STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING **01** B. WING _____	**06/16/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK REHAB & HEALTHCARE CENTER	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

(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 not 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		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		6/22/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/27/2022

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E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on documentation review and interview conducted on 6/14/22, in the presence of the Administrator and Regional Operations Director, it was determined that the facility failed to fully review the Emergency Preparedness Plan (EPP) annually. This deficient practice was evidenced for 1 of 4 provisions by the following: At 10:30 AM, the surveyor reviewed the EPP. A review of the manual revealed that the review signature page was left blank for 1 of 4 provisions required for review. In an interview, at the time, the facility's Administrator provided a document indicating the facility's communication plan was reviewed and signed on 10/7/21, but the Risk Assessment and Planning, Policies and Procedures and Training and Testing provisions, indicated that the complete manual was not signed and reviewed.	E 004	Plan of Correction E004 Element One. On 6.22.22 the facility developed and maintain an emergency preparedness plan with the local Fire Inspector and with the County OEM Reviewed the Risk Assessment and Planning, Policies and Procedures and Training and Testing provisions and signed. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance Director received re-education regarding facility must develop and maintain an emergency preparedness plan that must be [evaluated] and updated at least every 2 years. Element Four.	

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E 004	Continued From page 2 At the Life Safety Code exit conference, the Administrator and Regional Operations Director, was informed of the deficient practice and confirmed the EPP review document was left blank. NJAC 8:39-31.2(e), 31.6(i)	E 004	The Maintenance Director or designee will complete audits on the facility emergency preparedness plan weekly for the next four weeks and then monthly for three months and then quarterly basis. The results of these audits will be reported to the Administrator and QA Committee quarterly	
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 6/13/22 and 6/14/22, 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 Facility is a 3-story building that was certified in 90's, It is composed of Type I fire resistant construction. The facility is divided into 11- smoke zones. The generator does approximately 80 % of the facility. 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		

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K 000	Continued From page 3 The facility has 100 certified beds. At the time of the survey the census was 69. The completed FSES (fire safety evaluation system) dated 2/22/22 (as of a result of the 2019 survey) indicated that: Cranford Park Rehabilitation & Health Care Center, provider # 31-5390 is comprised of 3-buildings: Nursing Home (two stories and basement); Annex Section (two stories); and C-unit (three stories and basement).	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH)	K 161		8/4/22

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K 161	Continued From page 4 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/14/22, it was determined that the facility failed to comply with the construction requirements of NFPA 101:21012 as evidenced by the following: During a tour of the Annex section of the building from 9:30 AM to 1:00 PM, in the presence of the facility's Administrator and Corporate Operations Director, the Surveyor observed that it was a 2-story wood-frame structure, exceeding the 1-story height requirement for wood-frame structures. The condition noted above was confirmed by the facility's Administrator and Corporate Regional Operations Director, during the Life Safety Code exit conference on 6/14/22. NJAC 8:39-31.2(e)	K 161	K161 the facility has conducted an Fire Safety Evaluation System (SFES) on 8/4/2022 for compliance with NFPA 101A-20123. the FSES equivalency calculation did pass the FSES. Staff to be trained Quarterly extensively on enhanced level of safety concerning annex section for evacuating residents, five hazards, electrical hazards, sprinkler system and fire alarm system operations. Additional monitoring of building to be conducted by the administrator daily and corporate physical plant (Monthly) The results of these audits will be reported to the Administrator and QA Committee quarterly.	

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K 211	Continued From page 5	K 211		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on documentation review on 6/13/22, in the presence of the Maintenance Director, it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was evidenced for 9 of 9 fire doors observed by the following: At 10:00 AM, the surveyor reviewed all provided documentation from the Maintenance Director. The annual fire door inspection documentation was not provided for the facility's fire door assemblies. An interview was conducted with the Maintenance Director, during the document review, where they stated that currently no further documentation could be provided on fire door inspections (Annual) for the last 12-months as identified in the S&C 17-38-LSC documentation. The Administrator was informed of the finding at the Life Safety Code exit conference on 6/14/22. NJAC 8:39-31.1(c), 31.2(e)	K 211	Plan of Correction K211 Element One. On 6.20.22 Maintenance Director inspected all fire doors in the facility ensuring proper closing and documented the annual fire door inspection. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance staff received re-education regarding documenting the fire doors inspection. all staff were in-serviced to ensuring that all means of egress is continuously maintained free of all obstructions to full use in case of emergency in the facility. Element Four. The Maintenance Director or designee will complete weekly audits for the next 4 weeks and then monthly for three months and then quarterly basis and inspection all means of egress is continuously maintained free of all obstructions to full use in case of emergency in the facility.	6/20/22

