STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING **02** B. WING _____	**03/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	**214 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(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 in 2007 with no current major renovations or noted additions. It is a three story building Type II (222) construction and is fully sprinklered. The outside 150 KW natural gas generator does approximately 60 % of the building. An electric fire pump is utilized to provide support to the fire sprinkler system. 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 186 at certified beds. At the time of the survey the census was 157. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 291	Emergency Lighting	K 291		4/18/23

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

Electronically Signed | 03/22/2023

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K 291 SS=F	Continued From page 1 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/08/2023, in the presence of the Regional Director (RD) and Maintenance Director (MD), it was determined that the facility failed to provide a battery back-up emergency light above the (2) transfer switches (fire pump and generator) 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 2 of 2 transfer switches and was evidenced by the following: 1). At 11:05 AM, the surveyor in the presence of the (RD) and (MD), observed 1 generator transfer switch, ATS-1 inside the main electrical room. The room was provided with an emergency light fixture, but when the MD activated the test button the emergency light did not work. The MD stated the battery may be dead. 2). At 11:14 AM, the surveyor in the presence of the (RD) and (MD), observed 1 fire pump transfer switch, inside the fire pump electrical room. The general area was not provided with any emergency lighting. The RD and MD both confirmed the findings at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit on 03/08/23.	K 291	I. Corrective action(s)accomplished for resident(s)affected: " No residents were identified as effected by this practice. " The emergency light fixture located inside the main electrical room was replaced, tested, and is functional. It has a battery back up light. An emergency backup light was installed for the fire pump transfer switch, inside the fire pump electrical room. The light was tested and is functional. It has a battery backup light. II. Residents identified having the potential to be affected and corrective action taken: " Residents residing in the facility have the potential to be affected by this deficient practice. No residents were identified as being negatively impacted. III. Measures will be put into place to ensure the deficient practice will not recur: " The Administrator educated the Maintenance Director that the emergency lighting for the generator transfer switch and fire pump transfer switch are required and must be checked for function independent of the buildings electrical	

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K 291	Continued From page 2 NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	system and emergency generator. The Maintenance Director/designee will 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 monitored to ensure the deficient practice will not recur: " " The Maintenance Director will report audit findings to the Administrator weekly, with follow-up actions as necessary. " The Administrator will trend report outcomes to the Quality Assurance (QA) Committee quarterly for the next two quarters, with follow-up recommendations as necessary.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K 324		4/18/23

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K 324	Continued From page 3 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous 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 03/08/23, 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 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 of the ansul system was logged. At this time, the surveyor interviewed the MD and RPOD, who both confirmed that the ansul monthly inspection tag's was not completed and left blank. The Administrator was informed of the deficiency	K 324	I. Corrective action(s)accomplished for resident(s)affected: " No residents were identified having 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 residing in this facility. " The two Ansul systems were reinspected, and the monthly inspection tag was completed and logged. III. Measures will be put into place to ensure the deficient practice will not recur: " The Administrator provided education to the Maintenance Director regarding the Ansul system□s monthly inspection tag must be completed and the information must be logged. " The Maintenance Department/Designee will continue to ensure that monthly Ansul inspections are conducted, the inspection tag is complete, and the information is logged.	

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K 324	Continued From page 4 at the Life Safety Code exit conference on 03/08/23. NJAC 8:39-31.2(e) NFPA 96 and NFPA 10.	K 324	IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Maintenance Director/designee will audit the Ansul system logs and tags monthly to ensure compliance. " The Maintenance Director will report audit findings to the Administrator quarterly, with follow-up actions as necessary. " The Administrator will trend report outcomes to the Quality Assurance (QA) Committee quarterly for the next two quarters, with follow-up recommendations as necessary	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, on 03/07/23, in the presence of the Maintenance Director (MD), it was determined that the facility	K 374	I. Corrective action(s)accomplished for resident(s)affected: No residents were identified as having a	4/18/23

