STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**01/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/18/22 and 01/19/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This building is a 4-story building that was built in the 60's, It is composed of Type I fire resistant construction. The facility is divided into 10- smoke zones The generator does approximately 80 % of the building. The building's fire sprinkler system utilizes an electric fire pump. 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.	K 000		

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

Electronically Signed | 01/31/2022

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K 000	Continued From page 1 The facility has 300 certified beds, at the time of survey the census was 215.	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 01/18/22 to 01/19/22, it was determined that the facility failed to provide automatic emergency illumination that would automatically operate along a means of egress. This deficient practice was observed in 1 of 9 wings of the facility and evidence by the following: During a tour of the building from approximately 9:00 AM to 1:00 PM, in the presence of the facility's Maintenance Director and Administrator it was determined that the [redacted]-wing, resident rooms [redacted] corridor, did not have any emergency lighting. The 3 upper wall switches shut all the lights off, leaving no continuous emergency lighting. Based on observation and interview, the facility failed to provide emergency illumination that would operate automatically along the means of egress and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 Edition, Section	K 281	K281 1) Emergency lighting in corridor of rooms [redacted] were installed. [redacted] stairways of #1, #2, #3 emergency lightings are on and working efficiently. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to provide emergency illumination that would automatically operate along a means of egress. 4) Maintenance Director or designee will conduct audits of facility emergency lighting weekly times 4 then monthly times 2. Results of these audits will be forwarded to the Quality Assurance Performance Improvement committee monthly to ensure ongoing compliance. Any findings identified will be immediately corrected.	2/1/22

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K 281	Continued From page 2 19.2.8 7.8, 7.8.1.1, 7.8.1.2, 7.8.1.4 and 7.9.2.1. On 01/19/22, the surveyor observed outside the exit/egress doors outside # 2 and # 3 stairwell's,that no emergency light over the door was provided on the exterior of the building. Based on observation and interview on 01/19/21, in the presence of the Administrator and Maintenance Director, it was determined that the facility failed to ensure that the means of egress were provided with continuous lighting. While touring the building from 09:00 AM, to 01:00 PM, the surveyor observed that the [redacted]-stairwells, marked # 1, 2 and 3, were provided with wall lighting that was not on at the time of the observations. The Maintenance Director stated he was not sure why the fixtures were not on. The facility's Administrator was informed of the finding's, during the building tour and at the Life Safety Code survey exit on 01/19/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8, 7.8.1.1, 7.8.1.2	K 281		
K 291 SS=D	Emergency Lighting 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 01/19/22, it was determined that the facility failed to provide	K 291	K291 1) Facility installed an operational battery	2/1/22

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K 291	Continued From page 3 an operational battery backup emergency light above the emergency generator's transfer switches, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced for 2 of 2 transfer switches, observed by the following: 1. At 11:28 AM, the surveyor, Administrator and the Maintenance Director, observed in the electrical closet transfer switch outside the kitchen, for the generator marked C003, that no emergency lighting was provided. 2. At 11:38 AM, the surveyor, Administrator and the Maintenance Director, observed in the main electrical closet transfer switch for the generator marked ATS-2, that no emergency lighting was provided. This finding was verified by the Administrator and the Maintenance Director at the time of observation. The Administrator was notified of the above findings at the Life Safety Code exit conference on 01/19/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	backup emergency light above the emergency generator transfer switches outside the kitchen for the generator marked c003 and one in the main electrical closet transfer switch for the generator marked Ats-2. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to provide an operational battery backup emergency light above the emergency generator's transfer switches, independent of the building's electrical system and emergency generator. 4) Maintenance Director or designee will conduct random audits of battery backup emergency lights to ensure functionality and operational. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the Quality Assurance Performance Improvement committee monthly to ensure ongoing compliance. Any findings identified will be immediately corrected.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.	K 293		2/1/22