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K 211	Continued From page 6 NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC	K 211	The results of these audits will be reported to the Administrator and QA Committee quarterly.	
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 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	K 222		6/20/22

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K 222	Continued From page 7 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. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of the Maintenance Director on 6/13/22, it was determined that the facility failed to a.) provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 for 1 of 2 sets of exterior egress doors observed and b.)	K 222	Plan of Correction K222 Element One. On 6.18.22 Maintenance Director removed a hook-type deadbolt from the Physical Therapy exit/egress set of doors. On 6.20.22 Maintenance Director installed a new magnetic lock system that ties in the lock into the fire panel and removed the label from the doors on C unit from near room #9 and from the door near #14	

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K 222	Continued From page 8 ensure that the 15-second delayed egress feature for 2 of 6 exit discharge doors (with this feature) observed would activate when tested. This deficient practice was evidenced as follows: A. On 06/14/22 at 9:30 AM, the Surveyor and Maintenance Director observed at the Physical Therapy exit/egress set of doors, that 1 of 2 doors revealed that at the exterior-side of the set of doors, 1 of 2 doors had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The Maintenance Director was interviewed at the time of the observation, where he stated that no staff member had a key including himself and the lockset was never engaged. B. 1. On 06/14/22 at 12:50 PM, the Maintenance Director observed that the exit/egress set of door's to the main lobby by resident room 14, had a 15-second delayed egress feature and the door was labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door's egress feature did not function. The door had a keypad that opened the door and according to the Maintenance Director, the fire alarm would release the device if it is activated. B.) 2. On 06/14/22 at 1:22 PM, the Maintenance Director observed that the exit/egress door, by resident room 9, had a 15-second delayed egress feature and the door was labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door's egress feature did not function. The door had a keypad that opened the door and according to the	K 222	that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds.", all staff where instructed to use the keycode to open the door. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance staff received re-education regarding inspecting ensure that the 15-second delayed door egress feature that they activate. all staff were in-serviced to ensuring that all means of egress has delayed egress locking systems in accordance with 7.2.1.6.1 to full use in case of emergency in the facility. Element Four. The Maintenance Director or designee will complete audits and inspection all means of egress has delayed egress locking systems in accordance with 7.2.1.6.1 installed in the facility, The audit will be conducted weekly x 4, then monthly x 3. All findings will be presented during the monthly QAPI committee meeting for review.	

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K 222	Continued From page 9 Maintenance Director, the fire alarm would release the device if it is activated. An interview was conducted with the Maintenance Director, who confirmed the findings during the observations. The Administrator and Regional Operations Director, was notified of the findings at the Life Safety Code exit conference on 6/14/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222		
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/14/22, it was determined that the facility failed to provide 2 acceptable exits from each floor or fire section of the building as evidenced by the following: During a tour of the building from 9:30 AM, to 1:30 PM, in the presence of the facility's	K 252	K252 the facility has conducted a Fire Safety Evaluation System (SFES) on 8/4/2022 for compliance with NFPA 101A-20123. the FSES equivalency calculation shows	8/4/22

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K 252	Continued From page 10 Administrator and Corporate Regional Operations Director, the surveyor observed the following conditions: 1. The stairway leading from the 3rd floor of the older section of the building was of a winding design. Also, the basement stairway was of a winding design. 2. The 2nd exit/means of egress from the 3rd floor was through a dining room leading to a fire escape. The above conditions were confirmed in an interview with the facility's Maintenance Director, Administrator and Corporate Regional Operations Director at 1:35 p.m. who indicated that the issues identified in this section of the building was previously allowed through approved NJDOH and CMS waivers. The facility was informed to conduct an on-site Fire Evaluation System (FSES) survey for this recertification.	K 252	that Cranford Park Rehabilitation and Healthcare Center a passing score on the FSES calculation. Staff to be trained extensively on enhanced level of safety concerning annex section for evacuating residents, five hazards, electrical hazards, sprinkler system and fire alarm system operations. Additional monitoring of building to be conducted by the administrator daily and corporate physical plant (Monthly) The results of these audits will be reported to the Administrator and QA Committee quarterly.	
K 271 SS=E	NJAC 8:39-31.2(e) Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by:	K 271		6/17/22

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K 271	Continued From page 11 Based on observation and interview on 6/13/22, the facility failed to provide and maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient condition was evidenced for 1 of 3 exit discharges by the following finding: At 10:29 AM the Surveyor and Maintenance Director observed that outside the A-floor (rightside) exit/egress door stair landing, the approximately 5'x3' concrete landing at the curb-side, had receded approximately 1-1/2 inches, lower than the curbing. This unlevel walking surface, failed to maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency. The Maintenance Director confirmed the finding's during the observation. The Administrator and Regional Operations Director were informed of the finding at the Life Safety Code exit conference on 6/14/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.7, 19.2.7	K 271	Plan of Correction K271 Element One. On 6.17.22 Maintenance Director Removed landing at the curb- side receded 1-1/2 and renovated the walkway to a level walking surface and free of all obstructions or impediments. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance staff received re-education regarding maintaining all walkways to a level walking surface and free of all obstructions or impediments. all staff were in-serviced to ensuring that all walkways are level walking surface and free of all obstructions or impediments Element Four. The Maintenance Director or designee will complete audits weekly for the next 4 weeks and then monthly for three months and then quarterly basis. and inspection all walkways in the facility to a level walking surface and free of all obstructions or impediments, for four weeks and then monthly The results of these audits will be reported to the Administrator and QA Committee quarterly.	
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	K 281		6/17/22

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	315390	A. BUILDING **01** B. WING _____	**06/16/2022**

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K 281	Continued From page 12 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 interviews on 6/13/22, the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affects 4 of 6 areas observed and was evidenced by the following: 1. At 11:00 AM the Surveyor and Maintenance Director observed outside resident room 5 that the wall switch shut off all the corridor lights. The area had emergency lighting, but the Maintenance Director stated that the emergency lights only activate when the facility loses power. In an emergency, if the facility does not lose power, all the lighting in the exit/egress corridor can be shut off. 2. At 11:18 AM, the Surveyor and Maintenance Director observed in the B-unit the wall switch shut off all the corridor lights. The area had emergency lighting, but the Maintenance Director stated that the emergency lights only activate when the facility loses power. In an emergency, if the facility does not lose power, all the lighting in the exit/egress corridor can be shutoff. 3. At 11:52 AM, the Surveyor and Maintenance Director observed in the annex-C corridor, that the wall switch shut off all the corridor lights. The area had emergency lighting, but the Maintenance Director stated that the emergency light's only activate when the facility loses power,	K 281	Plan of Correction K281 Element One. On 6.17.22 Maintenance Director Removed the switch shut off all the corridor lights outside resident room 5. On 6.17.22 Maintenance Director Removed the switch shut off all the corridor lights B-unit. On 6.17.22 Maintenance Director Removed the switch shut off all the corridor lights in the annex-C corridor. On 6.17.22 Maintenance Director Removed the switch shut off in the stairwell chairlift location. Element Two. All residents of the facility had the potential to be affected. Element Three. Housekeeping staff and maintenance staff received re-education regarding keeping the corridor lights continuously in operation or capable of automatic operation without manual intervention. all staff were in-serviced to ensuring that the corridor lights always open in the facility. Element Four. The Maintenance Director or designee will complete audits and inspection weekly for the next four weeks and then monthly for three months and then quarterly basis. corridor lights in all the facility that they are continuously in operation, The results of these audits will be reported to the	

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K 281	Continued From page 13 and in an emergency, if the facility does not lose power, all the lighting in the exit/egress corridor can be shutoff. 4, At 12:10 PM, the Surveyor and Maintenance Director observed in the stairwell (chairlift location) by resident room 212, that the wall switch shut off all the corridor lights. The area had emergency lighting, but the Maintenance Director stated that the emergency light's only activate when the facility loses power, and in an emergency, if the facility does not lose power, all the lighting in the exit/egress corridor can be shutoff. The findings were verified by the Maintenance Director at the time of the observation's. The Administrator and Regional Operations Director were informed of the finding at the Life Safety Code exit conference on 6/14/22. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2)	K 281	Administrator and QA Committee quarterly.	
K 311 SS=F	NJAC 8:39-31.2(e) Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with	K 311		8/4/22

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K 311	Continued From page 14 construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/14/22, it was determined that the facility failed to ensure that vertical openings between floors were enclosed with 1-hour fire-rated construction as evidenced by the following: During a tour of the building from 11:25 AM to 1:00 PM, in the presence of the facility's Maintenance Director, Administrator and Corporate Regional Operations Director, the surveyor observed the stairway connecting the first and second floors in the C Unit was not enclosed with 1-hour fire rated walls on both sides and a fire-rated door at the bottom. This condition was confirmed by the facility's Administrator and Corporate Regional Operations Director during the Life Safety Code exit conference on 6/14/22. The facility was informed to conduct an on-site Fire Evaluation System (FSES) survey for this recertification. NJAC 8:39-31.2(e)	K 311	K311 the facility has conducted a Fire Safety Evaluation System (SFES)on 8/4/2022 for compliance with NFPA 101A-20123. the FSES equivalency calculation shows that Cranford Park Rehabilitation and Healthcare Center did pass the FSES. the open stairway is not being used as an exist for any emergency or resident transfer, only being for the style and layout of the interior lobby of the facility Safety programs will entail increased training for evacuating residents via this stairway (eg) additional fire/evacuation drills and additional facility in services. Daily monitoring of stairway by maintenance director and administrator to ensure stairway is free of obstructions. The results of these audits will be reported to the Administrator and QA Committee quarterly.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9.	K 321		6/20/22

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K 321	Continued From page 15 When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/14/22, in the presence of the Maintenance Director, it was determined that the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous area in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in 2 of 10 hazardous storage areas in the facility and was evidenced by the following: 1. At 10:50 AM, the Surveyor in the presence of	K 321	Plan of Correction K321 Element One. On 6.20.22 Maintenance Director installed door closer on the Medical Storage/Electrical door. On 6.20.22 Maintenance Director installed door closer on linen closet on floor #3. Element Two. All residents of the facility had the potential to be affected. Element Three.	

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K 321	Continued From page 16 the Maintenance Director observed in the basement, that the Medical Storage/Electrical room was observed to have 50 plus combustible cardboard boxes and the room was greater than 50 square feet in size. The door did not have a self-closing device installed. 2. At 11:35 AM, the Surveyor in the presence of the Maintenance Director observed that the floor #3 linen closet was filled with hazardous storage. The room was greater than 50 square feet in size and contained many combustible cardboard boxes and the door did not have a self-closing device installed. An interview was conducted with the Maintenance Director at the time of the observation, who confirmed that hazardous storage areas must have a door with a self-closing device. The Administrator and Regional Operations Director were informed of the findings at the Life Safety Code exit conference on 6/14/22. NJAC 8:39-31.2(e)	K 321	Maintenance staff received re-education regarding all Doors shall be self-closing on rooms that are greater than 50 square feet in size. all staff were in-serviced to ensuring that all Doors shall be self-closing in the facility. Element Four. The Maintenance Director or designee will complete audits and inspection all Doors shall be self-closing in the facility, weekly for four weeks and then monthly for three months and then quarterly basis. The results of these audits will be reported to the Administrator and QA Committee quarterly.	
K 345 SS=F	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	K 345		8/4/22

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K 345	Continued From page 17 by: Based on surveyor's observation, interview and record review on 6/13/22, it was determined the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents and was evidenced by the findings noted below: 1. At 12:15 PM, the Surveyor and Maintenance Director reviewed all fire alarm inspections dated: 2/12/21 and 2/25/22. The documentation stated the "fire alarm inspection and testing report" indicated that the service was conducted semiannually. The current inspection reports were 1-year apart and not done on the required semiannual basis. The document indicated that under "Battery Type" the system used Sealed Lead-Acid Batteries requiring a semi annual inspection. 2. On 6/13/22 during the Fire Alarm documentation review, the reports dated 2/12/21 and 2/25/22 indicated "Smokes more than 10-years old are recommended to be replaced." 3. On 6/13/22 during the Fire Alarm documentation review, The reports dated 2/12/21 and 2/25/22 both indicated that the manual pull stations 105 and 106 did not report to the panel (failed). The floor #1 manual pull stations were located in zones 105 (Solarium) and 106 (Main Entrance). An interview was conducted with the Maintenance Director during the document review and he stated that the repairs were completed, but he	K 345	Plan of Correction K345 Element One. On 8.04.22 facility conducted a fire alarm inspection on the entire facilities fire alarm system with specifically the Battery Type, Smokes more than 10- years old were replaced, and pull stations 105 and 106 have been inspected and working properly. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance staff and all staff received re-education regarding requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Element Four. The Maintenance Director or designee will complete audits and inspection for four weeks and then monthly for three months and then quarterly basis. all fire Alarm and Signaling Codes in the facility, The results of these audits will be reported to the Administrator and QA Committee quarterly.	

