STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/22/22 and 11/23/22 and Arbor Ridge Rehabilitation and Healthcare Center 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 Occupancies. Arbor Ridge Rehabilitation and Healthcare Center is a three-story, Type I Fire Resistant Protected building that was built in June 1986. The facility is divided into 9 smoke zones.	K 000		
K 222 SS=D	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		12/19/22

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

Electronically Signed | 12/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 222	Continued From page 1 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 11/22/22 in the presence of facility management, it was determined that the facility failed to maintain exit discharge doors in proper working condition. This deficient practice was identified for 1 of 6 exit doors (Stairwell F) and was evidenced by the following: During the survey entrance on 11/22/22 (day one of survey) at 9:41 AM, the surveyor requested the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility provided layout identified there were three floors in the facility with a total of six (6) exit discharge doors. Starting on 11/22/22 at approximately 10:02 AM and continued on 11/23/22, in the presence of the Regional Director of Plant Operations (RDPO) and MD a tour of the building was conducted. Along the tour, the surveyor observed and performed closure tests of six exit discharge doors (doors that lead you outside of the building) with the following results: 1. On 11/22/22 at approximately 12:04 PM, the surveyor made a request to the MD to enter the code on the keypad for Stairwell "F" exit discharge door and then push on the manual release to open the door. When the MD entered the code and pushed on the manual release, the	K 222	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. 1)Exit Door #F was immediately oiled, and rust was removed. 2)On 11/23/2022 all rust on Exit door and frame #F was sanded down and repainted, door now opens easily with less than 15 pounds of pressure. 3)On 11/23/2022 all other exit doors were inspected for any rust, and any identified rust was removed. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order and task management software system,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 222	Continued From page 3 door did not open. The door was caught on the bottom of the door's frame. The MD performed a second attempt using his full body weight and the door, which required more than 15 pounds of pressure to open the door. Along the tour the surveyor observed three (3) emergency evacuation diagrams posted in various locations that identified Stairwell "F" exit discharge door as the primary and/or secondary exit discharge door out of the building in the event of an emergency. The RDPO and MD confirmed the finding at the time of observation. During Life Safety Code exit conference on 11/23/22 at approximately 12:05 PM, the surveyor informed the Licensed Nursing Home Administrator of the finding. NJAC 8:39-31.2(e) NFPA 101 2012 7.2.1.6.1 (4)	K 222	he/she must thoroughly review the detailed step by step instructions for each audit. 2)There is a task in the facility's Maintenance Software system that is due monthly for the Maintenance Director or designee to audit, that all doors open and close and seal properly when closed. All "Open/due task reports" are automatically sent by email weekly to the Regional Director of Operations, Regional Director of Plant Operations and the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1)Starting on 12/19/2022 the Administrator will audit 2 doors post Maintenance Director's inspection for 3 months. Each month a different 2 doors. 2)Results of the audits will be submitted to, and reviewed by the Quality Assurance Performance Improvement Committee monthly for the duration of the audits and the committee will make recommendations to the Administrator for any further actions.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual	K 281		1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 281	Continued From page 4 intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation on 11/22/22 in the presence of facility management, it was determined 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. and National Electrical Code (NEC) 70. The deficient practice affected 1 of 6 exit discharge paths to reach a public way and was evidence by the following: Reference: 1) NEC 700.16 Emergency Illumination. Emergency Illumination shall include all required means of egress lighting, illuminated exit signs, and all other lights specified as necessary to provide required illumination. Emergency lighting systems shall be designed and installed so that the failure of any individual lighting element, such as the burning out of a light bulb, cannot leave in total darkness any space that requires emergency illumination. During the survey entrance on 11/22/22 (day one of survey) at 9:41 AM, the surveyor requested the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility provided layout identified that there were three (3) floors. The second floor had 28 resident sleeping rooms; the first floor had 29 resident sleeping rooms; and the ground floor had offices, Kitchen, Rehabilitation Gym, Commercial Laundry, Boiler Room and	K 281	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. 1)The facility will install a light that is operated automatically, to fully illuminate the mentioned pathway. 2) The facility will install a light illuminated keypad for visibility at night. The two installations noted above will be completed by 12/23/2022. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order and task management software system, he/she must thoroughly review the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 281	Continued From page 5 Mechanical Room. Starting On 11/22/22 at approximately 10:02 AM, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. At approximately 11:37 AM, an inspection outside a designated exit discharge door (illuminated exit sign above door) near Resident Room #123 identified a gated residents' patio area. The surveyor also observed no evidence of emergency lighting along the approximate 80 feet discharge path to reach the discharge gate. The surveyor observed no emergency lighting for the "Key-Pad" to unlock the magnetic hold close device. At this time the surveyor asked the MD do you have any lights here? The MD responded, "No". Along the tour the surveyor observed two (2) emergency evacuation diagrams posted that identified the discharge door as the primary and/or secondary exit discharge out of the building. The RDPO and MD confirmed the finding at the time. During Life Safety Code exit on 11/23/22 at approximately 12:05 PM, the surveyor informed the Licensed Nursing Home Administrator of the finding. NFPA 101-2012 edition Life Safety Code 7.8 Illumination of Means of Egress 7.8.1.3* (2). NJAC 8:39-31.2 (e).	K 281	detailed step by step instructions for each audit. 2)There is a task in the facility's Maintenance Software system that is due weekly for the Maintenance Director to check illumination of exit lighting. All open/due task reports are automatically sent by email weekly to the Regional Director of Operations, the Regional Director of Plant Operations and the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1)Starting on 1/23/2023 the Administrator or designee will audit all exit illumination lighting monthly for 3 months. 2)The above mentioned audits will be reviewed by the Quality Assurance Performance Improvement Committee at each monthly meeting for 3 months and the committee will make recommendations to the Administrator for any further actions. 3)An audit report of all open tasks will be ran from the facility's maintenance software system prior to each quarterly QAPI meeting for the next 4 Quarterly QAPI meetings and will be reviewed by the Quality Assurance Performance Improvement Committee and the committee will make recommendations to the Administrator for any further actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 321	Continued From page 6	K 321		
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. 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, interview, and review of facility provided documentation on 11/22/22 in the presence of facility management, it was determined that the facility failed to ensure fire-rated doors to hazardous areas were	K 321	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~	1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 321	Continued From page 7 self-closing, and were separated by smoke resisting partitions 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 for 1 of 7 fire-rated doors to hazardous areas (Stairwell D) and was evidenced by the following: During the survey entrance on 11/22/22 (day one of survey) at 9:41 AM, the surveyor requested the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility provided layout identified that there were three (3) floors. The second floor had 28 resident sleeping rooms; the first floor had 29 resident sleeping rooms; and the ground floor had offices, Kitchen, Rehabilitation Gym, Commercial Laundry, Boiler Room and Mechanical Room. On 11/22/22 starting at approximately 10:02 AM, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building and the surveyor observed the following hazardous locations: 1. At approximately 11:01 AM, an inspection on the second floor inside Stairwell "D" identified at the top level of the stairwell a 5 feet wide by 15 feet deep (75 square feet) room. The 1-1/2 fire-rated door was removed from its frame. The surveyor observed inside this room contained multiple combustible cardboard boxes, paintings, and other combustible products. The area is larger than 50 square feet which would allow fire, smoke, and poisonous gases to enter the exit	K 321	No residents were identified. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. 1)On 12/22/2022 the facility installed a new fire rated door on storage room located on top level within Stairwell "D" as required by code. 2)On 12/22/2022 the facility installed an automatic door closer arm on door to the storage room located in the exit access corridor right outside doorway to stairwell "D" as required by code. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced on requirement to have smoke resisting partitions and doors that are self closing as part of the required fire barrier to prevent fire or smoke from spreading. The in-service also included that when completing audits that are triggered by the facility's Maintenance/Safety work order and task management software system, he/she must thoroughly review the detailed step by step instructions for each audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 321	Continued From page 8 stairwell in the event of a fire. 2. At approximately 11:39 AM, an inspection of the exit access corridor next to the first floor Stairwell "D" identified a five feet ten inches wide by 12 feet deep room. This inspection identified approximately 45 boxes filled with combustible paper files and other combustible products stored in the room. The surveyor observed that the doors automatic door closure had been removed. This door did not self-close into its frame as required by code which would allow fire, smoke, and poisonous gases to enter the exit corridor in the event of a fire. The area was larger than 50 square feet. The RDPO and MD confirmed the finding at the time. During Life Safety Code exit conference on 11/23/22 at approximately 12:05 PM, the surveyor informed the Licensed Nursing Home Administrator of the finding. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	2)There is a task in the facility's Maintenance Software system that is due monthly for Maintenance Director or designee to audit that all doors seal properly when closed and latch automatically. All open/due task reports are automatically sent by email weekly to the Regional Director of Operations, the Regional Director of Plant Operations and the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1)Starting on 1/23/2023 the Administrator or designee will audit 10 doors monthly for 3 months that they seal properly when closed and latch automatically 2)The above mentioned audits will be reviewed by the Quality Assurance Performance Improvement Committee at their monthly meeting for 3 months and the QAPI committee will make recommendations to the Administrator for any further actions. 3)An audit report of all open tasks will be ran from the facility's maintenance software system prior to each quarterly QAPI meeting for the next 4 Quarterly QAPI meetings and will be reviewed by the Quality Assurance Performance Improvement Committee and the committee will make recommendations to the Administrator for any further actions.	