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K 374	Continued From page 5 failed to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame, or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. This deficient practice was observed for 1 of 6 sets of double smoke door sets observed and tested for closure and was evidenced by the following: At 11:53 AM, the surveyor observed that the floor #3 set of smoke doors by resident room A-324 and the dining room that when the doors were activated from the electro-magnetic door holding device and the doors closed. The surveyor and MD observed an approximately 1/4" gap between the doors. This would allow the transfer of smoke, fire and poisonous gases to pass from one smoke compartment to another in the event of a fire compromising the integrity of the (2) smoke zone. An interview was conducted with the MD, during the observations, where he stated and confirmed the finding's. The Administrator was informed of the finding at the Life Safety Code exit conference on 03/08/2023. NJAC 8:39-31.2(e)	K 374	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 residing in this facility. No residents were affected by this practice. An audit of smoke barrier doors was conducted by the Director of Maintenance. No other doors were identified as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The smoke barrier door located by resident room A-324 and the dining room was outfitted with an Astragal seal closing the penetration to prevent smoke, fire, and poisonous gases from passing from one smoke compartment to another in the event of a fire. All smoke barrier doors were checked by the Director of Maintenance to ensure there was no penetrations through the barrier. No additional penetrations were found. The Director of Maintenance was educated by the Administrator on the importance of maintaining the integrity of smoke barrier doors to prevent smoke, 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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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 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/07/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure resident bathroom ventilation systems were adequately maintained and operating in optimal condition, in accordance with the National Fire Protection Association (NFPA) 90 A. This deficient practice was identified for 8 of 50	K 521	I. Corrective action(s)accomplished for resident(s)affected: Residents residing in rooms 307, 309, 310, 312, 313, 315, 317 and 319 had the potential to be affected. No residents were negatively impacted by this practice. The belt for the exhaust fan motor was found to be broken and was replaced.	4/18/23

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K 521	Continued From page 7 resident room bathrooms vents observed and was evidenced by the following: At 11:55 AM,, during a tour of the building, the surveyor with the MD, toured the facility and observed that the ventilation in the floor #3 short-wing resident rooms: A-307, 309, 310, 312, 313, 315, 317 and 319 the bathroom ventilation systems did not function when the MD applied a piece of single-ply toilet tissue paper across the upper wall grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. An interview was conducted with the MD during the observations, and he confirmed the findings. The MD stated the roof unit may have a bad motor and/or a broken fan belt He stated currently the facility did not have a ventilation inspection log or operating check list to provide. The Administrator was informed of the findings at the Life Safety Code exit conference on 03/08/23. NFPA 90 A Standard for the installation of ventilating systems NFPA 101-2012 -19.5.2.1 section 9.2.1 and 9.2.2 NJAC 8:39-31.2(e)	K 521	The bathroom ventilation systems were retested in the rooms identifed and found to be functioning once the belt was replaced. II. 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. No other residents were identified as affected by this practice. A facility-wide audit was conducted by the Director of Maintenance to ensure bathroom ventilation systems were functioning in accordance with NFPA 90A. No other bathroom exhaust systems were identified as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The Administrator re-educated the Director of Maintenance about the importance of adequately maintaining bathroom ventilation systems operating in optimal condition, in accordance with the National Fire Protection Association (NFPA) 90 A. The Director of Maintenance created a ventilation inspection log that will be used for documenting monthly checks on bathroom exhaust systems. The Director of Maintenance/designee will conduct monthly checks on bathroom exhaust systems for the next 6 months to ensure they are operating at optimal condition, in accordance with NFPA 90 A. Any discrepancies will be corrected immediately by the Director of	

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K 521	Continued From page 8	K 521	Maintenance/designee and reported to the Administrator. 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 inspections of resident bathroom exhaust systems and any corrective actions required 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 resident bathroom exhaust systems.	
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	K 531		4/18/23

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K 531	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/07/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to maintain elevator emergency communication for 1 of 2 passenger elevator telephones tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: At 10:56 AM, the surveyor had the Maintenance Director conduct a test of the emergency communication telephone system in the number-one facility double-door passenger elevator. The emergency telephone did function when the button was activated. The MD confirmed the finding and indicated that the annual elevator inspection dated: 03/06/23, the elevator inspector confirmed the same problem with the telephone communication in the number-one elevator device. The Administrator was informed of this finding at the Life Safety Code exit conference on 03/08/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition: 9.4.2 elevator code compliance ASME-A17.3 Safety Code for existing elevators	K 531	I. Corrective action(s)accomplished for resident(s)affected: " No residents were identified having 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 utilize 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□s telephone system was repaired. III. Measures will be put into place to ensure the deficient practice will not recur: " The Administrator provided education 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 updated the log for the Fire Fighters Service Monthly Test Log to include the elevator number, date, key switch, bell, telephone and whether it was a pass or fail. " The Director of Maintenance/Designee will continue to conduct monthly inspections and tests for the Fire Fighters Emergency Operations Inspection and Test utilizing the updated Fire Fighters Service □ Monthly Test Log.	

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K 531	Continued From page 10	K 531	Any abnormal findings will be reported to the facility elevator vendor for immediate attention to rectify the situation. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Maintenance Director/designee will audit the elevators weekly times 4 weeks, then monthly. " The Maintenance Director will report audit findings to the Administrator weekly, with follow-up actions as necessary. " The Administrator will trend report outcomes to the Quality Assurance (QA) Committee quarterly, with follow-up recommendations as necessary	
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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 03/07/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire	K 712	I. Corrective action(s)accomplished for resident(s)affected: No residents were identified as having a negative impact from this deficient practice.	4/18/23

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ROYAL SUITES HEALTH CARE & REHABILITATION	**214 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

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K 712	Continued From page 11 conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was evidenced by the following: Based on document review and interview on 03/07/23, with the MD, the facility fire drill reports revealed method for the simulation of emergency fire conditions were not varied and specific to location for 11 of 13 fire drills: Date Type of alarm transmission: Pull, Smoke or Page - 02/22/23 kitchen grease fire (what kitchen) ? vendor drill - 01/11/23 code red employee lounge (where ?) vendor drill - 12/28/22 AC fire (where ?) In-house drill - 12/10/22 holiday tree fire ? lobby vendor drill - 11/21/22 AC unit fire resident room A-103 vendor drill - 11/16/22 Kitchen fire (what kitchen)? in-house drill - 10/20/22 fire-smoke ? in-house drill - 09/26/22 fire-smoke ? in-house drill - 08/25/22 fire-smoke 1st floor kitchen (what kitchen)? in house drill - 06/27/22 smoke-fire 1st floor utility room back in-house drill - 05/31/22 smoke code red 3rd floor ? in-house drill - 04/28/22 code red 1st floor ? in-house drill - 03/23/22 code red 3rd floor ? in-house drill An interview was conducted with the MD after documentation review, where he stated and confirmed the findings that currently fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions were not	K 712	II. 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. No residents were affected by this practice. The Administrator spoke to the facility vendor who conducts the fire drills and requested that simulation of emergency fire conditions, varied times, and specific locations are documented on the fire drill reports submitted to the facility. III. Measures will be put into place to ensure the deficient practice will not recur: The Director of Maintenance was educated by the Administrator on the importance of conducting 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. The Maintenance Department/designee will conduct monthly fire drills with varying activation types and simulation of specific emergency fire conditions at expected and unexpected times at least quarterly on each shift. Any infractions noted during these drills will be corrected immediately by the Director of Maintenance. The Director of Maintenance will audit the fire drills for varying activation types and simulation of specific emergency fire conditions monthly for six months to ensure the method for the simulation of emergency fire conditions are varied and specific to location. IV. Corrective actions will be monitored to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315503	A. BUILDING **02** B. WING _____	**03/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL SUITES HEALTH CARE & REHABILITATION	**214 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

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K 712	Continued From page 12 identified, varied and specific to areas for 11 of 13 fire drills documented on the form's. The Administrator was informed of the finding at the Life Safety Code exit conference on 03/08/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4	K 712	ensure the deficient practice will not recur: The Director of Maintenance will report the results of the monthly fire drills 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 fire drills after the 2nd quarterly meeting.	
K 914 SS=F	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 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 03/07/23 and 03/08/23,	K 914	I. Corrective action(s) accomplished for resident(s) affected:	4/18/23

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	315503	A. BUILDING **02** B. WING _____	**03/08/2023**

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K 914	Continued From page 13 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 47 of 75 resident rooms observed by the following: On 03/07/23 and 03/08/23, from approximately 9:30 AM to 1:30 PM, the surveyor, MD, and (RPOD 03/08/23 only) observed that resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The annual electrical inspection from the facility vendor dated: 12/19/2022 did not indicate any testing of resident room outlets. The MD and RPOD indicated they were not sure if the facility had hospital-grade or non-hospital grade outlets at the life safety code exit and indicated that the facility did not have any electrical testing log on-site at this time. The Administrator was informed of the findings at the Life Safety Code exit conference on 03/08/23. NJAC 8:39-31.2(e) NFPA 99	K 914	No residents were identified as having a 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 residing in this facility. No residents were affected by this practice. Electrical inspections of resident room receptacles were conducted on 6/14/2022 including grounding, polarity, and blade tension on resident room receptacles. A copy of the 6/14/2022 resident room receptacle inspection was obtained by the Administrator and provided to the Director of Maintenance for the inspection log book. III. Measures will be put into place to ensure the deficient practice will not recur: The Director of Maintenance was educated by the Administrator on the importance of maintaining records in-house on annual testing of electrical receptacles in residents□ rooms for grounding, polarity, and blade tension in accordance with NFPA 99. The next annual inspection for resident rooms receptacles is scheduled for June 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 to ensure the deficient practice will not recur:	

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	315503	A. BUILDING **02** B. WING _____	**03/08/2023**

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K 914	Continued From page 14	K 914	The Director of Maintenance will report the results of the annual resident room receptacle inspection and any corrective 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.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315503 Y1	A. Building 02 - ROYAL SUITES B. Wing Y2	4/25/2023 Y3

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE 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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	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? ☐ YES ☐ NO