PRINTED: 10/20/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	CON		OATE SURVEY OMPLETED
		315503	B. WING _			03/08/2023
	ROVIDER OR SUPPLIER  JITES HEALTH CARE 8	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S	K 0	00		
	stated to be in 2007 with no current additions. It is a three construction and is f 150 KW natural gas approximately 60 % fire pump is utilized sprinkler system.  There is supervised the corridors, spaced resident rooms. The is stated to be tied to cross corridor door he door releases, emer safety components of the facility utilized 1 regulatory flexibilities. Emergency for routing maintenance requires 2020. The flexibilitie following items: fire fire extinguisher more operation monthly to testing of generators.	of the building. An electric to provide support to the fire smoke detection located in sopen to the corridors and in generator outside the facility to the fire alarm control panel, hold open devices, exterior gency facility lighting and life utilized for preservation of life 135 waivers allowing for so during the Public Health the inspection, testing and ements beginning January 31, as did not extend to the poump weekly/monthly testing, anthly inspections, fire fighter esting for elevators, monthly so, and daily inspection of the areas of construction, repair,				
	The facility has 186 of the survey the cer	at certified beds. At the time nsus was 157.				
K 291	NOT MET as eviden Emergency Lighting	42 CFR Subpart 483.90(a) is ced by:	K 2	91		4/18/23

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

03/22/2023

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

**Electronically Signed** 

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G <b>02</b>	(X3) DATE COMF	E SURVEY PLETED
		315503	B. WING _		03.	/08/2023
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 291 SS=F	is provided automati 18.2.9.1, 19.2.9.1 This REQUIREMEN by: Based on observati 03/08/2023, in the p Director (RD) and M was determined that battery back-up emetransfer switches (fir independent of the k and emergency gen NFPA 101:2012 - 19 deficient practice was witches and was even to the the (RD) and (MD), switch, ATS-1 inside The room was provifixture, but when the the emergency light the battery may be considered area was not emergency lighting.	of at least 1-1/2-hour duration cally in accordance with 7.9.  T is not met as evidenced on and interview on resence of the Regional aintenance Director (MD), it is the facility failed to provide a ergency light above the (2) the pump and generator) ouilding's electrical system the erator, in accordance with 1.2.9.1 7.9.1 (general) This is identified for 2 of 2 transfer or videnced by the following:  Surveyor in the presence of observed 1 generator transfer the main electrical room. It is identified for 2 of 2 transfer the main electrical room. It is identified for 2 of 2 transfer the main electrical room. It is identified for 2 of 2 transfer the main electrical room. It is identified for 2 of 2 transfer the main electrical room. The observed 1 fire pump transfer the pump electrical room. The intervioled with any	K 2	I. Corrective action(s)accomplis resident(s)affected:  "No residents were identified a effected by this practice.  "The emergency light fixture inside the main electrical room wareplaced, tested, and is functional. battery back up light.  An emergency backup light winstalled for the fire pump transfer inside the fire pump electrical room light was tested and is functional. I battery backup light.  II. Residents identified having the potential to be affected and correct action taken:  "Residents residing in the facilithe potential to be affected by this deficient practice. No residents we identified as being negatively impair.  III. Measures will be put into place ensure the deficient practice will not make the deficient practice.	e located s. It has a vas switch, n. The lt has a e tive ere eacted.	
	the time of the obse	as informed of the findings at		Maintenance Director that the eme lighting for the generator transfer s and fire pump transfer switch are r and must be checked for function independent of the buildings electr	switch required	

			(X3) DATE COMF	SURVEY PLETED			
		315503	B. WING _			03/	/08/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROYAL SU	JITES HEALTH CARE & I	REHABILITATION			4 WEST JIMMIE LEEDS ROAD ALLOWAY TOWNSHIP, NJ 08205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 291	CFR(s): NFPA 101  Cooking Facilities Cooking equipment is with NFPA 96, Standa and Fire Protection of Operations, unless: * residential cooking a appliances such as m toasters) are used for cooking in accordanc * cooking facilities ope compartments with 30 with the conditions un or * cooking facilities in secondary	exprotected in accordance and for Ventilation Control Commercial Cooking equipment (i.e., small dicrowaves, hot plates, food warming or limited e with 18.3.2.5.2, 19.3.2.5.2 en to the corridor in smoke or fewer patients comply der 18.3.2.5.3, 19.3.2.5.3, smoke compartments with comply with conditions under	Ka	291	system and emergency generator.  The Maintenance Director/designwill audit the emergency backup lights weekly times 4 weeks, then monthly to assure function. Any corrective actions required will be done immediately by Maintenance.  IV. Corrective actions will be monitore ensure the deficient practice will not remained the monitore ensure the deficient practice will repeated the follow-up actions as necessary.  The Administrator will trend report outcomes to the Quality Assurance (Quanters, with follow-up recommendations as necessary.	ed to cur: ort kly, t A)	4/18/23

DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG <b>02</b>		TE SURVEY MPLETED
	315503	B. WING _		0	3/08/2023
VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FEO LIEALTIL CADE O I	DELLA DIL ITATIONI		214 WEST JIMMIE LEEDS ROAD		
IES HEALIH CARE & I	REHABILITATION		GALLOWAY TOWNSHIP, NJ 08205		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
Cooking facilities protoer 9.2.3 are not requazardous areas, but corridor.  18.3.2.5.1 through 18	ected according to NFPA 96 ired to be enclosed as shall not be open to the .3.2.5.4, 19.3.2.5.1 through	К3	24		
Based on observation 23/08/23, in the preservation 23/08/23, in the preservation Director (ID) of the control o	n, interview and review, on ence of the Regional Plant RPOD) and Maintenance determined that the facility of 2 kitchen ansul system inspected monthly in A 96 and NFPA 10.  was evidenced by the surveyor, RPOD and MD to kitchen, that the monthly ank and no required monthly all system was logged.  Surveyor, RPOD and MD to kitchen, that the monthly all system was logged.  Surveyor, RPOD and MD to kitchen, that the monthly ank and no required monthly all system was logged.  Syor interviewed the MD and firmed that the ansul g's was not completed and		resident(s)affected:  " No residents were identified hany negative impact from this defipractice.  II. Residents identified having the potential to be affected and correct action taken:  " This deficient practice had the potential to affect all residents residents residents residents and the monthly inspected, and the monthly inspected and logged.  III. Measures will be put into place ensure the deficient practice will now the Maintenance Director regar Ansul system smonthly inspected and the information must be logged.  " The Maintenance Department/Designee will continue ensure that monthly Ansul inspection."	naving icient ne ctive e iding in ection ce to not recur: ducation iding the on tag ination et to to to tag ination et to to to tag ination et to to to to tag ination	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page Cooking facilities protoner 9.2.3 are not requinazardous areas, but corridor.  18.3.2.5.1 through 18. 19.3.2.5.5, 9.2.3, TIA  This REQUIREMENT by: Based on observation 03/08/23, in the presence of the	DISTRIBUTION NUMBER:  315503  DIVIDER OR SUPPLIER  TES HEALTH CARE & REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as nazardous areas, but shall not be open to the corridor.  18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  This REQUIREMENT is not met as evidenced by:  Based on observation, interview and review, on 13/08/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to ensure that 2 of 2 kitchen ansul system inspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10.  The deficient practice was evidenced by the following:  1). At 11:17 AM, the surveyor, RPOD and MD observed in the (meat) kitchen, that the monthly inspection tag was blank and no required monthly inspection tag was not completed and	DENTIFICATION NUMBER:  315503  B. WING  DIAMONDER OR SUPPLIER  TES HEALTH CARE & REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  Cooking facilities protected according to NFPA 96 ber 9.2.3 are not required to be enclosed as nazardous areas, but shall not be open to the corridor.  18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  This REQUIREMENT is not met as evidenced by:  Based on observation, interview and review, on 13/08/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to ensure that 2 of 2 kitchen ansul system inspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10.  The deficient practice was evidenced by the following:  1). At 11:17 AM, the surveyor, RPOD and MD observed in the (meat) kitchen, that the monthly inspection tag was blank and no required monthly inspection tag's was not completed and eff blank.	A BUILDING 02  315503  STREET ADDRESS, CITY, STATE, ZIP CODE 214 WEST JIMMEL LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205  SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY YOLL RESULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 3  Cooking facilities protected according to NFPA 96 rep 9.2.3 are not required to be enclosed as nazardous areas, but shall not be open to the corridor.  Bla. 3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review, on 30/08/23, in the presence of the Regional Plant Diperations Director (RPOD) and Maintenance Director (RPOD) and the information of the ansul system was logged.  1). At 11.17 AM, the surveyor, RPOD and MD observed in the (meat) kitchen, that the monthly inspection of the ansul system was logged.  2). At 11.22 AM, the surveyor, RPOD and MD observed in the (dairy) kitchen, that the monthly inspection tag was blank and no required monthly inspection to the ansul system was logged.  31. Corrective action(s)accomplist residents (s)affected:  32.4  32.4  33.4  34  34. BUILDING 2  34. WEST JIMMIEL LEEDS ACTIVE, STATE, ZIP CODE 214 WEST JIMMIEL LEEDS ACTIVE, STATE, ZIP CODE 214 WEST JIMMIEL LEEDS ACTIVE ACTI	A BUILDING 02  315503  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 214 WEST JIMMIE LEEDS ROAD  SUMMANY STATEMENT OF DEPICIENCIES (EACH OFFICIENCY MUST SE PERCEIGED BY PULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMANY STATEMENT OF DEPICIENCIES (EACH OFFICIENCY MUST SE PERCEIGED BY PULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  Cooking facilities protected according to NFPA 96 ber 9.2.3 are not required to be enclosed as nazardous areas, but shall not be open to the coordinor.  18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  This REQUIREMENT is not met as evidenced by:  Bassed on observation, interview and review, on 13/08/23, in the presence of the Regional Plant Operations Director (RPCD) and Maintenance Director (MD), it was determined that the facility ailed to ensure that 2 of 2 kitchen ansul system nspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10.  The deficient practice was evidenced by the following:  This REQUIREMENT is not met as evidenced by:  Bassed on observation, interview and review, on 13/08/23, in the presence of the Regional Plant Operations Director (RPCD) and Maintenance  In Residents identified having any negative impact from this deficient practice.  In Residents identified having the potential to be affected and corrective action taken:  "This deficient practice had the potential to affect all residents residing in this facility.  "The two Ansul systems were reinspected, and the monthly inspection tag was blank and no required monthly nspection of the ansul system was logged.  It is the facility.  "The two Ansul systems were reinspected and logged.  III. Measures will be put into place to ensure the deficient practice will not recur:  "The Administrator provid

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION 2	(X3) DATE COMP	SURVEY PLETED
		315503	B. WING _			03/	08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROYAL SU	JITES HEALTH CARE & I	REHABILITATION			14 WEST JIMMIE LEEDS ROAD		
				G	FALLOWAY TOWNSHIP, NJ 08205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 324	Continued From page	÷ 4	K 3	324			
	at the Life Safety Coo 03/08/23.	le exit conference on			IV. Corrective actions will be monitore ensure the deficient practice will not re		
	NJAC 8:39-31.2(e) NFPA 96 and NFPA 1	0.			" The Maintenance Director/designed will audit the Ansul system logs and take monthly to ensure compliance.  " The Maintenance Director will repaudit findings to the Administrator quarterly, with follow-up actions as necessary.  " The Administrator will trend report outcomes to the Quality Assurance (Quarterly, with follow-up recommendations as necessary.	gs ort t A)	
K 374 SS=D	Subdivision of Buildin CFR(s): NFPA 101	g Spaces - Smoke Barrie	K 3	374	30y		4/18/23
	Doors 2012 EXISTING Doors in smoke barrie bonded wood-core do resists fire for 20 minu plates of unlimited he are permitted to have assemblies per 8.5. E automatic-closing, do are not required to sw egress travel. Door of clear width of 32 inch doors. 19.3.7.6, 19.3.7.8, 19 This REQUIREMENT by: Based on observatio 03/07/23, in the prese	oors are self-closing or not require latching, and ving in the direction of pening provides a minimum es for swinging or horizontal .3.7.9			Corrective action(s)accomplished for resident(s)affected:     No residents were identified as having		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 02 315503 B. WING 03/08/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 214 WEST JIMMIE LEEDS ROAD **ROYAL SUITES HEALTH CARE & REHABILITATION GALLOWAY TOWNSHIP, NJ 08205** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 374 Continued From page 5 K 374 failed to provide smoke barrier wall doors that negative impact from this deficient completely closed to resist the passage of practice. smoke, flame, or gases during a fire in II. Residents identified having the potential accordance with NFPA 101, 2012 LSC Edition, to be affected and corrective action taken: Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, This deficient practice had the potential to 8.5.4. 8.5.4.1. affect all residents residing in this facility. No residents were affected by this This deficient practice was observed for 1 of 6 practice. sets of double smoke door sets observed and An audit of smoke barrier doors was tested for closure and was evidenced by the conducted by the Director of Maintenance. following: No other doors were identified as affected by this practice. At 11:53 AM, the surveyor observed that the floor III. Measures will be put into place to #3 set of smoke doors by resident room A-324 ensure the deficient practice will not recur: and the dining room that when the doors were The smoke barrier door located by activated from the electro-magnetic door holding resident room A-324 and the dining room device and the doors closed. The surveyor and was outfitted with an Astragal seal closing MD observed an approximately 1/4" gap between the penetration to prevent smoke, fire, the doors. This would allow the transfer of smoke. and poisonous gases from passing from one smoke compartment to another in the fire and poisonous gases to pass from one smoke compartment to another in the event of a event of a fire. fire compromising the integrity of the (2) smoke zone. All smoke barrier doors were checked by the Director of Maintenance to ensure An interview was conducted with the MD, during there was no penetrations through the the observations, where he stated and confirmed barrier. No additional penetrations were the finding's. found. The Administrator was informed of the finding at The Director of Maintenance was the Life Safety Code exit conference on educated by the Administrator on the 03/08/2023. importance of maintaining the integrity of smoke barrier doors to prevent smoke, NJAC 8:39-31.2(e) fire, and poisonous gas from passing through to other smoke compartments in the event of a fire. The Director of Maintenance/designee will conduct monthly audits for the next 6 months on smoke barrier doors to ensure

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 02 315503 B. WING 03/08/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 214 WEST JIMMIE LEEDS ROAD **ROYAL SUITES HEALTH CARE & REHABILITATION GALLOWAY TOWNSHIP, NJ 08205** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 374 Continued From page 6 K 374 there are no gaps when closed that would permit the transfer of smoke, fire and poisonous gases to pass from one smoke compartment to another in the event of a fire. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will report the results of the monthly audits on the smoke barrier doors and any corrective actions to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of the smoke barrier doors. K 521 **HVAC** K 521 4/18/23 SS=E CFR(s): NFPA 101 **HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced bv: Based on observation and interview on 03/07/23, I. Corrective action(s)accomplished for in the presence of the Maintenance Director resident(s)affected: (MD), it was determined that the facility failed to Residents residing in rooms 307, ensure resident bathroom ventilation systems 309, 310, 312, 313, 315, 317 and 319 had were adequately maintained and operating in the potential to be affected. No residents optimal condition, in accordance with the National were negatively impacted by this practice. Fire Protection Association (NFPA) 90 A. This The belt for the exhaust fan motor was deficient practice was identified for 8 of 50 found to be broken and was replaced.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	LTIPLE CONSTRUCTION DING <b>02</b>		(X3) DATE SURVEY COMPLETED	
		315503	B. WING _			03/	/08/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROYAL SI	JITES HEALTH CARE & I	REHABILITATION			4 WEST JIMMIE LEEDS ROAD ALLOWAY TOWNSHIP, NJ 08205		
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K 521  K 531 SS=E	CFR(s): NFPA 101  Elevators 2012 EXISTING Elevators comply with Elevators are inspect ASME A17.1, Safety Escalators. Firefighte monthly with a writter Existing elevators cor Safety Code for Exist Escalators. All existin distance of 25 feet or level that best serves personnel for firefight Firefighter's Service F A17.3. (Includes firefi recall and smoke dete firefighter's service PI	a the provision of 9.4. ed and tested as specified in Code for Elevators and r's Service is operated a record. Inform to ASME/ANSI A17.3, ing Elevators and g elevators, having a travel more above or below the the needs of emergency ing purposes, conform with Requirements of ASME/ANSI ghter's service Phase I key ector automatic recall, hase II emergency in-car key form smoke detectors, and	K 5		Maintenance/designee and reported to Administrator.  IV. Corrective actions will be monitored ensure the deficient practice will not reconsure the results of Maintenance will report the results of the monthly inspections of resident bathroom exhaus systems and any corrective actions required to the Quality Assessment and Assurance (QAA) Committee for the netwo quarters. The QAA Committee will determine the need for any additional monitoring of the resident bathroom exhaust systems.	d to cur: ust d ext	4/18/23

	OF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED			
		315503	B. WING _			03/	08/2023
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				2	14 WEST JIMMIE LEEDS ROAD		
ROYAL SU	JITES HEALTH CARE & I	REHABILITATION		G	GALLOWAY TOWNSHIP, NJ 08205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 531	Continued From page This REQUIREMENT by: Based on observation in the presence of the (MD), it was determine maintain elevator emet 1 of 2 passenger elevaccordance with ASM This deficient practice following: At 10:56 AM, the survable Director conduct a test communication teleph number-one facility delevator. The emerge when the button was The MD confirmed the the annual elevator in the elevator inspector problem with the teleph number-one elevator. The Administrator was the Life Safety Code of NJAC 8:39-31.2(e)	is not met as evidenced  n and interview on 03/07/23, Maintenance Director ed that the facility failed to ergency communication for rator telephones tested, in IE/ANSI A17.3.  was evidenced by the  reyor had the Maintenance st of the emergency none system in the buble-door passenger ncy telephone did function activated.  e finding and indicated that espection dated: 03/06/23, confirmed the same chone communication in the device.  s informed of this finding at exit conference on 03/08/23.		531	I. Corrective action(s)accomplished resident(s)affected:  "No residents were identified havin any negative impact from this deficient practice.  II. Residents identified having the potential to be affected and corrective action taken:  "This deficient practice had the potential to affect all residents that utilist the elevator.  "The two facility elevators have been reinspected to include manual operation key switch and bell, telephone and whether it was a pass or fail.  "Elevator #1 stelephone system were paired.  III. Measures will be put into place to ensure the deficient practice will not remained.  The Administrator provided educate to the Director of Maintenance regarding Fire Fighters Emergency Operations Inspection and Test must be performed monthly and include manual operation, key switch and bell, telephone and whether it was a pass or fail.  "The Director of Maintenance updates."	for g ze en on, vas cur: tion ng	
	elevator code complia	Code 2012 edition: 9.4.2 ance Code for existing elevators			the log for the Fire Fighters Service Monthly Test Log to include the elevate number, date, key switch, bell, telepho and whether it was a pass or fail.  "The Director of Maintenance/Designee will continue to conduct monthly inspections and tests the Fire Fighters Emergency Operatior Inspection and Test utilizing the update Fire Fighters Service  Monthly Test L	ne for ns ed	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED	
		315503	B. WING _		03	3/08/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROYAL SU	JITES HEALTH CARE & I	REHABILITATION		214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
K 531 K 712 SS=F	Continued From page Fire Drills CFR(s): NFPA 101	÷ 10	K 5	Any abnormal findings will be report the facility elevator vendor for immattention to rectify the situation.  IV. Corrective actions will be more ensure the deficient practice will not "The Maintenance Director/des will audit the elevators weekly time weeks, then monthly.  "The Maintenance Director will audit findings to the Administrator with follow-up actions as necessar.  "The Administrator will trend re outcomes to the Quality Assurance Committee quarterly, with follow-up recommendations as necessary.	ediate itored to of recur: eignee s 4 report weekly, y, port e (QA)	4/18/23	
	Fire Drills Fire drills include the signal and simulation conditions. Fire drills unexpected times uncleast quarterly on each with procedures and it established routine. When the signal and the stablished routine with procedures and it established routine. When the signal is a signal is a signal is a signal in the present the signal is a signal included in the signal is a signal in the present the signal is a signal included in the signal is a signal in the present the signal is a signal included in the signal includes t	are held at expected and der varying conditions, at the shift. The staff is familiar is aware that drills are part of Where drills are conducted to 6:00 AM, a coded to used instead of audible		Corrective action(s)accomplisher resident(s)affected:     No residents were identified as have negative impact from this deficient practice.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION  02	(X3) DATE SURVEY COMPLETED
	315503	B. WING		03/08/2023
NAME OF PROVIDER OR SUPPLIER  ROYAL SUITES HEALTH CARE &	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 214 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
Edition, Section 19.7. deficient practice was Based on document r 03/07/23, with the ME revealed method for t fire conditions were n location for 11 of 13 fi Date Type of Smoke or Page  - 02/22/23 kitchen gr vendor drill - 01/11/23 code red e vendor drill - 12/28/22 AC fire (w - 12/10/22 holiday tre - 11/21/22 AC unit fir vendor drill - 11/16/22 Kitchen fir drill - 10/20/22 fire-smoke - 09/26/22 fire-smoke - 08/25/22 fire-smoke kitchen)? in house drill - 06/27/22 smoke-fire in-house drill - 05/31/22 smoke co drill - 04/28/22 code red 3 An interview was con documentation review confirmed the finding include the transmiss	nce with NFPA 101, 2012 1.4 through 19.7.1.7. This is evidenced by the following: review and interview on the facility fire drill reports the simulation of emergency of varied and specific to fire drills:  alarm transmission: Pull,  ease fire (what kitchen)?  employee lounge (where?)  there?) In-house drill there is in-house drill there? in-house drill	K 712	II. Residents identified having the poto be affected and corrective action of This deficient practice had the potent affect all residents residing in this far No residents were affected by this practice.  The Administrator spoke to the facility vendor who conducts the fire drills a requested that simulation of emerge fire conditions, varied times, and spellocations are documented on the fire reports submitted to the facility.  III. Measures will be put into place to ensure the deficient practice will not. The Director of Maintenance was educated by the Administrator on the importance of conducting fire drills warying activation types and simulating specific emergency fire conditions in accordance with NFPA 101, 2012 Eccitor 19.7.1.4 through 19.7.1.7.  The Maintenance Department/design will conduct monthly fire drills with vactivation types and simulation of spemergency fire conditions at expected and unexpected times at least quarton each shift. Any infractions noted during these drills will be corrected immediately by the Director of Maintenance.  The Director of Maintenance will audifire drills for varying activation types simulation of specific emergency fire conditions monthly for six months to ensure the method for the simulation emergency fire conditions are varied specific to location.  IV. Corrective actions will be monitor.	taken: citial to cility.  ty nd ncy ecific e drill orecur: e vith on of dition, nee earying ecific ed erly  dit the and e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING 02		' '	(X3) DATE SURVEY COMPLETED			
		315503	B. WING		03	/08/2023
NAME OF P	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ROYAL S	UITES HEALTH CARE &	REHABILITATION		214 WEST JIMMIE LEEDS ROAD		
				GALLOWAY TOWNSHIP, NJ 08205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 712	Continued From pag	e 12	K 7	12		
	identified, varied and fire drills documented	I specific to areas for 11 of 13 d on the form's.		ensure the deficient practice will no The Director of Maintenance will re the results of the monthly fire drills	ort	
		as informed of the finding at exit conference on 03/08/23.		any corrective actions to the Quality Assessment and Assurance (QAA) Committee for the next two quarters		
	NJAC 8:39-31.2(e) NFPA 101 Life Safet	y Code 2012 edition 19.7.1.4		QAA Committee will determine the for any additional monitoring of the drills after the 2nd quarterly meeting	fire	
K 914 SS=F	_	Maintenance and Testing	K 9 <sup>-</sup>	14		4/18/23
	Hospital-grade receptocations and where anesthesia is adminited installation, replacent testing is performed documented performisted as hospital-gratested at intervals not isolation monitors (Lintervals of less than actuating the LIM test which activates both LIM circuits with automanual test is perfor equal to 12 months. 6.3.3.3.2 after any reflectric distributions maintained of require repairs or modification area tested, and results (3.3.4 (NFPA 99)). This REQUIREMENT by:  Based on observation	otacles at patient bed deep sedation or general stered, are tested after initial nent or servicing. Additional at intervals defined by nance data. Receptacles not de at these locations are of exceeding 12 months. Line IM), if installed, are tested at or equal to 1 month by st switch per 6.3.2.6.3.6, visual and audible alarm. For omated self-testing, this med at intervals less than or LIM circuits are tested per expair or renovation to the system. Records are end tests and associated ons, containing date, room or cults.  T is not met as evidenced		Corrective action(s) accomplishe     resident(s) affected:	d for	
	Electrical Systems - Hospital-grade recep locations and where anesthesia is admini installation, replacen testing is performed documented perform listed as hospital-gra tested at intervals no isolation monitors (L intervals of less than actuating the LIM tes which activates both LIM circuits with auto manual test is perfor equal to 12 months. 6.3.3.3.2 after any re electric distribution s maintained of require repairs or modificatio area tested, and resi 6.3.4 (NFPA 99) This REQUIREMEN' by: Based on observation	deep sedation or general stered, are tested after initial nent or servicing. Additional at intervals defined by nance data. Receptacles not de at these locations are of exceeding 12 months. Line IM), if installed, are tested at or equal to 1 month by st switch per 6.3.2.6.3.6, visual and audible alarm. For omated self-testing, this med at intervals less than or LIM circuits are tested per expair or renovation to the system. Records are ed tests and associated ons, containing date, room or ults.		Corrective action(s) accomplish resident(s) affected:	nec	ned for

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI COMPLE  A. BUILDING 02 (X3) DATE SI COMPLE		E SURVEY IPLETED				
		315503	B. WING			03	3/08/2023
NAME OF F	PROVIDER OR SUPPLIER	•	,	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
DOVAL C	INTER HEALTH CARE 9	DELIABILITATION		21	14 WEST JIMMIE LEEDS ROAD		
RUTAL S	UITES HEALTH CARE &	REPABILITATION		G	ALLOWAY TOWNSHIP, NJ 08205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 914	Continued From pag	e 13	K	914			
	in the presence of the Director (MD) and Robirector (RPOD), it is facility failed to funct receptacles in reside grounding, polarity, a accordance with NFF This deficient practic resident rooms observed on 03/07/23 and 03/9:30 AM to 1:30 PM, (RPOD 03/08/23 only rooms were provided that were less than han annual electrical inspection dated: 12/19/2022 diresident room outlets. The MD and RPOD if the facility had hos grade outlets at the I indicated that the face electrical testing log.	e facility's Maintenance egional Plant Operations was determined that the ionally test electrical ents' rooms annually for and blade tension in PA 99.  The was evidenced for 47 of 75 rived by the following:  To 8/23, from approximately the surveyor, MD, and the surveyor, MD, and the surveyor of the resident did with electrical receptacles to spital grade and required the spection. The annual from the facility vendor did not indicate any testing of the safety code exit and cility did not have any		914	No residents were identified as having negative impact from this deficient practice.  II. Residents identified having the pote to be affected and corrective action tal This deficient practice had the potentia affect all residents residing in this facili No residents were affected by this practice.  Electrical inspections of resident room receptacles were conducted on 6/14/2 including grounding, polarity, and blad tension on resident room receptacles. copy of the 6/14/2022 resident room receptacle inspection was obtained by Administrator and provided to the Dire of Maintenance for the inspection log book.  III. Measures will be put into place to ensure the deficient practice will not resident practice will not resident practice of maintaining records in-house on annual testing of electrical receptacles in residents of electrical receptacles in residents of electrical receptacles in residents of rooms for grounding, polarity, and blade tension accordance with NFPA 99.  The next annual inspection for resident rooms receptacles is scheduled for Ju 2023 to include grounding, polarity and blade tension. Results of this inspection and any corrective actions will be presented at the following Quality Assessment and Assurance (QAA) Committee meeting.  IV. Corrective actions will be monitored ensure the deficient practice will not recensure the deficient practi	ntial ken: all to ty.  022 e A the ctor  cur:	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	1 00		(X3) DATE COMP	MPLETED	
		315503	B. WING _			03/	08/2023	
	ROVIDER OR SUPPLIER	REHABILITATION		21	TREET ADDRESS, CITY, STATE, ZIP CODE 14 WEST JIMMIE LEEDS ROAD ALLOWAY TOWNSHIP, NJ 08205			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 914	Continued From page	÷ 14	KS	014	The Director of Maintenance will report the results of the annual resident room receptacle inspection and any correcting actions to the Quality Assessment and Assurance (QAA) Committee when conducted. The QAA Committee will determine the need for any additional monitoring of resident room receptacles.	/e		

#### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	Γ		
IDENTIFICATION NUMBER	A. Building 02 - ROYAL SUITES					
315503 <sub>Y1</sub>	B. Wing	Y2	4/25/2023 <sub>Y3</sub>			
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
ROYAL SUITES HEALTH CARE &	REHABILITATION	214 WEST JIMMIE LEEDS ROAD				
		GALLOWAY TOWNSHIP, NJ 08205				

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

ITEM DATE		DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg.#	NFPA 101		Completed
LSC	K0291	04/18/2023	LSC	K0324	04/18/2023	LSC	K0374		04/18/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg.#	NFPA 101		Completed
LSC	K0521	04/18/2023	LSC	K0531	04/18/2023	LSC	K0712		04/18/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #		Completed	Reg.#			Completed
LSC	K0914	04/18/2023	LSC			LSC			-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #		Completed	Reg.#			Completed
LSC			LSC			LSC			-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #		Completed	Reg.#			Completed
LSC			LSC			LSC			-
REVIEWED BY STATE AGENCY		DATE	SIGNATURI	OF SURVEYOR			DATE		
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/8/2023			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				YE:	s 🗆 no	