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K 293	Continued From page 4 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 on 01/19/22, in the presence of the Maintenance Director and Administrator, it was determined that the facility failed to ensure that illuminated exit signs were illuminated at all times, to clearly identify the exit access path. This deficient practice was evidenced for 2 of 24 exit signs by the following: 1. On 01/19/22 at 10:51 AM, the surveyor, Administrator and the Maintenance Director observed the ceiling mounted exit sign by stairwell #2 by resident room [redacted] was not illuminated. 2. On 01/19/22 at 11:48 AM, the surveyor, Administrator and the Maintenance Director observed the ceiling mounted exit sign by stairwell #3 on the ground floor, was not illuminated. Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2	K 293	K293 1) batteries were replaced in both emergency exit signs by stairway #2 near resident room [redacted] and exit sign by stairway #3 on ground floor. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure that exit signs are installed and illuminated. 4) Maintenance Director or designee will conduct random audits of illuminated exit signs to ensure proper functionality. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	

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K 293	Continued From page 5 The facility Administrator was informed of the findings during the Life Safety Code survey exit conference at 1:46 PM on 01/19/22. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/19/22, the facility did not provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment. Also, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition,	K 351	K351 1) Sprinkler heads were installed in kitchen janitor closet and in [redacted] unit manger office closet. 2) All residents have the potential of being affected by this deficient practice.	2/8/22

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K 351	Continued From page 6 Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in this area. This deficient practice was evidenced by the following: 1. At 11:08 AM, the surveyor, in the presence of the Administrator and the Maintenance Director observed that the kitchen janitors closet approximately 3' x 2' was observed to have no fire sprinkler coverage. 2. At 12:07 PM, the surveyor, in the presence of the Administrator and the Maintenance Director observed that the [redacted] unit managers office closet approximately 3' x 3' was observed to have no fire sprinkler coverage. An interview was conducted with the Maintenance Director who stated and agreed that the above areas of the building, did not have any fire sprinkler coverage. The Administrator was informed of the deficiencies at the Life Safety Code exit conference on 01/19/22.	K 351	3) Administrator or designee will re-educate Maintenance staff on the requirement to provide complete sprinkler coverage. 4) Maintenance Director or designee will conduct random audits of facility to ensure proper sprinkler coverage. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	
K 363 SS=E	NJAC 8:39-31.2(e) Corridor - Doors CFR(s): NFPA 101 Corridor - Doors 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	K 363		2/1/22

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K 363	Continued From page 7 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 from 1/18/22 to 1/19/22, 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	K 363	K363 1) The facility repaired doors to ensure proper latching on rooms: [redacted] and [redacted].	

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K 363	Continued From page 8 practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 13 of 40 resident room door's and was evidenced by the following: From 1/18/22 to 1/19/22, during the building tour from 9:00 AM, to 1:00 PM, the surveyor, in the presence of the Administrator and the Maintenance Director observed that the doors to resident rooms did not latch into the door frame in the following room numbers: [redacted] An interview was conducted with the Maintenance Director who stated and confirmed that the above resident room doors, had hardware issues that prevented the doors from latching into there frame's properly. The Administrator was informed of the finding at the Life Safety Code exit conference on 1/19/22. NJAC 8:39-31.1(c), 31.2(e)	K 363	2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure proper door latching. 4) Maintenance Director or designee will conduct random audits of facility to ensure proper door latching. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	
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	K 374		2/8/22

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K 374	Continued From page 9 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, interview, and review of facility provided documentation from 1/18/22 to 1/19/22, it was determined that the facility failed to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. This deficient practice was observed for 2 of 8 sets of double smoke doors tested for closure and was evidenced by the following: 1. At 12:46 PM, the surveyor and the Maintenance Director observed the set of smoke-doors by resident room's [redacted] that when released from their hold open device. The left side door on the [redacted] side remained open approximately 1" allowing the passage of smoke, flame or gases to enter, compromising the integrity of the smoke zone. 2. At 1:18 PM, the surveyor and the Maintenance Director observed the set of smoke-doors by resident room's [redacted], that when released from their hold open device. The left side door on the [redacted] side remained fully open allowing the passage of smoke, flame or gases to enter,	K 374	K374 1) Facility repaired 1 inch gap by the smoke door next to room [redacted] and the mag lock attached to the smoked doors by room [redacted] when fire alarm goes off to release the door appropriately. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame or gases during a fire. 4) Maintenance Director or designee will conduct random audits to smoke barrier wall doors close completely. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	

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K 374	Continued From page 10 compromising the integrity of the smoke zone. This observation was due to an alarm activation in the building from a Maintenance worker spraying ceiling tiles. When the fire alarm was activated the door automatically should have closed to protect the smoke zone. The Administrator was notified of the finding at the Life Safety Code exit conference on 1/19/22. NJAC 8:39-31.2(e)	K 374		
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 from 1/18/22 to 1/19/22, in the presence of the facility Administrator and Maintenance Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 52 of 85 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: While touring the building from 1/18/22 to 1/19/22, from approximately 10:30 AM to 1:30	K 521	K521 1) Facility repaired bathroom ventilation system to ensure compliance and installed in accordance with the manufacturer's specifications. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure HVAC system is	2/18/22

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K 521	Continued From page 11 PM, the surveyor, in the presence of the Administrator and Maintenance Director observed that the ventilation in the following resident room bathrooms did not function: [redacted] - 17 bathrooms Central shower room [redacted] - 17 bathrooms [redacted] - 17 bathrooms The surveyor requested that the Maintenance Director, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling 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. At that time, the surveyor interviewed the Maintenance Director who confirmed that the exhaust vents in the above resident room bathrooms, were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference on 01/19/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	installed per regulation and in accordance with the manufacturer's specifications. 4) Maintenance Director or designee will conduct random audits of facility to ensure ventilation system is operational and being used per manufacturer's specifications. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other	K 911		1/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**01/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 911	Continued From page 12 List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that electrical panels were up to code as per NFPA 99. This deficient practice was evidenced for 1 of 10 electrical panels observed by the following: On 1/19/22 at 10:32 AM, the surveyor and the Maintenance Director observed the [redacted] electrical closet that the LPH2B Main Bk-A panel was missing the # 41 breaker and/or spacer. The # 41 open spacer in the panel, now could allow someone to touch the main breaker bar and get a shock. The door to the electrical room was locked at the time of the observation. The Maintenance Director confirmed the finding during the observation. The Administrator was informed of the finding at the Life Safety Code exit conference on 1/19/22. NFPA 99 NJAC 8:39-31.2(e)	K 911	K911 1) Facility replaced breaker #41 in electrical closet near [redacted] that has lph2b main bk-a panel . 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure to ensure that electrical panels were up to code as per NFPA 99 and operational. 4) Maintenance Director or designee will conduct random audits of facility to ensure functionality of electrical panels. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	
K 916 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator	K 916		2/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**01/19/2022**

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RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

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K 916	Continued From page 13 A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 1/19/22, it was determined that the facility failed to ensure that the facility's emergency generator annunciator was functional as evidenced by the following: At 11:50 AM, in the presence of the facility's Maintenance Director where he stated the facility generator did not have a remote annunciator panel. The Administrator upon further investigation indicated that there was an annunciator panel at the nurse station. The annunciator panel at the [redacted] floor nurses station column was confirmed. The panel did not have any identification indicating what it was for or any labels as to what the eight panel lights would indicate if activated. There was a push button on the panel that did not activate the lights so there was no way to test the panel for activation. The unit failed to emit a visual and/or audible signal to verify its hardwired connection to the emergency generator. The Administrator was informed of this observation at the Life Safety Code exit conference on 1/19/22. NJAC 8:39-31.2(e)	K 916	K916 1) Contracted services repaired emergency generator annunciator panel. 2) All residents have the potential of being affected by this deficient practice. 3) Administrator or designee will re-educate Maintenance staff on the requirement to ensure that the facility's emergency generator annunciator is functional. 4) Maintenance Director or designee will conduct random audits of facility to ensure panel is functioning correctly. Audits will be conducted weekly times 4 then monthly times 2. Results of these audits will be forwarded to the monthly Quality Assurance Performance Improvement committee to ensure ongoing compliance. Any findings identified will be immediately corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING **01** B. WING _____	**01/19/2022**

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RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY** **BERKELEY HEIGHTS, NJ 07922**

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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
315009 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

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 K0281	02/01/2022	LSC K0291	02/01/2022	LSC K0293	02/01/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	02/08/2022	LSC K0363	02/01/2022	LSC K0374	02/08/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	02/18/2022	LSC K0911	01/20/2022	LSC K0916	02/01/2022
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	
1/19/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO