

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315233</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/22/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINCOLN SPECIALTY CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360</b>	
(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	E 000		
K 000	INITIAL COMMENTS  LIFE SAFETY CODE 101:2012	K 000		
K 916 SS=E	THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R. Electrical Systems - Essential Electric System CFR(s): NFPA 101  Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review in the presence of facility management, it was determined that the facility failed to provide a remote alarm annunciator for the emergency electrical generating system, intended to alert staff of the operating condition of the generator in accordance with NFPA 99.	K 916	A Generator contractor has been hired and completed installation of a remote annunciator panel onto our generator so that the control panel can be read from inside the facility.  This has the ability to affect all the	4/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/05/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315233</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/22/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINCOLN SPECIALTY CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 916	<p>Continued From page 1</p> <p>This deficient practice was evidenced by the following:</p> <p>From 03/15/21 to 03/16/21, the surveyor and the facility's Director of Maintenance (DM) observed a remote alarm for the generator located at the [REDACTED] nursing station. The alarm device consisted of a small electronic box mounted to the wall that would provide only an audible signal.</p> <p>In an interview at that time, the DM stated that the device was an audible signal but did not provide the required visual fault notifications required by NFPA 99 at the observable panel. The DM noted that there was a visual panel outside, within the generator housing, which the surveyor observed at the time.</p> <p>In an interview on 03/15/2021 at 11:00 AM, the facility's Licensed Nursing Home Administrator (LNHA) stated that the facility was cited for the generator alarm at the last Standard survey (05/01/2019) and was granted a waiver because the licensed vendor determined that the generator would not support the required remote alarm annunciator (provided) and would request a continuance for a one-year time-limited waiver.</p> <p>The LNHA further stated that the facility was in the process of converting their heating systems to gas to reduce the electrical load of the building and subsequently purchase and install a new generator with a remote alarm annunciator to power the entire building. The LNHA further stated that all maintenance staff was trained in the operation of the emergency generator, the nursing supervisors were trained on the generator alarm procedures at orientation and annually</p>	K 916	<p>residents in the facility.</p> <p>The maintenance director has inserviced his staff and the facility supervisors on the annunciator panel.</p> <p>The maintenance director or designee will be monitoring the remote annunciator panel for any issues.</p> <p>The maintenance director will report any issues right away to the administration and will be reviewed at the quarterly meetings.</p>		

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

PRINTED: 12/10/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315233</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/22/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINCOLN SPECIALTY CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1640 SOUTH LINCOLN AVENUE VINELAND, NJ 08360</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 916	<p>Continued From page 2</p> <p>thereafter, and all staff were trained for emergency preparedness at orientation and thereafter in procedures for "loss of power" and "evacuation."</p> <p>In an interview on 03/16/21 at 11:30 AM, the nursing staff at the [REDACTED] nursing station stated they were aware of the generator alarm and emergency procedures.</p> <p>In an interview with the Maintenance Director during the observation investigation, he stated that the facility's electric hot water heaters were changed over to natural gas units to reduce the building's electrical load.</p> <p>The K-916 was cited at the following standard surveys dated: 02/24/2017, 04/05/2018, and 05/08/2019.</p> <p>NJAC 8:39-31.2(e) NFPA 99</p>	K 916		