilizes an electric fire pump to support the fire sprinkler system. The floor plan indicates 14- smoke zones throughout the facility. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 180 certified beds. At the time of the survey the census was 106. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101	K 211		4/21/23

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

Electronically Signed | 04/14/2023

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 211	Continued From page 1 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 interviews and documentation review on 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was identified for 8 of 9 fire doors observed and was evidenced by the following: On 3/28/23 at approximately 9:45 AM, the surveyor asked the MD and RPOD to provide the annual testing requirements for fire door assemblies in accordance with NFPA 80. The MD stated that currently the facility did inspect fire doors and the last inspection was completed by the previous Maintenance Director. The documents provided by the (current) Maintenance Director were dated 3/1/22. The following information on the "annual inspection of swinging fire door assemblies" were provided revealing that 8 out of 9 reports indicated under "inspection Activity" #4 "are there any missing or broken parts". The report indicated "YES" and the comment section on the form was "BLANK". The MD and RPOD could not provide any further information, and both stated they did not realize the reports indicated: "missing or broken parts"	K 211	The annual fire door inspection was done on 06/30/2022 by [redacted] Commercial. All residents have the potential to be affected. All fire doors in facility were tested as per required annual fire door test. Annual inspection of fire doors to be completed annually. A new form for the "annual inspection of swinging fire door assemblies" is being created to ensure that all issues on report are not overlooked and are addressed promptly. Regional Director of Maintenance to educate the Director of Maintenance on this new form. Annual Fire Door Inspection Report is to be filed in Maintenance log by Maintenance Director or designee. Director of Maintenance or Designee to ensure annual inspection of fire doors. Upon completion of inspection, Director of Maintenance or Designee to give Annual Fire Door Inspection report to Administrator or Designee to ensure all issues have been addressed and that doors are functioning properly. Annual Fire Door Inspection Report to be reviewed by administrator at quarterly	

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K 211	Continued From page 2 for 8 out of 9 fire doors on the 3/1/22 annual inspection of swinging fire door assemblies and they could not provide any further information. The Licensed Nursing Home Administrator was informed of the finding at the Life Safety Code Exit Conference on 3/29/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80: Standard for fire doors assemblies and other opening protectives NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	QAPI meeting directly following inspection for 12 months.	
K 222 SS=F	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	K 222		4/21/23

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K 222	Continued From page 3 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 detection system and an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 4 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review on 3/29/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD) it was determined that the facility failed to provide exit doors 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 This deficient practice was identified for 3 of 9 sets of exterior egress doors and was evidenced as follows: On 3/29/23 at 09:50 AM, the surveyor in the presence of the MD and RPOD observed a testing of the fire alarm system to test the operation of the facility nine (9) fire doors. The activation of the fire alarm system revealed 3 of 9 fire doors did not release and open as designed. The three (3) doors were located in the EX. Order 26.(4) B1 wing identified as: Applewood EX. O hall 23 zone left door # 25 right door # 26 Applewood EX. O hall 21 zone left door # 28 right door # 29 Applewood EX. O hall 20 zone left door # 30 right door # 31 The three (3) doors were provided with an emergency door release indicating when activated the door would open in 15-seconds. The three (3) fire doors did not open when the fire	K 222	1) On 03/30/2023 EX. Order and EX. Order 26.(4) EX. Order 26.(4) B1 came and replaced the relays on all of the affected doors on EX. Order 26.(4) B1 thereby enabling all of the electrical locks to release upon fire alarm engagement. The means of egress is readily accessible and free of all obstructions and/or impediments to allow for full instant use in case of fire or other emergencies. 2) In services were conducted on 03/30/2023 for all staff to ensure that they were aware of the emergency door release that activated the egress set of doors in 15 seconds. All residents on EX. Order 26.(4) B1 had the potential to be affected. All egress doors throughout the facility were tested for functionality of release upon fire alarm engagement. Regional Director of Maintenance to educate Director of Maintenance/Designee to test all exit doors on Applewood weekly for 3 months and monthly thereafter facility wide to ensure the electrical locks release upon fire alarm engagement. Results of monthly tests will be brought by Director of Maintenance or Designee to monthly QAPI meeting for 3 months to be reviewed by Administrator or Designee to determine compliance.	

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K 222	Continued From page 5 alarm was activated in 15-seconds. The newly hired Maintenance Director and newly hired Regional Plant Operations Director both indicated that they did not conduct a test of the fire alarm system and did not check the operation of the fire doors to see if they opened when the system was activated at this time since they were hired. The three (3) most recent fire drills that were completed by the fire drill vendor dated: 3/27/23, 2/27/23, and 1/29/23. The documents did not indicate when a fire drill was conducted and that any fire doors were tested for proper operation. A review of the most recent fire alarm system inspection and testing form from the facility vendor dated 6/30/22, included under "auxiliary control & functions tests and inspections" device type that door control/release was checked for visual, functional and pass. The document confirmed all door control/release features PASSED and no other comments were provided. The facility provided a policy statement for "exits" dated 10/1/22, which included that "it is the responsibility of all personnel to keep exit-ways clear always and report such violation to his or her immediate supervisor." Interviews were conducted after the fire alarm test was conducted with the following staff members of the Applewood unit: On 3/29/23 at 10:14 AM, the surveyor interviewed the newly hired Licensed Practical Nurse (LPN) who confirmed that they were aware of the "emergency door release" that activated the	K 222		

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K 222	Continued From page 6 egress set of doors in 15-seconds. On 3/29/23 at 10:18 AM, the surveyor interviewed the Part-time (PT) LPN who confirmed that they were aware of the "emergency door release" that activated the egress set of doors in 15-seconds. On 3/29/23 at 11:15 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who confirmed that they were aware of the "emergency door release" that activated the egress set of doors in 15-seconds. On 3/29/23 at 11:20 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who confirmed that they were aware of the "emergency door release" that activated the egress set of doors in 15-seconds. An interview was conducted with the Maintenance Director and Regional Plant Operations Director, and both stated that the facility fire door vendor was called and notified of the findings and responded immediately to identify the issue. The Licensed Nursing Home Administrator was informed of the findings during and at the Life Safety Code Exit Conference on 3/29/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration	K 291		4/17/23

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K 291	Continued From page 7 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 3/29/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to provide a battery back-up emergency light above the electric fire pump transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 19.2.9.1.- 7.9.1 (general). This deficient practice was identified for 1 of 1 transfer switches and was evidenced by the following: On 3/29/23 at 11:14 AM, the surveyor in the presence of the RPOD and MD, observed one fire pump transfer switch, inside the fire pump electrical room. The general area was not provided with any emergency lighting. The RPOD and MD both confirmed the findings at the time of the observation. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit on 3/29/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	On 04/05/2023 battery back-up emergency lights were installed in the sprinkler rooms above the electric fire pump transfer switch. All residents had the potential to be affected. Audit conducted on any transfer switch in building for emergency lighting requirement. Regional Director of Maintenance educated Director of Maintenance on requirement of emergency lighting above transfer switch. Director of Maintenance/designee to check for proper functioning of battery back-up emergency lights weekly for 4 weeks and then monthly thereafter for two months. Director of Maintenance/designee to report findings of audits to Administrator at monthly QAPI meeting for 3 months to determine compliance.	
K 293 SS=E	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		4/21/23

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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 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the facility failed to provide exit signs showing the direction of travel, in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 3 of 25 exit signs observed and was evidenced by the following: On 3/28/23 at 10:28 AM, the surveyor in the presence of the Maintenance Director and Regional Plant Operations Director observed that the exit/egress corridor was not provided with illuminated exit signs. The set of smoke doors by the EX. Order 26.(4) B1EX. Order 26.(4) B1 unit intersection were not provided with an illuminated exit sign on either side of the smoke doors. The long exit/egress corridor leading to the lobby/green house exit was not provided with an exit sign and until you walked three quarters of the way to the lobby exit, it was not obvious where the exit was located. The findings was verified by the Maintenance Director and Regional Plant Operations Director at the time of the observations. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 3/29/23.	K 293	On 04/11/2023 three new exit signs were installed. They are located on either side of the set of smoke doors by the EX. Order 26.(4) B1 unit as well as the long exit/egress corridor leading to the lobby/greenhouse exit. The exit signs show the direction of travel to reach the nearest exit. All residents have the potential to be affected by this deficient practice. Facility wide audit was conducted to ensure appropriate exit signage is located in required locations. Regional Director of Maintenance to educate Director of Maintenance/Designee on exit signage location requirements. Director of Maintenance/designee to conduct weekly audits for 1 month then monthly for 2 months to ensure all signage in proper locations and illuminated. Results of audits to be reviewed by Administrator or Designee on monthly QAPI meeting for 3 months to ensure compliance.	

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K 293	Continued From page 9 NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. NJAC 8:39-31.2(e)	K 293		
K 345 SS=F	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 observation, interview, and document review on 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the facility failed to ensure a). smoke detection sensitivity testing was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. and .b) to provide an updated fire alarm system & testing inspection report as per NFPA 70 & 72. The deficient practice was identified for 2 of 2 inspection reports and was evidenced by the following: On 3/28/23 at 11:10 AM, the surveyor reviewed all related fire alarm documentation provided by the MD from the fire alarm vendor to determine if the sensitivity test was performed. The reports were dated 12/15/22 (Company Name #1 redacted)	K 345	Annual smoke detection sensitivity test and fire alarm system and testing inspection was completed on 06/30/2022. On page 2 of the annual inspection and test report all smoke detectors are shown to pass annual test. All smoke detectors were audited to ensure compliance. Inspections will continue to occur annually. Next inspection due to be completed by June 30, 2023. Regional Director of Maintenance to educate Director of Maintenance or Designee to ensure copy of Annual Fire Alarm and Testing Inspection report is filed in Maintenance log. Director of Maintenance/designee will conduct monthly audit for 3 months to ensure proper paperwork reports are filed in Maintenance log.	4/21/23

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K 345	Continued From page 10 and 6/30/22 (Company Name #2 redacted). The reports provided did not indicate any information on the testing of the smoke detector for sensitivity. An interview was conducted with the MD and RPOD during document review who both indicated they were not sure if the required sensitivity test for the facility smoke detectors were performed. The MD contacted the facility fire alarm vendor to see if sensitivity report was performed, and no further documentation was provided. On 3/28/23 at 11:40 AM, during document review the surveyor reviewed all fire alarm documentation from the fire alarm vendor. The inspection reports were dated 12/15/21 and 6/30/22 were inspected on a semi-annual basis. The current date of 3/28/23 indicated the last inspection was conducted almost 9-months ago. The fire alarm system utilizes sealed lead acid batteries as a backup and requires the semi-annual inspection as per NFPA 70 & 72. An interview was conducted with the MD during document review, and he stated that he was informed that the fire alarm inspection was only conducted on an annual basis, no further information was provided. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code Exit conference on 3/29/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	Administrator or Designee to review results of audits of Annual Fire Alarm and Testing Annual Inspection report in Maintenance log during monthly QAPI meeting for 3 months to determine compliance.	

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K 353	Continued From page 11	K 353		
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 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: Based on interview and record review on 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to a.) annually inspect 2 of 2 private property fire hydrants as per NFPA 25 and b). to ensure that their automatic sprinkler system was inspected/tested at the required 5-year interval in accordance with the National Fire Protection Association (NFPA) 25. This deficient practice was evidenced by the following: On 3/28/23 at approximately 11:30 AM, the surveyor reviewed all related documentation from the fire sprinkler vendor. The reports did not	K 353	Electronic Security Solutions has been contracted to perform the annual inspection private property fire hydrant as well as to perform the 5 year automatic sprinkler system test/inspection. All residents have the potential to be affected. All fire hydrants on private property assessed for inspection compliance. Regional Director of Maintenance in serviced Director of Maintenance on the importance of performing the annual test on 2 of 2 private property fire hydrants as well as then need to perform the	4/28/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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K 353	Continued From page 12 indicate any annual inspection of the two (2) private fire hydrants on the facility's property as required by NFPA 25. The MD and RPOD both indicated that the annual fire hydrant inspection requirement was not performed, and no further documentation was provided. During document review, the surveyor reviewed all fire sprinkler inspection reports dated: 1/31/22, 4/28/22, 7/28/22, 10/28/22, and 1/30/23. The inspections did not indicate the fifth-year internal observation of the fire sprinkler pipe investigation was completed. The MD and RPOD both stated that they were unsure if the inspection was completed and could not provide any further information from the fire sprinkler vendor indicating so. NFPA 25 requires an internal inspection of the fire sprinkler system piping every five years; this needs to be conducted to inspect for the presence of foreign organic material that can cause obstructions to pipe and sprinklers. The Licensed Nursing Home Administrator was notified of the findings at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 25	K 353	inspection/test on the automatic sprinkler system every 5 years. Director of Maintenance to audit annual inspection report of 2 of 2 fire hydrants as well as report five year test/inspection on automatic sprinkler system monthly for 3 months to ensure appropriate documentation is logged in Maintenance log for compliance. Director of Maintenance or Designee to bring reports from annual test of 2 of 2 private property fire hydrants as well as 5 year automatic sprinkler system test/inspection and audit results to monthly QAPI meeting x3 months for Administrator or Designee to check for compliance.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K 363		4/21/23

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K 363	Continued From page 13 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. 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 3/29/23,	K 363	1) EX. Order 26.(4) B1 doors EX. Order 26.(4) B1 –	

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K 363	Continued From page 14 in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), 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. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in [redacted] resident room doors observed and was evidenced by the following: During the building tour on 2/29/23 from 9:15 AM to 2:00 PM, the surveyor in the presence of the MD and RPOD toured the facility and observed the following: Resident Room doors: [redacted] wing: [redacted] door did not latch [redacted] door did not latch [redacted] door did not latch [redacted] door did not latch [redacted] door did not latch [redacted] door stuck into frame [redacted] wing: [redacted] top of door warped [redacted] top of door warped [redacted] top of door warped and loose hardware [redacted] door did not latch [redacted] door did not latch [redacted] door did not latch	K 363	were repaired to latch properly. [redacted] repaired to not stick to frame. [redacted] doors [redacted] were repaired. [redacted] loose hardware repaired. #[redacted] were repaired to latch properly. [redacted] doors #[redacted]-adaptive chair and wheelchair were removed. [redacted] was repaired. [redacted] was repaired to not stick to frame and to latch properly.2) All resident room doors to be inspected to ensure that all resident rooms close completely to properly confine fire and smoke products and to properly defend occupants in place All residents have the potential to be affected. All resident room doors to be inspected to ensure that all resident rooms latch properly. Director of Maintenance or Designee to inspect resident room doors weekly for four weeks and then monthly for two months to ensure that all resident rooms latch properly when being closed. Results of this inspection should be brought by Director of Maintenance or Designee monthly to Administrator or Designee. Administrator or Designee to review audit results during monthly QAPI meeting for 3 months to ensure compliance.	

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K 363	Continued From page 15 EX. C Order 26.(4) B wing: EX. Orde door hitting an adaptive chair EX. Orde door hitting resident wheelchair EX. Orde door stuck into frame EX. Orde door stuck into frame and did not latch At the time of observations, the surveyor interviewed the MD and RPOD, who both confirmed the above findings. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.1(c), 31.2(e) 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		
K 522 SS=F	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 3/29/23 in the presence of the Maintenance Director (MD)	K 522	A cover plate was placed over exposed wires in mechanical rooms on EX.EX. Order 26.(4) B,	4/21/23

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K 522	Continued From page 16 and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide combustion air from the outside to fuel fired HVAC units. This deficient practice was evidenced for 3 of 3 mechanical rooms by the following: 1). On 3/29/23 at 11:48 AM, the surveyor observed in the EX. Order 26.(4) B1 unit mechanical room that the back wall was provided with a make-up air ventilation system. The MD and RPOD indicated the system was not in operation as the electric motors had exposed wires and seemed to be disconnected and inoperable at the time of observation. The door to the mechanical door did not close freely as the make-up air was being taken from the occupied exit/egress corridor and resident rooms to now supply air to the HVAC system. 2). On 3/29/23 at 12:08 PM, the surveyor observed in the EX. Order 26.(4) B1 unit mechanical room that the back wall was provided with a makeup air ventilation system. The MD and RPOD indicated the system was not in operation as the electric motors had exposed wires and seemed to be disconnected and inoperable at the time of observation. The MD indicated the HVAC system was out of service at the time of observation and will be replaced. 3). On 3/29/23 at 12:54 PM, the surveyor observed in the EX. Order 26.(4) B1 unit mechanical room that the back wall was provided with a make-up air ventilation system. The MD and RPOD indicated the system was not in operation as the electric motors had exposed wires and seemed to be disconnected and inoperable at the time of observation. The door to the mechanical door did	K 522	EX. Order 26.(4) B1 and EX. Order 26.(4) B1. A door closer was put on doors on mechanical rooms in EX. Order 26.(4) B1 and EX. Order 26.(4) B1 to ensure doors close freely and no longer take air from the occupied exit/egress corridor to supply air to the HVAC system. All residents have the potential to be affected. Facility wide audit conducted to ensure vented air from outside only. Regional Director of Maintenance to inservice Director of maintenance on the requirement to ensure that all exposed wires are covered and that mechanical doors should close freely and not take up make up air from the occupied exit/egress corridor and resident rooms to supply air to the HVAC system. Director of Maintenance or Designee to check for proper closure of mechanical room doors on all unit for 4 weeks and then monthly thereafter for 2 months. Director of Maintenance or Designee to report findings of audit to Administrator or Designee at monthly QAPI meeting for 3 months to determine compliance.	

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K 522	Continued From page 17 not close freely as the make-up air was being taken from the occupied exit/egress corridor and resident rooms to now supply air to the HVAC system. An interview was conducted with the MD and RPOD who both stated that they were unsure about the operation of the make-up air systems in the three (3) mechanical rooms observed and agreed 2 of 3 rooms when the doors were closed slowly were taking air from the atmosphere of the occupied area. The Licensed Nursing Home Administrator was informed of the findings at the [redacted] exit conference on 3/29/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.5.2.2 (1) (c) they shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area.	K 522		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712		4/21/23

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K 712	Continued From page 18 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview and document review on 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 10 of 12 fire drills and was evidenced by the following: A review of the facility fire drill reports revealed method for the simulation of emergency fire conditions were not varied and specific to location for 10 of 12 fire drills. The drills should include date; type of alarm transmission: pull, smoke or page; specific location, what was the topic of the drill; and how do staff respond with no specific location? The reports identified the following: 3/25/22 smoke, laundry, page 4/15/22 smoke and flame due to electrical fire, EX. Order 26.(4) B1 unit where? 5/23/22 smoke, rehab 6/22/22 smoke, rehab, page 8/21/22 smoke and fire due to electrical fire, Applewood 9/25/22 smoke, EX. Order 26.(4) B1 page, where? 10/19/22 smoke in hall, EX. Order 26.(4) B1 unit, from what? 11/28/22 smoke, dietary, what happened? 12/13/22 smoke, EX. Order 26.(4) B1, page only, where? 1/29/23 electrical fire, EX. Order 26.(4) B1, room EX. O, area of room? 2/27/23 smoke and flame due to electrical fire	K 712	Regional Maintenance Director in serviced EX. Order 26.(4) B fire safety director on 04/05/2023 on noted deficient drills on 3/25/22, 4/15/22, 5/23/22, 6/22/22, 8/21/22, 9/25/22, 10/19/22, 11/28/22, 12/13/22, 1/29/23, 2/27/23, 3/27/23 on the importance of conducting fire drills with at expected and unexpected times, at least quarterly on each shift, varying activation types and simulation of specific emergency fire conditions and specific locations. All residents have the potential to be affected. Audit conducted on all fire drills to ensure compliance. Maintenance Director or Designee to audit future drills to ensure fire drills are held at expected and unexpected times, at least quarterly on each shift, with varying activation types and simulation of specific emergency fire conditions and specific locations. Fire drill audits will be done monthly for 3 months by Director of Maintenance/designee to ensure compliance. Director of Maintenance or designee to report findings of fire drill audits to Administrator or Designee at monthly QAPI meeting for 3 months to determine compliance.	

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K 712	Continued From page 19 Where? 3/27/23 smoke, faulty heater, [redacted] room [redacted], page An interview was conducted with the MD after documentation review, where he stated and confirmed the findings that current fire drills included the transmission of a fire alarm signal and simulation of emergency fire conditions were not identified, varied, and specific to areas for 10 of 12 fire drills documented on the forms. In addition, 5 of 12 alarm activations were page; no fire alarm pull stations were activated and no smoke detectors were activated. The Licensed Nursing Home Administrator was informed of the finding's at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.2(e)	K 712		
K 914 SS=E	NFPA 101 Life Safety Code 2012 edition 19.7.1.4 Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this	K 914		4/28/23

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K 914	Continued From page 20 manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and documentation review on 3/29/23, in the presence of the facility's Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 31 of 50 resident rooms observed by the following: On 3/29/23 from approximately 9:30 AM to 1:30 PM, the surveyor, MD, and RPOD observed resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection in the following resident rooms: EX. Order 26.(4) B1 unit: #EX. Order 26.(4) B1 EX. Order 26.(4) B1 unit: EX. Order 26.(4) B1 EX. Order 26.(4) B1 unit: EX. Order 26.(4) B1 A review of the last annual electrical inspection from the facility vendor dated 12/30/21, did not indicate any testing of resident room outlets.	K 914	All electrical receptacles in EX. Order 26.(4) B1 resident's room #'s EX. Order 26.(4) B1, EX. Order 26.(4) B1 were tested for grounding, polarity and blade tension. EX. Order 26.(4) B1 room #'s EX. Order 26.(4) B1 EX. Order 26.(4) were tested for same. EX. Order 26.(4) B1 room #'s 1EX. Order 26.(4) B1 were tested for same. All residents with less than hospital grade electrical receptors in their rooms have the potential to be affected. Receptacles in all resident rooms were tested by Maintenance director/designee to ensure compliance. Regional Director of Maintenance in serviced Director of Maintenance on the importance of annual testing of electrical receptacles in residents' rooms that are less than hospital grade. Director of Maintenance or Designee to audit all electrical receptacles with less than hospital grade electrical receptors weekly for 4 weeks and then monthly for 2 months and then annually thereafter to ensure all required testing is being performed timely. Director of Maintenance or Designee to	

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K 914	Continued From page 21 The MD and RPOD indicated that the facility did not have any electrical testing log on-site at this time. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.2(e) NFPA 99	K 914	report findings to Administrator or Designee at quarterly QAPI meetings x4 meetings to determine compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		4/21/23

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K 918	Continued From page 22 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 observations, interview, and review of facility documents on 3/28/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was identified for 1 of 1 generator logs provided by the MD and the evidence was as follows: On 3/28/23 at 10:25 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the Maintenance Director was performing weekly generator testing, but did not indicate on the provided document when he was conducting the monthly load testing that would include the required transfer times. An interview was conducted with the MD and RPOD, during document review and they stated that currently the transfer time was not provided on the current document. They stated that the	K 918	Generator log was updated to show that the generator will start to transfer power to the building within 10 seconds during monthly load testing. All residents have the potential to be affected. All generator logs were audited by maintenance director to ensure appropriate documented transfer times on generator logs Regional Director of Maintenance in serviced Director of Maintenance that all monthly generator load testing must show that the generator will start to transfer power to the building within 10 seconds. Director of Maintenance or Designee to audit documention in updated log that the generator will start to transfer power to the building within 10 seconds during monthly load testing monthly for 3 months. Director of Maintenance or Designee to report finding of audits to administrator at monthly QAPI meetings for 3 months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING _____	**03/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 23 current document needed to be updated and required a separate column for identifying monthly load testing and transfer times. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		