STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. BUILDING **01** B. WING _____	**03/24/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	**415 SOUTHERN BLVD** **CHATHAM, NJ 07928**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 3/22/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 1-story building that was built in 70's, It is composed of Type III unprotected construction. The facility is divided into 7- smoke zones. The generator does 100% of the building. 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. The facility has 108 certified beds. At the time of	K 000		

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

Electronically Signed | 04/06/2022

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K 000	Continued From page 1 the survey the census was 94.	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/22/22, it was determined that the facility failed to provide an operational battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was observed for 1 of 1 transfer switches and was evidenced by the following: At 11:52 AM, the Surveyor and Maintenance Director, observed outside the facility, where the generator transfer switch was located, that no emergency lighting was provided. This finding was verified by the Maintenance Director, at the time of the observation. The Administrator was notified of the above findings at the Life Safety Code exit conference on 3/22/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	Based on observation and interview on 3/22/22, it was determined that the facility failed to provide an operational battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. No residents were affected by this deficient practice All residents have the potential to be affected by the deficient practice The Director of Maintenance will install the required light. All work will conform with all applicable NFPA standards The Director of Maintenance will conduct a quarterly audit of all areas requiring emergency battery backup lighting as per NFPA standards. The Director Maintenance/Designee will report findings of audit to administrator. Director of Maintenance/Designee will	5/4/22

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K 291	Continued From page 2	K 291	report the results of the audits at the quarterly QA meeting for review and feedback. Responsible party: Environmental Services Director	
K 363 SS=F	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 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	K 363		5/4/22

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K 363	Continued From page 3 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 3/22/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will fully close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 9 of 52 resident room door's and was evidenced by the following: On 3/22/22, during the building tour from 9:00 AM to 2:00 PM, the Surveyor and Maintenance Director, observed that the doors to resident rooms, latched into the door frame, but the top of the doors were warped and left a gap approximately 1/4" to 1/2" in the following resident rooms: # 4, 5, 8, 12, 13, 21, 40, 42 and 44 An interview was conducted with the Maintenance Director, who stated and confirmed that the above resident room doors were warped.	K 363	Based on observation and interview on 3/22/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will fully close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. No residents were affected by this deficient practice All residents have the potential to be affected by the deficient practice All doors have been audited to ensure compliance with NFPA requirements. No further findings. The Director of Maintenance will coordinate with vendor to make corrective repairs to doors. The Director of Maintenance will conduct a quarterly audit of all resident doors to	

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K 363	Continued From page 4 The Administrator was informed of the finding at the Life Safety Code exit conference on 3/16/22. 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	ensure all resident doors meet NFPA standards. The Director of Maintenance will report the results of the audits at the quarterly QA meeting for review and feedback. Responsible party: Environmental Services Director	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 3/22/22, in the presence of the Maintenance Director, it was determined that the facility failed to maintain their Packaged Terminal Air Conditioner (PTAC) units in a safe and optimal condition. This deficient practice was identified for 13 of 50 PTAC units observed and was evidenced by the following: While touring the facility from approximately 09:00 AM, to 02:30 PM, the surveyor observed dirty PTAC filters that were clogged and dirty	K 521	Based on observation and interview conducted on 3/22/22, in the presence of the Maintenance Director, it was determined that the facility failed to maintain their Packaged Terminal Air Conditioner (PTAC) units in a safe and optimal condition. Residents # 3, 5, 6, 9, 12, 13, 18, 19, 22, 24, 27, 28 and 31 PTAC Filters were cleaned within all applicable NFPA standards. All residents have the potential to be	5/4/22

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K 521	Continued From page 5 throughout the facility in the following resident rooms: # 3, 5, 6, 9, 12, 13, 18, 19, 22, 24, 27, 28 and 31 When interviewed at the time of the observations, the Maintenance Director agreed that 13 of 50 PTAC unit's had clogged and dirty filters throughout the facility. No policy and procedure on the maintenance of PTAC units were provided or a PTAC filter cleaning log, at the time of the Life Safety Code exit. The Administrator was informed of the finding at the Life Safety Code exit conference on 3/22/22. N.J.A.C. 8:39 - 31.2(e) 19.5.2.1 Heating, Ventilating, and Air-Conditioning.	K 521	affected by the deficient practice All PTAC units were audited for safe and optimal conditions and addressed accordingly Environmental Services team will be educated on NFPA standards for cleaning PTAC units Director of Maintenance will audit all PTAC units quarterly to ensure all are maintained in compliance with NFPA standards The Director of Maintenance will report the results of the audits at the quarterly QA meeting for review and feedback. Responsible party: Director of Maintenance	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		5/4/22

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K 918	Continued From page 6 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on review of facility documents, observations and interview on 03/22/22, 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. B. The facility did not 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:	K 918	Based on review of facility documents, observations and interview on 03/22/22, 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. B. The facility did not 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. No residents were affected by this	

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K 918	Continued From page 7 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 not performing a monthly load test and could not provide any documentation. An interview was conducted with the Maintenance Director at the time of record 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 3/22/22, the Surveyor and Maintenance Director observed that the facility generator was outside and encased. Further observation revealed that there was a manual stop station to prevent inadvertent or unintentional operation on the outside of the steel encased generator, but the manual stop station must be installed remote of the generator. An interview was conducted during the observation with the Maintenance Director, where he stated that he was unaware the installation of the manual stop station was in the wrong location and must be remote of the encased unit in the event of inadvertent or unintentional operation including a fire. The Maintenance Director was informed of the finding's at the Life Safety Code exit conference on 3/22/22. The Administrator was not present due to a religious holiday. NJAC 8:39-31.2(e), 31.2(g) NFPA 99	K 918	deficient practice All residents have the potential to be affected by the deficient practice. The Director of Maintenance will test the generator for transfer of power under load. The generator service vendor will move emergency stop button to remote location conforming with all applicable NFPA standards. The Director of Maintenance will conduct a monthly audit of Generator transfer of power and a log will be kept on file at the facility. The Director of Maintenance will report the results of the audits at the quarterly QA meeting for review and feedback. Responsible party: Environmental Services Director	

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K 918	Continued From page 8 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=F	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 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	K 923		5/4/22

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K 923	Continued From page 9 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 3/22/22, in the presence of the Maintenance Director, it was determined that the facility failed to store 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 7 of 24 portable oxygen cylinders and was evidenced by the following: At 11:00 AM, the surveyor observed in the oxygen cylinder storage room that 7 of 24 oxygen cylinders were free standing and not secured from tipping, rupture and damage. 3 of 20 small oxygen cylinders were observed to have approximately 500 PSI each and were not secured and 4 of 4 large filled H-tanks were in the middle of the room free standing and not secured. An interview was conducted with the Maintenance Director, who stated that the cylinders must be individually secured from tipping, rupture and damage at all times in the facility. The Administrator was informed of the finding at the Life Safety Code exit conference on 3/22/22. NJAC 8:39-31.2(e) NFPA 99	K 923	Based on observations and interview on 3/22/22, in the presence of the Maintenance Director, it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. No residents were affected by this deficient practice All residents have the potential to be effected by the deficient practice The Director of Maintenance will have the vendor remove all additional tanks and educated vendor to not leave any extra tanks beyond our storage capacity per all applicable NFPA standards The Director of Maintenance will conduct a monthly audit to ensure all gas storage conforms to NFPA standards The Director of Maintenance/designee will report findings to the Administrator Administrator will report findings of this audit in quarterly QA meeting	

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