STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315500	A. BUILDING **01** B. WING _____	**09/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (VOORHEES WEST)	**1086 DUMONT CIRCLE** **VOORHEES, NJ 08043**

(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 09/09/21 and 09/10/21, and Promedica Skilled Nursing & Rehab (Voorhees West) 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 Promedica Skilled Nursing and Rehab (Voorhees West) 31-5500 is a 2-story building that was built in 2006. The facility is composed of brick and concrete. The facility is divided into 11 smoke zones. The generator does 100% of the building. During a Standard Survey conducted on 09/17/2021, it was determined that effective 09/03/2021, the Facility was found to have been in Immediate Jeopardy for K346. The NJ Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 09/09/2021, including the Immediate Jeopardy Template. The Facility failed to:	K 000		

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

Electronically Signed | 09/30/2021

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K 000	Continued From page 1 - implement a fire watch procedure when the facility's fire alarm system was unable to notify the authorities in the event of a fire. On 09/09/2021, the NJ Department of Health received an acceptable plan for the Removal of Immediate Jeopardy. On 09/10/2021, the NJ Department of Health conducted an onsite survey and determined that the Immediacy of the Jeopardy could be removed effective 09/09/2021. The non-compliance remained on 9/10/2021 at 2:00 p.m., at no actual harm that is not immediate jeopardy based on the following: See K-346.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS	K 222		10/19/21

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K 222	Continued From page 2 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 3 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/10/21, in the presence of the Maintenance Director and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that the 15-second delayed egress feature on 2 of 6 exit discharge doors observed would activate when tested. This deficient practice was evidenced by the following: 1. The surveyor observed at approximately 9:28 AM, that the egress door to the stairwell, by the elevator and salon exit, had a 15-second delayed egress feature installed. The Maintenance Director attempted to activate the delayed egress feature, but this feature did not work. The door was provided with a key pad that opened the door and the fire alarm would open the door when activated, as per the Maintenance Director. 2. The surveyor observed at approximately 10:45 AM, that the egress door to the stairwell, by resident rooms [redacted] and [redacted] had a 15-second delayed egress feature installed. The Maintenance Director attempted to activate the delayed egress feature, but this feature did not work. The door was provided with a key pad that opened the door and the fire alarm would open the door when activated, as per the Maintenance Director. These findings were verified by the Maintenance Director and RPOD, during the observations and testing of the doors.	K 222	Both sets of egress doors have been properly fixed as of 9/11/21 by the Director of Maintenance. A comprehensive review of all egress doors was completed by the Director of Maintenance on 9/11/21-current of egress doors to ensure all egress doors are functioning and closing appropriately, and that the 15 second fixture is working properly. To prevent the deficient practice from re-occurrence the Director of Maintenance will be educated on the “Focus on K-tag 222” and “Clinical or Security locking requirements” on or before the date of compliance. Director of Maintenance will monitor the performance of the Egress doors weekly to ensure the 15 second fixture is working properly. The Nursing Home Administrator/designee will audit the in-house inspection reports completed by the Director of Maintenance and investigate weekly x4 weeks to ensure all inspections are completed with fire door checks and are in working condition. Results will be reviewed with QA&A weekly until substantial compliance is met and then reports will be reviewed with monthly QA.	

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K 222	Continued From page 4 The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 09/10/21. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents on 09/09/21 and 09/10/21, in the presence of the Maintenance Director and Regional Plant Operations Director (RPOD), it was determined that the facility failed to inspect the fire alarm system batteries semi-annually in accordance with NFPA 72. This deficient practice was evidenced by the following: On 09/09/21, a review of the facility's fire alarm system inspection for the previous 12 months revealed that the fire alarm system was inspected by the licensed vendor on 06/16/20 and 06/18/21. These reports indicated the facility's system utilized sealed lead-acid batteries requiring semi-annual load voltage testing.	K 345	A semi-annual fire alarm system testing and inspection was completed on 10/18/21 and inspection was completed with no improvements needed at this time. A comprehensive review of inspection reports was completed by the Director of Maintenance /Nursing Home Administrator with a look-back period of 9.1.21-current for missed inspections/testing to ensure appropriate inspections/testing were completed. To prevent the deficient practice from re-occurrence the Director of Maintenance was educated by the Regional Plant Operations Manager on the fire alarm inspection maintenance and “Focus on	10/19/21

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K 345	Continued From page 5 In an interview on 09/10/21 at 9:45 AM, the RPOD stated he would check with the facility's fire alarm inspection vendor and then stated that the semi-annual inspection was not done and may not have been done, due to Covid-19. The facility was asked to provide any emails or documents stating so, but no confirmation was provided, at the Life Safety Code exit conference. On 09/10/21, the facility's Administrator was informed of the deficiency at the Life Safety Code exit conference. NJAC 8:39-31/1(c), 31.2(e) NFPA 72	K 345	K-tag 345" on or before the date of compliance. Director of Maintenance will conduct weekly Fire Alarm Testing/Maintenance inspections. The Nursing Home Administrator/designee will audit Fire Alarm Testing/Maintenance inspection reports weekly x4 to ensure all inspections are done timely and documented. Results will be reviewed with QA&A weekly until substantial compliance is met and then reports will be reviewed with monthly QA.	
K 346 SS=L	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to implement a fire watch procedure when the facility's fire alarm system was unable to notify the authorities in the event of a fire. The facility's failure to implement its Emergency	K 346	A Reportable Event/Record Report was completed for the Fire Alarm System-Out of Service/fire panel in trouble mode to the Department of Health on 9/10/21 at 1452 and incident was concluded. Fire watch was initiated on 9/10/21 due to fire alarm panel reading "trouble mode.	10/19/21

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K 346	Continued From page 6 Response policy and procedures posed a serious and immediate threat to the safety and well-being of all the residents, staff, and visitors in the facility. This resulted in an Immediate Jeopardy (IJ) situation that began on 09/03/21 at 3:15 PM, when the facility was notified that the fire alarm system would not notify the authorities in the event of a fire. The facility Administration was notified of the IJ on 09/09/21 at 2:00 PM. The immediacy was removed on 09/09/21 at 5:17 PM. The removal plan was accepted and verified by surveyors on 09/10/21 at 2:00 PM. The non-compliance remained on 9/10/2021 at 2:00 p.m., at no actual harm that is not immediate jeopardy based on the following: The evidence was as follows: On 09/09/21 at 9:30 AM, the Life Safety Code (LSC) Surveyor observed the fire alarm annunciator panel located in the front entrance between the two sets of entrance doors. The panel indicated "TROUBLE MODE" and flashed "COMMUNICATION ERROR." During an interview with the LSC Surveyor on 09/09/21 at 10:00 AM, the Maintenance Director (MD) stated the fire alarm annunciator panel had been in "trouble mode" since a storm on 09/03/21. The MD further stated that the fire alarm company emailed him on 09/03/21, to inform him that there was no phone service to the fire alarm panel, and it would not notify the authorities in the event of a fire. When asked if a fire watch was implemented, the MD stated, "no." Review of the email, dated 09/03/21 at 3:15 PM, from the fire alarm company to the MD included	K 346	Fire watch was concluded on 9/11/21 at 1500 due to panel restored to proper functioning and no longer in “trouble mode”. To prevent the practice from re-occurrence, the Maintenance Director was educated by the Regional Plant Operations Manager, in addition to the Nursing Home Administrator by the Quality Assurance Consultant on the Emergency Response policy, “Focus on K-tag 346”, and procedure and the Fire Watch Policy on 9/10/21. Director Of Nursing/Nursing Home Administrator educated the interdisciplinary team on the “Fire Alarm Panel Communication” as well as Fire Watch process on or before the date of compliance. The Director of Maintenance will monitor the fire alarm panel daily to ensure the panel is functioning properly and to ensure there are no error messages displayed. The Director of Maintenance/Nursing Home Administrator will audit the fire alarm panel fire alarm panel will be completed daily x4 weeks to ensure the panel is reading normal and no “trouble mode” or communication errors are present. Results of the audits will be reviewed with QA&A weekly until substantial compliance is met and then reports will be reviewed with monthly QA.	

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K 346	Continued From page 7 that the facility's fire panel "is unable to notify the authorities and contact list at this time," and, "until [the provider company] is able to correct the problem, there will be no phone service to that panel." Further review of the email included that the MD forwarded the email to the facility's Administrator (LNHA) and Regional Plant Operations Director (RPOD) on 09/03/21 at 3:25 PM. During an interview with Surveyor #1 on 09/09/21 at 10:15 AM, the LNHA stated that the issue with the fire alarm notification system was not reported to the New Jersey Department of Health (NJ DOH). During an interview with the LSC Surveyor and Surveyor #1 on 09/09/21 at 10:30 AM, the LNHA reviewed the aforementioned email and stated a fire watch was not implemented because "we still have service" and "it definitely rings to the fire company." On 09/09/21 at 11:00 AM, Surveyor #1 asked the MD to activate the fire alarm in the facility. Upon activation, the annunciator panel indicated, "Dialer Reporting." On 09/09/21 at 11:04 AM, the MD called the fire alarm company in the presence of the LSC Surveyor and Surveyor #1. The dispatcher stated that they received a signal that the fire alarm was ringing, but the phone lines were down, so the Central Station would not be notified, and no emergency response from the police or fire department would occur. The dispatcher further stated that the communication hub was currently under 2-feet of water since 09/03/21. When asked what the facility should do, the dispatcher	K 346		

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K 346	Continued From page 8 noted the facility should have implemented a fire watch and would have to call the fire and police departments themselves. On 09/09/21 at 11:14 AM, in the presence of the LSC Surveyor and Surveyor #1, the MD called the fire department because there was no emergency response to the activated fire alarm. When asked what the facility should have done after receiving notification of the downed communication lines, the Fire Commander stated the facility should have set up a fire watch since 09/03/21 when the communication system was compromised due to the flood of the hub. During an interview with Surveyor #2 on 09/09/21 at 11:30 AM, Registered Nurse/Unit Manager (RN/UM) #1 stated she was unsure if she received any additional education related to fire safety since 09/03/21. She further noted that during a fire emergency, she would make sure that the residents' bedroom doors were closed, assign staff to monitor the hallways, look at the annunciator panel, and listen for an announcement. When asked who was responsible for contacting emergency services in the event of a fire, the RN/UM stated she would have to double-check the facility's policy to know who was responsible. She further stated that the fire system should automatically communicate with the authorities when activated but that the "highest-level" person in the building should place the call to emergency services. During an interview with Surveyor #4 on 09/09/21 at 11:37 AM, the LNHA stated that on 09/03/21, she received an email from the fire alarm company, indicating the fire alarm would not notify the authorities. She further said she	K 346		

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K 346	Continued From page 9 notified the RPOD but that the fire alarm company and RPOD did not provide any recommendations. The LNHA also stated she did not notify the fire department or initiate a fire watch because she was "under the impression the fire alarm would function correctly" and that "the fire alarm company would receive a signal." She further stated, "I should have started a Fire Watch knowing what I know now." The LNHA also said that she should have reported the fire alarm to the NJ DOH. During an interview with Surveyor #3 on 09/09/21 at 11:42 AM, RN/UM #2 stated he had not received training on fire safety since 09/03/21, but a mock fire drill occurred in the last two weeks and was documented on an in-service sign-in sheet. He further stated that if the fire alarm sounds, the staff make sure patients are safe, ensure corridors are clear, doors are closed, find out fire location, and assist or evacuate as needed. When asked who was in charge when the fire alarm sounds, the RN/UM stated the UM is responsible for the unit and reports to the Director of Nursing. The RN/UM further noted that if there is no emergency response to the fire alarm, someone calls 911 according to "the proper chain of command." During an interview with Surveyor #2 on 09/09/21 at 2:35 PM, the Regional Director of Operations (RDO) stated that he was unaware that the facility's fire system was not communicating to emergency services. The RDO further noted that he would have instructed the facility to implement the necessary procedures and educate the staff if he had known of the issue. A review of the facility's Emergency Response	K 346		

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K 346	Continued From page 10 Manual Chapter 2 Fires, dated 01/2020, included, "A plan of action (Attachment C Fire Watch Procedure) is to be implemented should the Fire Alarm System or Automatic Fire Sprinkler System fail to work properly so continuous facility-wide detection, and alarm capabilities continue. The center will implement a fire watch under the following circumstances: 1. A fire system failure and is inoperable for a combined time period of four hours or more in a 24-hour period ... 6. Other circumstances determined by the Administrator or designee or as recommended by the local police/fire agency." Review of the facility's Fire Watch Procedure, dated 05/01/19, included, "Where a required Fire Alarm System is out of service for more than four (4) hours in a 24-hour period, or a Fire Sprinkler System is out of service for more than ten (10) hours in a 24 hour period, the authority having jurisdiction shall be notified and the building shall be evacuated, or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the system(s) have been returned to service." NJAC 8:39-31.2(e)	K 346		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where	K 372		11/10/21

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K 372	Continued From page 11 an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents on 09/09/21 and 09/10/21, it was determined that the facility failed to ensure that 11 of 108 fire/smoke dampers were operating correctly as per NFPA 80, 90A & 105. This deficient practice was evidenced by the following: On 09/09/21, the surveyor reviewed the documentation provided by the Maintenance Director. The "Damper Inspection History Report," from the facility vendor, dated 12/16/2019, indicated 11 of 108 dampers "failed" in the following locations of the facility and that "New Dampers are Required" as per the deficiency on the report: inside therapy, outside therapy, outside elevators, inside conference room, above front door, private dining, left of auxiliary storage, above auxiliary, outside private dining, inside kitchen, and inside janitors closet by kitchen. The 11 dampers that failed were confirmed by the Maintenance Director and Regional Plant Operations Director. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 09/10/21. NJAC 8:39-31.2(e)	K 372	Contracts are established and set for 11/9/21 to replace the 11 non-working fire/smoke dampers to be replaced so all 108 fire/smoke dampers will be operating correctly. All 11 non-worker dampers were repaired on 11/10/21 and are working properly. A comprehensive review of all fire/smoke dampers in the building have been tested on 9.11.21-current to ensure the remaining fire/smoke dampers are operating correctly. To prevent the deficient practice from re-occurrence, the Director of Maintenance was educated by the Regional Plant Operations Manager on the Focus on K-tag 372 on or before date of compliance. Director of Maintenance will audit the remaining fire/smoke dampers weekly to ensure they are operating correctly. The Nursing Home Administrator/designee will audit weekly maintenance inspection reports of the smoke barriers monthly to ensure all fire/smoke dampers are operating correctly. Results of the audits will be reviewed with QA&A weekly until	

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	315500	A. BUILDING **01** B. WING _____	**09/17/2021**

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K 372	Continued From page 12 NFPA 80, 90A & 105 NFPA 101 2012 Edition Life Safety Code -19.3.7.3-8.5.5.2	K 372	substantial compliance is met and the reports will be reviewed with monthly QA.	
K 521 SS=D	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 9/10/21, in the presence of the facility Maintenance Director and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure resident bathroom ventilation systems for 7 of 20 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: From 9:30 AM to 1:48 PM, the surveyor observed that the ventilation in the following resident room bathrooms did not function: Rooms [redacted] and [redacted] The surveyor requested that the Maintenance Director and RPOD, confirm if the units were functioning by placing a piece of single-ply toilet	K 521	Exhaust vents were inspected, cleaned and have been functioning properly as of 9.12.21 A comprehensive review of all Exhaust vents were inspected and cleaning was completed by the Director of Maintenance from 9.12.21-current to ensure all exhaust ventilation units are working properly. To prevent the deficient practice from re-occurrence, The Director of Maintenance was educated by the Regional Plant Operations Manager on the “Focus on K-tag 521” on or before the date of compliance. Director of Maintenance will conduct weekly HVAC inspections to ensure all exhaust vents are functioning properly.	10/19/21

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K 521	Continued From page 13 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 and RPOD, who confirmed that the approximately 6" x 6" 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 09/10/21. 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	K 521	The Nursing Home Administrator/designee will audit weekly maintenance inspection reports pertaining to exhaust ventilation units weekly x4 weeks to ensure all HVAC systems/exhaust ventilation units are operating correctly. Results will be reviewed with QA&A weekly until substantial compliance is met and then reports will be reviewed with monthly QA.	
K 531 SS=E	NJAC 8:39-31.2(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	K 531		10/28/21

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K 531	Continued From page 14 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/10/21, in the presence of the Maintenance Director and Regional Plant Operations Director (RPOD), it was determined that the facility failed to maintain elevator emergency communication for 2 of 2 passenger elevator telephones tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: The surveyor had the Maintenance Director and RPOD conduct a test of the emergency communication telephone system in the (2) facility's passenger elevators. The emergency telephone did not function properly at the time of the observation and the Maintenance Director and RPOD both confirmed this observation. The alarm bell was activated and worked properly during the observation. The Administrator was informed of this finding at the Life Safety Code exit conference on 09/10/21. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	A contract was established for repairs to replace the phones in the elevators; work was completed on 10.1.21 for replacement of phones in the elevators. One phone was replaced on 10.1.21 in elevator #2, and the phone was replaced on 10.20.21 in elevator #1. A comprehensive review of Elevator communication and function was completed by the Director of Maintenance from 10.1.21-current to ensure lines of communication and operation are working properly. The Maintenance Director was educated by the Regional Plant Operations Manager on the “Focus on K-tag 531”, as well as education on Safety Code for Elevators and Escalators, and the Firefighter’s Service Requirements on or before the date of compliance. Director of Maintenance will conduct weekly elevator inspections to ensure the elevators are functioning properly as well as all telephone communication in both elevators are working properly. The Nursing Home Administrator/designee will audit elevator	

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K 531	Continued From page 15	K 531	inspection reports weekly x4 weeks to ensure all elevator communication is tested and working in accordance with safety codes and requirements. Results of the audits will be reviewed with QA&A weekly until substantial compliance is met and then reports will be reviewed with monthly QA.	
K 918 SS=E	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	K 918		10/19/21

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K 918	Continued From page 16 circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents on 09/09/21 and 09/10/21, in the presence of the Maintenance Director and Administrator, it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame in accordance with NFPA 99 for emergency electrical generator systems. A review of the generator records for the previous nine months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds, when the load test was conducted. The log dated 05/01/19 indicated the generator was tested under load weekly from 12/21/20 to 09/03/21, and the log column for the "LOAD TRANSFER TIME" (seconds) was left blank. The Maintenance Director confirmed there was no transfer time data on the current weekly/monthly load tests documented on his report. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 09/10/21. NJAC 8:39-31.2(e), 31.2(g)	K 918	Maintenance Director has been educated by the Regional Plant Operations Manager on Generator Log Records and Recordings of weekly/monthly load test documentation. Generator logs have been implemented as of 9.11.21-current to reflect the transfer load times in accordance with the weekly and monthly generator load tests. To prevent the deficient practice from re-occurrence; The Maintenance Director was educated by the Regional Plant Operations Manager on the “Focus on K-tag 835” and the Essential Electric System Maintenance and Testing. On-going audits of the generator load logs (both weekly and monthly) will be completed by Director of Maintenance and reviewed by Nursing Home Administrator weekly x4 weeks to ensure the logs are being filled out properly and times are being recorded and documented. Results of the audits will be reviewed with QA&A weekly until substantial compliance is met and then reports will be reviewed monthly QA.	

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K 918	Continued From page 17 NFPA 99	K 918		