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K 345	Continued From page 18 could not provide any documentation indicating so. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70,National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. The Administrator and Regional Operations Director were informed of the deficiency at the Life Safety Code exit conference on 6/14/22. NFPA 70 NFPA 72 NJAC 8:39-31.2(e)	K 345		
K 351 SS=E	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,	K 351		8/10/22

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K 351	Continued From page 19 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 6/13/22 in the presence of the Maintenance Director, it was determined that the facility failed to provide automatic fire sprinkler system protection to all areas in accordance with NFPA 13. This deficient practice was identified for 1 of 10 closets observed and was evidenced by the following: At 9:00 AM, the surveyor observed there was no fire sprinkler protection provided to the closet outside the conference room. The closet was approximately 3' x 2' in size and contained combustible storage (Wooden Night Stand). An interview was conducted with the Maintenance Director at the time of the observation, where he confirmed that the closet did not have any fire sprinkler coverage. The Administrator and Regional Operations Director were informed of the observation at the life Safety Code exit conference on 6/14/22. NJAC 8:39-31.2(e) NFPA 13, 25	K 351	Plan of Correction K351 Element One. On 8.10.22 the facility installed fire sprinkler coverage protection to the closet outside the conference room. On 6.20.22 Maintenance Director Removed the combustible storage Wooden Nightstand from the closed. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance staff received re-education regarding the requirement to provide automatic fire sprinkler system protection to all areas in accordance with NFPA 13. all staff were in-serviced to ensuring that all closets in the facility provide automatic fire sprinkler system protection. Element Four. The Maintenance Director or designee will complete audits and inspection all Closets automatic sprinkler in all the facility, weekly for the next four weeks and then monthly for three months and then quarterly basis. The results of these audits will be reported to the Administrator and QA Committee quarterly.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		6/20/22

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K 353	Continued From page 20 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interviews on 6/13/22, it was determined that the facility failed to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. This deficient practice was evidenced by the following: 1. At 1:00 PM, the Surveyor and Maintenance Director observed on floor #2, that the concealed fire sprinkler head was missing the finish cap outside the" nurse in charge" room. 2. At 1:15 PM, the Surveyor and Maintenance Director observed in room marked #5, that the ceiling was open around pipes and wiring approximately 3' x 2'. The Maintenance Director confirmed the above	K 353	Plan of Correction K353 Element One. On 6.20.22 Maintenance Director installed finish cap on fire sprinkler head outside the nursing office on floor #2 On 6.20.22 Maintenance Director fireproofed with Fire Block SEALANT (3m) the opening in room #5 around pipes and wiring . Element Two. All residents of the facility had the potential to be affected. Element Three. Housekeeping staff and maintenance staff received re-education regarding keeping the Automatic sprinkler and standpipe systems from openings. all staff were in-serviced to ensuring that the ceiling was smoke resistant, and fire rated in the facility.	

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K 353	Continued From page 21 findings during the observations. The Administrator and Regional Operations Director, was informed of the findings at the Life Safety Code Exit Conference on 6/14/22. NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1.	K 353	Element Four. The Maintenance Director or designee will complete audits and inspection automatic sprinkler head in all the facility, and inspect the automatic sprinkler system's source pipe are cleared from openings, weekly for four weeks and then monthly for three months and then quarterly basis. The results of these audits will be reported to the Administrator and QA Committee 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		6/17/22

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K 363	Continued From page 22 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 06/13/22, in the presence of the Maintenance Director, 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 was identified for 4 of 30 corridor doors observed and was evidenced by the following: 1. At 10:20 AM, the Surveyor and Maintenance Director observed that the door to resident room 106, would not latch into the frame, due to tape on the strike plate of the latch jamb. 2. At 1:00 PM, the Surveyor and Maintenance Director observed on floor #3 that the door to the "old house" had an approximately 1/2" hole due to missing hardware. 3. At 1:32 PM, the Surveyor and Maintenance Director observed that the door to resident room UA-4 would not close properly, due to the doorside privacy curtain getting caught in the door	K 363	Plan of Correction K363 Element One. On 6.17.22 Maintenance Director fixed the door to resident room 106 to latch into the frame. On 6.17.22 Maintenance Director fixed the door to old house on floor #3 and replaced hardware to latch into the frame. On 6.17.22 Maintenance Director fixed the door to resident room UA-4 and removed the privacy curtain from near the door. On 6.17.22 Maintenance Director fixed door to resident room #3 and removed the bedframe from doorway to latch into the frame. Element Two. All residents of the facility had the potential to be affected. Element Three. Housekeeping staff and maintenance staff received re-education regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING **01** B. WING _____	**06/16/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK REHAB & HEALTHCARE CENTER	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

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K 363	Continued From page 23 frame, when the surveyor attempted to close the door. 4. At 1:40 PM, the Surveyor and Maintenance Director observed that the door to resident room #3 stuck into the frame of the door causing an impediment to the closing of the door. The Maintenance Director confirmed the findings during the observations. The Administrator and Regional Operations Director were informed of the findings at the Life Safety Code exit conference on 06/13/22. 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	maintaining all residents room doors latch into the frame. all staff were in-serviced to ensuring that all residents room doors latch into the frame in the facility. Element Four. The Maintenance Director or designee will complete audits and inspection for four weeks and then monthly for three months and then quarterly basis residents□ doors in all the facility that they latch into the frame, The results of these audits will be reported to the Administrator and QA Committee quarterly.	
K 531 SS=F	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,	K 531		6/30/22

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	315390	A. BUILDING **01** B. WING _____	**06/16/2022**

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K 531	Continued From page 24 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 documentation review and interview on 6/13/22, in the presence of Maintenance Director, it was determined that the facility failed to test and inspect the elevator annually with the Authority Having Jurisdiction.This deficient practice was evidenced by the following: A review of the facility's elevator inspection certificate, revealed that 2 of 2 elevator devices marked Device Type: Winding Drum and Inclined Platform Lifts were inspected 2/16/21. The required annual inspection was not completed as of 6/14/22, almost 4 months overdue. In an interview, at 11:30 AM, the facility's Maintenance Director stated they would contact their elevator inspection vendor to schedule the inspection. The Administrator was informed of this issue at the Life Safety Code exit conference on 6/14/22. He stated that he telephoned and notified the DCA for an inspection, but could not provide any information or documentation indicating any communication was verified as of 6/14/22. NJAC 8:39-31.2(e)	K 531	Plan of Correction K531 Element One. On 6.30.22 annual inspection was done by the State Elevator Department on the Winding Drum and Inclined Platform Lifts and passed. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance staff received re-education regarding maintaining all annual inspections up to date. Element Four. The Maintenance Director or designee will complete audits to ensure all annual inspection on the Winding Drum and Inclined Platform Lifts in the facility are done on time, The audit will be conducted weekly x 4, then monthly x 3. All findings will be presented during the monthly QAPI committee meeting for review.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99	K 911		7/27/22

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K 911	Continued From page 25 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 observation, document review and interview on 6/14/22, the facility did not demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. The deficient practice could affect all residents. At 12:05 PM, the Surveyor and Maintenance Director reviewed all generator documentation. The facility currently has a natural gas generator and could not produce a documented reliability letter from the natural gas provider. Reliability letters from natural gas vendor regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The finding was verified by the Administrator and Maintenance Director at the time of the observation. The Administrator provided a document from the generator vendor for a portable Backup Generator, but did not produce a	K 911	Plan of Correction K911 Element One. On 7.27.22 Maintenance Director received a statement regarding the low probability of no natural gas delivery and a written agreement with the local Natural Gas provider regarding fuel reliability of the natural gas delivery in case of an emergency. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance staff and all staff received re-education regarding reliability regarding fuel supply in accordance with NFPA 99, 2012. in case of emergency in the facility. Element Four. The Maintenance Director or designee will complete audits for four weeks and then monthly for three months and then quarterly basis with the Natural Gas provider in case of emergency in the facility, The audit will be conducted weekly x 4, then monthly x 3. All findings will be presented during the monthly QAPI committee meeting for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 911	Continued From page 26 documented reliability letter from the natural gas provider. The Administrator and Regional Operations Director were informed of the finding at the Life Safety Code exit conference on 6/14/22. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911		
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	K 918		6/17/22

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K 918	Continued From page 27 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: Based on review of facility documents, observations and interview on 6/14/22, in the presence of the Maintenance Director, it was determined that a.) 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 and b.) the facility failed to ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. A. This deficient practice was evidenced for 1 of 1 generator logs provided by the Maintenance Director by the following: A review of the generator records for the previous twelve months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently the Maintenance Director was performing a monthly load test, but he was not recording the required transfer times on the testing log. An interview was conducted with the Maintenance Director at the time of record	K 918	Plan of Correction K918 Element One. On 6.17.22 Maintenance Director conducted a Generator test, start and transfer power to the building within ten seconds and logged in the Generator logbook. On 6.17.22 the facility had installed a manual stop station to prevent inadvertent or unintentional operation. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance staff received re-education regarding documenting and maintaining a log of start and transfer power to the building within ten seconds. Element Four. The Maintenance Director or designee will complete audits for four weeks and then monthly for three months and then quarterly basis to ensure transfer time data documented on the facilities reports, The audit will be conducted weekly x 4, then monthly x 3. All findings will be presented during the monthly QAPI committee meeting for review.	

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K 918	Continued From page 28 review, who confirmed there was no transfer time data documented on the facilities report's for the generator's required monthly load tests. B. On 6/14/22, the Surveyor and Maintenance Director observed that the facility natural gas generator was outside and encased. Further observation revealed that there was no manual stop station to prevent inadvertent or unintentional operation. The Maintenance Director opened the generator cabinet and a stop button was located on the inside of the cabinet, but no manual stop station was installed "remote" of the generator. An interview was conducted during the observation with the Maintenance Director. He stated that he was unaware that the manual stop station must be remote of the encased unit in the event of inadvertent or unintentional operation including a fire. The Administrator and Regional Operations Director were informed of the finding's at the Life Safety Code exit conference on 6/14/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet	K 923		6/17/22

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K 923	Continued From page 29 Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 6/14/22, in the presence of the Maintenance Director, it was determined that the facility failed to store	K 923	Plan of Correction K923 Element One. On 6.17.22 Maintenance Director secured	

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K 923	Continued From page 30 cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 3 of 3 portable H-type oxygen cylinders and was evidenced by the following: At 11:18 AM, the surveyor observed in the exterior oxygen cylinder storage shed (yellow) that 3- portable oxygen H-type cylinders were free standing and not secured. The securing chain was on the floor of the cabinet. An interview was conducted with the Maintenance Director at the time of the observation. He stated the cylinders must be secured from tipping, rupture and damage at all times. The Administrator and Regional Operations Director were informed of the findings at the Life Safety Code exit conference on 6/14/22. NJAC 8:39-31.2(e) NFPA 99	K 923	the portable oxygen H-type cylinder storage shed with a chain. Element Two. All residents of the facility had the potential to be affected. Element Three. Maintenance staff received re-education regarding properly securing portable oxygen H-type cylinder in the shed. Element Four. The Maintenance Director or designee will complete audits to ensure all portable oxygen H-type cylinder in the facility are secure and the chain is installed, The audit will be conducted weekly x 4, then monthly x 3. All findings will be presented during the monthly QAPI committee meeting for review.	

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
315390 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK REHAB & HEALTHCARE CENTER	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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				
Reg. # NFPA 101	Completed				
LSC K0923	06/17/2022				

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	
6/16/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315390 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/25/2022 Y3

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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 K0161	08/04/2022	LSC K0211	06/20/2022	LSC K0222	06/20/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0252	08/04/2022	LSC K0271	06/17/2022	LSC K0281	06/17/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	08/04/2022	LSC K0321	06/20/2022	LSC K0345	08/04/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	08/10/2022	LSC K0353	06/20/2022	LSC K0363	06/17/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	06/30/2022	LSC K0911	07/27/2022	LSC K0918	06/17/2022

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE