STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315104	A. BUILDING **01** B. WING ______	**11/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	**234 CHESTNUT STREET** **UNION, NJ 07083**

(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 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/9/22, 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 The facility is a 1-story building that was built in 60's, It is composed of Type II protected construction. The facility is divided into 6- smoke zones. The generator does approximately 40% of the facility. The building: 55,715 sq. ft. single story, wood truss roof, concrete slab floor 2- basements.	K 000		
K 281 SS=F	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 on 11/9/22, in the presence of the assistant Maintenance Director and Maintenance Director (from another sister facility), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of	K 281	Exit/egress area located in front foyer and corridor by room [redacted] where illumination failed to continuously operate without manual intervention have been identified and addressed. The emergency lighting is no longer controlled by a switch	11/28/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/01/2022

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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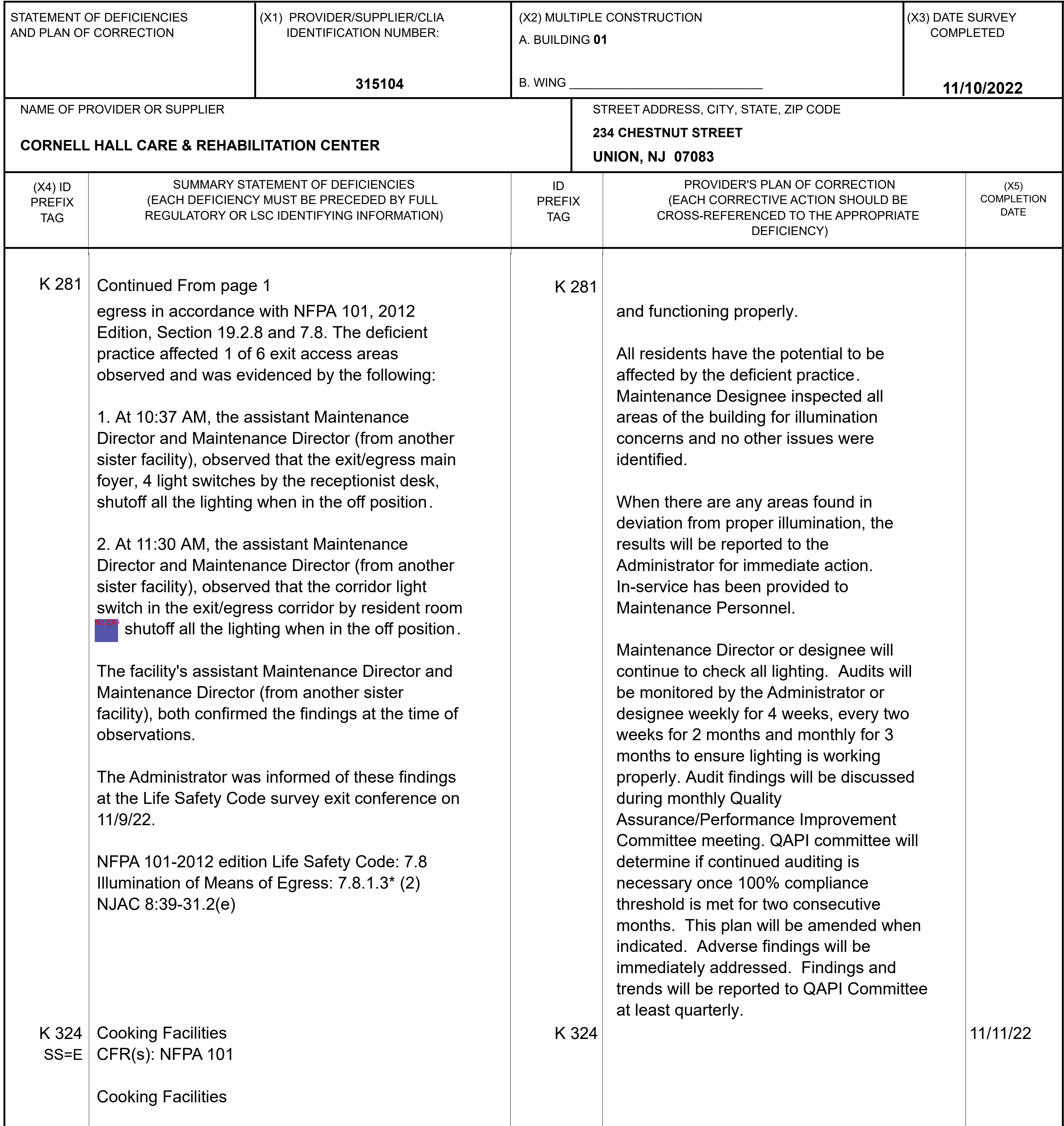

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K 281	Continued From page 1 egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 1 of 6 exit access areas observed and was evidenced by the following: 1. At 10:37 AM, the assistant Maintenance Director and Maintenance Director (from another sister facility), observed that the exit/egress main foyer, 4 light switches by the receptionist desk, shutoff all the lighting when in the off position. 2. At 11:30 AM, the assistant Maintenance Director and Maintenance Director (from another sister facility), observed that the corridor light switch in the exit/egress corridor by resident room shutoff all the lighting when in the off position. The facility's assistant Maintenance Director and Maintenance Director (from another sister facility), both confirmed the findings at the time of observations. The Administrator was informed of these findings at the Life Safety Code survey exit conference on 11/9/22. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	and functioning properly. All residents have the potential to be affected by the deficient practice. Maintenance Designee inspected all areas of the building for illumination concerns and no other issues were identified. When there are any areas found in deviation from proper illumination, the results will be reported to the Administrator for immediate action. In-service has been provided to Maintenance Personnel. Maintenance Director or designee will continue to check all lighting. Audits will be monitored by the Administrator or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months to ensure lighting is working properly. Audit findings will be discussed during monthly Quality Assurance/Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities	K 324		11/11/22

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K 324	Continued From page 2 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. 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	K 324		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and review, on 11/9/22, the Assistant Maintenance and Maintenance Director (from another sister facility), it was determined that the facility failed to ensure that 1 of 1 Kitchen ansul system inspection tags, were inspected monthly, in accordance with NFPA 96 and NFPA 10. The deficient practice was evidenced by the following: At 12 50 PM, the surveyor observed in the facility		The ansul system inspection was addressed by the Maintenance Director and the inspection tag completed. All residents have the potential to be affected by the deficient practice. All Maintenance personnel have been in-serviced on the importance of inspecting and logging areas of fire protection.	

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K 324	Continued From page 3 kitchen, that the monthly inspection tag was blank and no required monthly inspection of the ansul system was logged. The surveyor interviewed the Assistant Maintenance and Maintenance Director (from another sister facility), during the observation and they confirmed, that the ansul monthly inspection tag was not completed and left blank. The Administrator was informed informed of the deficiency at the Life Safety Code exit conference on 11/9/2022. NJAC 8:39-31.2(e) NFPA 96 and NFPA 10.	K 324	Maintenance Director will audit inspection tags. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance/Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341		12/29/22

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K 341	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/9/22, in the presence of facility management, it was determined that the facility failed to install supervised smoke/heat detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. This deficient practice was observed in 1 of 1 areas and was evidenced by the following: During the tour of the building, in the presence of the Assistant Maintenance Director and Maintenance Director (from another sister facility), it was observed that the facility failed to provide supervised smoke/heat detection in the following location: At 12:15 PM, an inspection inside the main kitchen was performed. The surveyor observed no evidence of a smoke/heat detector within 20 feet of the cooking system as required by code. The Assistant Maintenance Director and Maintenance Director (from another sister facility), confirmed the finding at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 11/9/22. NJAC 8:39 -31.2 (a).	K 341	Maintenance Director addressed by contacting vendor and scheduled installation of heat detector in the location specified. Heat detector was installed 12/21/22. All residents have the potential to be affected by the deficient practice. The maintenance personnel were in-serviced on the need of having a heat sensor within 20 feet of the cooking system as required by code. The Maintenance Director or designee will monitor the heat detector weekly for 3 weeks, monthly for 6 months, and then semi-annually by the vendor inspection. Findings will be reported quarterly to the Quality Assurance Committee.	
K 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals	K 352		11/30/22

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K 352	Continued From page 5 Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review on 11/9/22, in the presence of the Assistant Maintenance Director and Maintenance Director (from another sister facility), it was determined that the facility failed to maintain the fire sprinkler system in accordance with NFPA 13 and 72, by failing to ensure that the water supply valves were provided with tamper alarms. This deficient practice was identified for 1 of 1 post indicator valve's and was evidenced by the following: At 12:30 PM, the surveyor observed on the outside of the facility that the red wall mounted unlocked post indicator valve was not monitored. The red wall mounted post indicator valve window that indicates open or closed was not obvious, as the window was dirty inside and out with debris. The sign on the wall indicated "wall hydrant". Assistant Maintenance Director and Maintenance Director (from another sister facility) were interviewed during the observation and they stated that the post indicator valve window was filled with debris and was unclear if the valve was open or closed. The fire sprinkler vendor documentation did not indicate if the post	K 352	Maintenance Director contacted vendor and they were scheduled to arrive on site and inspect the valve on 11/30/22. 11/30/22 vendor arrived at 1:56 pm. The outdoor valve was cleaned, tested, and said to be in good working order. All residents have the potential to be affected by this deficient practice. There were no other issues identified. Maintenance Director/designee along with contracted Fire Sprinkler company will maintain scheduled quarterly inspections to ensure system is in proper functioning order. The Maintenance Director/designee will check to ensure that the site glass is clear. Inspections will take place quarterly. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance/Performance Improvement Committee meeting. QAPI committee will	

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K 352	Continued From page 6 indicator valve was annually inspected and it was unclear if the post indicator valve wall hydrant had anything to do with the fire sprinkler system. The Administrator was notified of the finding at the Life Safety Code exit conference on 11/9/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25, 72 NFPA 101 2012 edition Life Safety Code 9.7.2.1* (Supervisory Signals)	K 352	determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	
K 363 SS=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 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	K 363		2/8/23

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K 363	Continued From page 7 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/9/22 in the presence of the Assistant Maintenance Staff member and Maintenance Director (from another sister facility), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was further identified in 12 of 50 residents' room doors observed and was evidenced by the following: During the building tour from 9:15 AM to 3:00 PM, the surveyor, the Assistant Maintenance Staff member and Maintenance Director (from another sister facility), toured the facility and observed:	K 363	Maintenance Director contacted vendor to replace the listed doors that maintenance personnel is unable to fix in house due to warping. Four (4) doors were fixed in-house immediately (NJ EX Order. 26). Doors NJ EX Order. 264b1 NJ EX, and NJ EX need to be replaced by the vendor. The completion date for replacement of doors is April 26, 23. We are requesting a Time-Limited Waiver. All residents have the potential to be affected by this deficient practice. Maintenance Director inspected all other doors and corridors, and no apparent issues were found. If any If there are any doors found that do not close properly, the results will be reported to the Administrator for immediate action. In-service has been provided to Maintenance Personnel. The Maintenance Director/designee will	

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K 363	Continued From page 8 Resident Room # the door would not fully close due to the warped wooden door. Resident Room # will not latch due to a hardware malfunction. Resident Room # the door would not latch due to a hardware malfunction. Resident Room # 37 the top of the door when closed, produced a 1/4" opening. Resident Room the top of the door was warped. Resident Room the door sticks into its frame. Resident Room the door sticks into its frame. Resident Room the door sticks into its frame. Resident Room the door sticks into its frame. Resident Room the door sticks into its frame. Resident Room the door sticks into its frame. Resident Room the door sticks into its frame and will not latch, At the time of observations, the surveyor interviewed the Assistant Maintenance Staff member and Maintenance Director (from another sister facility), who both confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 11/9/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	conduct weekly audits. The completion of audits will be monitored by the Administrator or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance/Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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K 918	Continued From page 9	K 918		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918		2/8/23

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K 918	Continued From page 10 Based on observation and interview on 11/9/22, in the presence of the assistant Maintenance Director and Maintenance Director (from another sister facility), it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 generator's and installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 1:05 PM, the assistant Maintenance Director and Maintenance Director (from another sister facility), observed the interior 60 KW generator. There was no remote manual stop station to prevent inadvertent or unintentional operation, located remotely outside the area of the enclosure housing the prime mover. The assistant Maintenance Director and Maintenance Director (from another sister facility), stated and confirmed the finding above. The Administrator was informed of the finding's at the Life Safety Code exit conference held on 11/9/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	Maintenance Director scheduled vendor to arrive on site and provide a quote to install the remote generator shut off switch. The completion date of the installation of the remote manual stop station is March 28, 2023. We are requesting a Time-Limited Waiver. All residents have the potential to be affected by this deficient practice. Maintenance personnel were educated to ensure that by code a remote manual stop station is needed. Maintenance Director/designee will schedule remote generator shut off switch to be tested by the vendor as part of the quarterly inspection. Findings will be reported quarterly at QA. Vendor quarterly reports will be reviewed by the QA committee in making sure the shut off is working properly.	