K 324 SS=E	Cooking Facilities	K 324		1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 324	Continued From page 9 CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation on 11/22/22 and 11/23/22, in the presence of facility management, it was determined that the facility failed to inspect the range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. This deficient practice was identified in 1 of 4 range-hood fire suppression systems inspected and was evidenced by the	K 324	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified. 2. How the Facility will identify other	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 324	Continued From page 10 following: During the survey entrance on 11/22/22 (day one of survey) at 9:41 AM, the surveyor requested the Maintenance Director (MD) to provide all mandatory inspections from 1/1/21 to 11/21/22 for review. Review of the facility's range-hood fire suppression system inspections for the previous 22 months identified the system had three (3) semi-annual inspections on 5/11/21, 12/15/21 and 8/5/22 (8 months between semi-annual inspections). On 11/22/22 at approximately 2:05 PM, a request was made to the Regional Director of Plant Operations (RDPO) and MD if they can provide a semi-annual inspection between 12/15/21 and 8/5/22. On 11/23/2022 (day two of survey) at approximately 9:11 AM, the surveyor interviewed the RDPO and asked if the facility had performed a semi-annual inspection of the Kitchen suppression system between 12/15/21 and 8/5/22. The RDPO informed the surveyor the inspection had not been done. The RDPO and MD confirmed the finding at the time. During Life Safety Code exit conference on 11/23/22 at approximately 12:05 PM, the surveyor informed the Licensed Nursing Home Administrator of the finding. NFPA 101, NFPA 96 NJAC 8:39-31.2(e)	K 324	residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. 1)The facility has scheduled an inspection of the range hood which was completed by 12/23/2022. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order and task management software system, to thoroughly review the detailed step by step instructions for each audit. 2)There is a task in the facility's Maintenance Software system that is due every 6 months for Maintenance Director to complete and to schedule the range hood inspection. All open/due task reports are automatically sent by email weekly to the Regional Director of Operations, the Regional Director of Plant Operations and the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 324	Continued From page 11	K 324	program will be put into place. ~~ 1)On 1/23/2023 and every 6 months thereafter for a duration of 18 months the Administrator or designee will audit all range-hood fire suppression systems to ensure they were inspected satisfactorily within the last 6 months. 2)The above audits and an audit report of all open tasks in the facility's maintenance software system will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee every other quarterly QAPI meeting (bi-annually) for the next 18 months and the committee will make recommendations to the Administrator for any further actions.	
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		1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 351	Continued From page 12 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/22/22 and 11/23/22, it was determined that the facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. This deficient practice was identified for 7 out of 200 sprinkler heads observed and was evidenced by the following: During the survey entrance on 11/22/22 (day one of survey) at 9:41 AM, the surveyor requested the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility provided layout identified there were three floors in the facility. Starting on 11/22/22 at approximately 10:02 AM and continued on 11/23/2022, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. On 11/22/22 at approximately 10:54 AM, the surveyor observed on the second floor corridor near stairwell "F" two (2) sprinklers that had no evidence of escutcheon caps (covers the gap	K 351	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. 1)On 11/23/2022 the facility installed 7 Escutcheon Caps on the 7 mentioned sprinkler heads. 2) On 11/23/2022 the facility installed a deflector plate for the mentioned Up-Rite sprinkler. 3)On 11/23/2022 the facility repaired sprinkler head stated to be hanging down from the drop ceiling 1/2 of an inch. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order and task management software system,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 351	Continued From page 13 between the sprinkler head and the ceiling tile); one (1) sprinkler head left a 1/4 of an inch gap in the ceiling tile and one (1) sprinkler head left a 3/8 of an inch gap in the ceiling tile. This would not allow the fire sprinkler to function properly in the event of a fire. 2. On 11/22/22 at approximately 11:09 AM, the surveyor observed on the first floor next to the elevators one (1) sprinkler. This fire sprinkler had no evidence of an escutcheon cap leaving a 1/4 of an inch gap in the ceiling tile. This would not allow the fire sprinkler to function properly in the event of a fire. 3. On 11/22/22 at approximately 11:18 AM, the surveyor observed inside the first floor residents' dining room #2 closet one "Up-Rite" sprinkler head installed approximately two (2) inches away from the wall board. This Up-Rite sprinkler had no evidence of a deflector plate. 4. On 11/22/22 at approximately 11:52 AM, the surveyor observed on the first floor Nurse Station area one (1) sprinkler head. This fire sprinkler had no evidence of an escutcheon cap leaving a 1/2 of an inch gap in the ceiling tile. This would not allow the fire sprinkler to function properly in the event of a fire. 5. On 11/23/22 at approximately 10:16 AM, the surveyor observed in the kitchen's dish washing machine area one sprinkler head. This sprinkler head was hanging down from the drop ceiling 1/2 of an inch. This left a 3/8 of an inch gap in the ceiling tile. This would not allow the fire sprinkler to function properly in the event of a fire. 6. On 11/23/22 at approximately 10:20 AM, the	K 351	he/she must thoroughly review the detailed step by step instructions for each audit. 2)There is a task in the facility's Maintenance Software system that is due monthly for the Maintenance Director or designee to audit the sprinkler heads to ensure Escutcheon ring is present and clean. All open/due task reports are automatically sent by email weekly to the Regional Director of Operations, the Regional Director of Plant Operations and the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1)Starting on 1/23/2023 the Administrator or designee will audit all sprinkler heads monthly for 3 months to ensure they have Escutcheon rings installed with no gaps and deflector plate is present for any Up-Rite sprinkler heads 2)The above mentioned audits will be reviewed monthly for 3 months by the Quality Assurance Performance Improvement Committee and the committee will make recommendations to the Administrator for any further actions. 3)An audit report of all open tasks will be ran from the facility's maintenance software system prior to each quarterly QAPI meeting for the next 4 Quarterly QAPI meetings and will be reviewed by the Quality Assurance Performance Improvement Committee and the committee will make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 351	Continued From page 14 surveyor observed in the kitchen by the plating area one (1) sprinkler head. This fire sprinkler had no evidence of an escutcheon cap leaving a 1/2 of an inch gap in the ceiling tile. This would not allow the fire sprinkler to function properly in the event of a fire. With the openings in the ceilings, in the event of a fire the heat would bypass the fire sprinkler in the areas and not activate the fire sprinkler system. The RDPO and MD confirmed the finding at the time. On 11/23/22 at approximately 12:05 PM, the surveyor informed the Licensed Nursing Home Administrator of these findings. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	recommendations to the Administrator for any further actions.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 11/22/22 and 11/23/22 in the presence of facility management, it was determined that the facility failed to failed to inspect all portable fire extinguishers annually, as required by National Fire Protection Association	K 355	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified.	1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 355	Continued From page 15 as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. This deficient practice was identified for 1 of 20 portable fire extinguishers and was evidenced by the following: Reference: NFPA 10 Edition 2010 Standard for portable fire extinguishers: - 7.3 Maintenance. - 7.3.1.1 All Fire Extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference: NFPA 10- 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. During the building tour on 11/22/22 and 11/23/22, the surveyor in the presence of the facility Regional Director of Plant Operations (RDPO) and Maintenance Director (MD) observed and inspected twenty (20) portable fire extinguishers in various locations with the following: 1. On 11/22/22 at 11:57 AM, one (1) ABC type fire extinguisher on the first floor outside the resident patio area had no evidence of an annual inspection tag attached to the extinguisher. At this time, the MD informed the surveyor that the extinguisher was a newly installed extinguisher.	K 355	2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. 1)The facility has scheduled an inspection of Fire Extinguisher #13 which will be completed by 12/23/2022. 2)On 11/23/2022 the Maintenance Director was in-serviced to ensure that the inspector inspects external Extinguishers during annual inspection. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order and task management software system, to thoroughly review the detailed step by step instructions for each audit. 2)There is a task in the facility's Maintenance Software system that is due monthly for Maintenance Director to check all fire extinguishers in building to ensure they are in good working order and that annual inspection tag is present and up to date. All open/due task reports are automatically sent by email weekly to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 355	Continued From page 16 The surveyor made a request to obtain the key to open the front plastic break-away panel of the fire extinguisher cabinet. The MD opened the cabinet. The surveyor removed the extinguisher, turned the extinguisher over, and observed the manufacture's date of the fire extinguisher which was manufactured in 2016. A review of the facility provided monthly fire extinguisher log for October 2022 identified that the extinguisher had a monthly inspection of fire extinguisher #13 in the resident outside patio area on 10/28/22. The RDPO and MD confirmed the findings at the time of observations. During Life Safety Code exit on 11/23/22 at approximately 12:05 PM, the Licensed Nursing Home Administrator was notified of the finding. NFPA 10 NJAC 8:39-31.1(c); 31.2(e)	K 355	Regional Director of Operations, the Regional Director of Plant Operations and the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1)Starting on 1/23/2023 the Administrator or designee will audit all fire extinguishers in building monthly for 3 months to ensure they are in good working order and that annual inspection tag is present and up to date. 2)The above mentioned audits will be reviewed each month for 3 months by the Quality Assurance Performance Improvement Committee and the committee will make recommendations to the Administrator for any further actions. 3)An audit report of all open tasks will be ran from the facility's maintenance software system prior to each quarterly QAPI meeting for the next 4 Quarterly QAPI meetings and will be reviewed by the Quality Assurance Performance Improvement Committee and the committee will make recommendations to the Administrator for any further actions.	
K 372 SS=D	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	K 372		1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 372	Continued From page 17 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 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 observation, interview, and review of facility provided documentation on 11/22/22, it was determined that the facility failed to maintain the integrity of smoke barrier partitions. This deficient practice was identified for 1 of 6 smoke barrier walls and was evidenced by the following: During the survey entrance on 11/22/22 (day one of survey) at 9:41 AM, the surveyor requested the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility provided layout identified that there were two (2) smoke barrier walls on the second floor; two (2) smoke barrier walls on the first floor; and two (2) smoke barrier walls on the ground floor. On 11/22/22 starting at approximately 10:02 AM, the surveyor in the presence of the Regional Director of Plant Operations (RDPO) and MD conducted a tour of the building. Along the tour at approximately 10:18 AM, the surveyor observed the following smoke barrier wall failed to maintain the 1/2-hour fire-rated	K 372	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. 1)On 12/15/2022 the facility sealed the above mentioned penetration in fire/smoke wall. 2)On 12/15/2022 the facility properly mounted above mentioned "Illuminated Exit Sign". 3. What measures will be put into place or what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 372	Continued From page 18 construction as required by code in the following location: On the second floor next to Resident Room #228 above the double smoke barrier doors an illuminated exit sign that was not fastened securely to the wall. The surveyor observed behind the hanging exit sign a 1 inch by 1-1/2-inch penetration with a BX electrical cable running through the smoke barrier wall. This penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes, and fire from passing through to the other smoke compartment. The RDPO and MD confirmed the finding at the time. During Life Safety Code exit conference on 11/23/22 at approximately 12:05 PM, the surveyor informed the Licensed Nursing Home Administrator of the deficiency finding. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 372	1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order and task management software system, to thoroughly review the detailed step by step instructions for each audit. 2)There is a task in the facility's Maintenance Software system that is due monthly for Maintenance Director to inspect all walls for damage or holes. All open/due task reports are automatically sent by email weekly to the Regional Director of Operations, the Regional Director of Plant Operations and the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1)Starting on 1/23/2023 the Administrator or designee will audit all walls monthly for 3 months to ensure no damage or holes exist. 2)The above mentioned audits will be reviewed monthly for 3 months by the Quality Assurance Performance Improvement Committee and the committee will make recommendations to the Administrator for any further actions. 3)An audit report of all open tasks will be ran from the facility's maintenance software system prior to each quarterly QAPI meeting for the next 4 Quarterly QAPI meetings and will be reviewed by the Quality Assurance Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 372	Continued From page 19	K 372	Improvement Committee and the committee will make recommendations to the Administrator for any further actions.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/22/22 and 11/23/22, in the presence of facility management, it was determined that the facility failed to ensure that all electrical outlets located next to a water source were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was identified for 2 of 13 electrical outlets located near a water source observed and was evidenced by the following: During the survey entrance on 11/22/22 (day one of survey) at 9:41 AM, the surveyor requested the Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility provided layout identified that there were three (3) floors in the facility. Starting on 11/22/22 at approximately 10:02 AM, the surveyor in the presence of the Regional	K 911	1. What corrective action(s) will be accomplished for those residents stated to have been affected by the deficient practice. ~~ No residents were identified. 2. How the Facility will identify other residents having the potential to be affected by the same stated deficient practice and what corrective action will be taken. ~~ All residents have the potential to be affected. On 11/23/2022 the facility replaced both mentioned duplex outlets with new duplex outlets equipped with GFCI. 3. What measures will be put into place or	1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 911	Continued From page 20 Director of Plant Operations (RDPO) and MD conducted a tour of the building. During the two-day tour (11/22/22 and 11/23/22) of the facility, the surveyor observed and tested thirteen (13) electrical outlets (within 4 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: 1. On 11/22/22 at approximately 11:03 AM, the surveyor observed inside the second floor Social Workers office one (1) duplex electrical outlet located 14 inches to the left of a sink. When the surveyor tested the duplex electrical outlet with a GFCI tester to de-energize, the outlet did not de-energize as required by code. 2. On 11/22/22 at approximately 11:52 AM, the surveyor observed inside the second floor resident Central Bathing room one (1) duplex electrical outlet located 16 inches to the left of a sink. When surveyor tested the duplex electrical outlet with a GFCI tester to de-energize, the outlet did not de-energize as required by code. The RDPO and MD confirmed the finding at the time. During Life Safety Code exit conference on 11/23/22 at approximately 12:05 PM, the surveyor informed the Licensed Nursing Home Administrator of these findings. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	what systemic changes will the facility make to ensure that the stated deficient practice will not recur. ~~ 1)On 11/28/2022 the Maintenance Director was in-serviced that when completing audits that are triggered by the facility's Maintenance/Safety work order and task management software system, to thoroughly review the detailed step by step instructions for each audit. 2)There is a task in the facility's (Maintenance Software system) that is due annually for Maintenance Director or designee to audit physical integrity of all electrical receptacles and where applicable the GFCI function. All open/due task reports are automatically sent by email weekly to the Regional Director of Operations, the Regional Director of Plant Operations and the Facility Administrator to review and follow-up as necessary. 4. How the corrective actions will be monitored to ensure the stated deficient practice will not recur, i.e. what QA program will be put into place. ~~ 1)On 1/23/2023 and every 6 months thereafter for a duration of 18 months the Administrator or designee will audit all outlets located next to a water source to ensure they have properly working Ground-Fault Circuit Interrupter (GFCI) protection. 2)The above audits and an audit report of all open tasks in the facility's maintenance software system will be reviewed by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING **01** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	**261 TERHUNE DRIVE** **WAYNE, NJ 07470**

(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 911	Continued From page 21	K 911	Quality Assurance Performance Improvement (QAPI) Committee every other quarterly QAPI meeting (bi-annually) for the next 18 months and the committee will make recommendations to the Administrator for any further actions.	

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
315234 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	12/19/2022	LSC K0281	01/23/2023	LSC K0321	01/23/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	01/23/2023	LSC K0351	01/23/2023	LSC K0355	01/23/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0372	01/23/2023	LSC K0911	01/23/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/23/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO