STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING **01** B. WING _____	**03/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE** **EDISON, NJ 08817**

(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 . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 02/28/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/28/23 and was found not to be in compliance with 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. Embassy Manor at Edison Nursing and Rehabilitation is a three-story building constructed in 1966. Residents are on all three floors with a behavior/dementia unit on the third floor. The facility has concrete flooring, concrete steel frame roofing and block bearing walls and brick façade exterior. Embassy Manor is noted to be a type II (III) noncombustible construction with complete sprinkler system and smoke detection in all corridors. The facility has a 113 KW (kilowatt) diesel generator that operates at 57% of load when tested. The facility has 204 occupied beds. The facility has 15 smoke zones. .	K 000		
K 211	Means of Egress - General	K 211		3/14/23

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

Electronically Signed | 03/28/2023

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.

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K 211 SS=E	Continued From page 1 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 observations and interview, the facility failed to ensure that one of eight exit discharges serving the second and third floor dining areas and smoke zones were maintained continuously free of obstructions and impediments for full and instant use in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.1.10.1. This deficient practice had the potential to affect 12 total residents residing in the area and residents in the second-floor dining room. Findings include: An observation on 02/27/23 at 12:45 PM revealed the second-floor exit door for the stairwell, serving the second and third floor dining rooms and adjoining smoke zones, would not open and was rusted shut. The stairwell was labeled as an exit with an exit sign above the door and also in the fire exit plan posted on the wall in the smoke zone. The door had to be pushed vigorously three times with the shoulder of the Maintenance Director before the door would open. An observation on 02/27/23 at 12:45 PM revealed the second-floor exit discharge, off of the stairwell	K 211	K211 SS=E Means of Egress CFR: NFPA 101 Section 7.1.10.1 Date: 3/14/23 1. The exit serving the second and third dining and smoke zones was immediately freed of all debris, obstructions, and impediments for full and instant use on its walking path in accordance with NFPA 101 Life Safety Code, Section 7.1.10.1 on 2/27/23. The Director of Maintenance immediately shaved down the egress on the second-floor exit which served the second and third floor dining room residents and freed it from rust buildup enabling the door to swing freely when pressure was applied. The Maintenance Director then cleared all of the debris, including a cardboard box, three more boxes, and three large wooden crates, that extended over the entire width of the walkway; all	

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K 211	Continued From page 2 serving the second and third floor dining rooms and adjoining smoke zones, had debris in the exit discharge to the public way. The exit door could not be completely open because a cardboard box was between the door and the outside wall. In addition, the sidewalk leading to the public way from this exit discharge, contained three boxes and three large wooden crates that extended over the entire width of the sidewalk. An interview with the Maintenance Director and Regional Operations Director (ROD) at the time of the observation verified the conditions of the door and sidewalk to the public way. The ROD stated the debris on the sidewalk was from the boiler repair/installation group that did not put their materials away. The facility had no records of checking this exit door. NJAC 8:39-31.1(c), 31.2(e) .	K 211	were removed on 2/27/23. 2. Every resident has the potential to be affected by these deficient practices. 3. An In-service to all Maintenance employees/groundkeepers was conducted on 2/27/23 by the Regional Administrator, the Administrator, and the Director of Maintenance to ensure that all staff understood and recognized the deficient practice of Means of Egress immediately. Nearby resources, like the outside dumpsters and nearby storage rooms were identified as resources for the staff to use in order to ensure that each employee would know how to avoid these deficient practices in the future. The in-service was held in a language they could all understand and a tour of local resources was provided during the in-service. 4. Daily rounds of all Means of Egresses will be made by the Director of Maintenance/designee and logged onto the □Maintenance Daily Logs□ report sheet. The Director of Maintenance will meet with his staff weekly to ensure that these practices are being upheld and his findings will be reported to the Administrator on a monthly basis in the Morning Meeting. Results of all audits will be presented at the Quality Assurance Performance Improvement Meeting, held quarterly for (1) year.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101	K 281		3/16/23

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K 281	Continued From page 3 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 intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure that one of eight exit discharge had illumination of the means of egress in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 7.8.1.1 and 7.8.1.4. This deficient practice had the potential to affect 12 residents. Findings include: An observation of a stairway exit discharge, serving the dining rooms on the second and third floors, on 02/27/23 at 12:45 PM revealed the area lacked illumination of any type above the door or in the discharge area. An interview with the Regional Operations Director and Maintenance Director at the time of the observation verified the area lacked two lights above the door. NJAC 8:39-31.2(e) .	K 281	K281 SS= E Illumination of Means of Egress CFR: NFPA 101 Section 7.8, 18.2.8, 19.2.8 Date: 3/16/23 1. Vendor, AM Electric was immediately notified to come and assess the building's external illumination of means of egress and a quote was created for the installation of an Emergency Light outside of the stairway exit mentioned, which served the dining rooms on the second and third floors. The Director of Maintenance immediately scheduled and ordered AM Electric to install the Emergency Light on the outside Means of Egress and the work was completed on 3/16/23. 2. Every resident has the potential to be affected by these deficient practices. 3. An In-service was given to all Maintenance employees/groundkeepers on 2/27/23 by the Regional Administrator,	

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K 281	Continued From page 4	K 281	the Administrator, and the Director of Maintenance to ensure that all staff understood and recognized the deficient practice of the Illumination of Means of Egress immediately. Rounds will be completed by the Director of Maintenance/designee daily to ensure its proper functioning. 4. Rounds will be made by the Director of Maintenance/designee daily to ensure that all emergency light are checked and logged for proper placement and functioning status on the 'Maintenance Daily Logs' report sheet. The Director of Maintenance will meet with his staff weekly to ensure that these practices are being upheld and that findings will be reported to the Administrator on a monthly basis in the Morning Meeting. Results of all audits will be presented at the Quality Assurance Performance Improvement Meeting, held quarterly for (1) year.	
K 291 SS=F	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, the facility failed to ensure emergency lighting was provided for the generator transfer switch in accordance with NFPA 101 "Life Safety Code" (2012 Edition) Section 7.9.2.4. and NFPA 110 "Standard for	K 291	K291 SS= F Emergency Lighting CFR: NFPA 101 Date: 3/16/23	3/16/23

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K 291	Continued From page 5 Emergency and Standby Power Systems" (2010 Edition) Sections 7.3.1 and 7.3.2. This deficient practice had the potential to affect all 204 residents. Findings include: An observation on 02/27/23 at 1:50 PM revealed the electrical room, which contained one generator transfer switch, lacked battery operated emergency lighting for the transfer switch for the 113 KW diesel generator. An interview with the Maintenance Director at the time of the observation confirmed the electrical room, which contained the transfer switch, lacked battery powered emergency lighting and stated he did not know it was a requirement. NJAC 8:39-31.2(e) .	K 291	1. The Director of Maintenance immediately notified the vendor, AM Electric of the missing Emergency Light located in the electric room and was provided with a quote to furnish and install (1) Emergency Light in the Electric Room. Approval was granted and the work was completed on 3/16/23. 2. Every resident has the potential to be affected by these deficient practices. 3. An In-service to all Maintenance employees/groundkeepers was conducted on 2/27/23 by the Regional Administrator, the Administrator, and the Director of Maintenance to ensure that all staff understood and recognized the deficient practice immediately. Rounds will be completed by the Director of Maintenance/designee daily to ensure its proper functioning. 4. Daily rounds will be made by the Director of Maintenance/designee to ensure that all emergency lights are checked and logged for proper placement and functioning status on the □Maintenance Daily Logs□ report sheet. The Director of Maintenance will meet with all Maintenance staff weekly to ensure that these practices are being upheld and that findings will be reported to the Administrator on a monthly basis in Morning Meeting for (12) months and will report findings at the Quality Assurance Performance Improvement Meeting quarterly for (1) year.	

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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 observations and interviews, the facility failed to ensure that hazardous areas were equipped with self-closing doors and resisted the passage of smoke/fire on two of three floors in accordance with NFPA 101 Life Safety Code	K 321	K321 SS=E Hazardous Area □ Enclosure CFR: NFPA 101 19.3.2.1, 19.3.5.9.	3/14/23

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K 321	Continued From page 7 (2012 Edition) Sections 19.3.2.1.3 and 8.7.1.3. This deficient practice had the potential to affect seven residents in two smoke zones on two floors. Findings include: An observation of a biohazard room, located on the second floor near the main dining room and room 245, on 02/27/23 at 12:30 PM revealed the room contained a 33 gallon red garbage can used for biohazard trash storage and the door was not equipped with a self-closing device. An observation of a soiled linen room, located on the third floor, on 02/28/23 at 8:40 AM revealed the door had two holes the diameter of a pencil above and below the door knob allowing for the passage of smoke. The room contained two large containers partially full of soiled linen. An observation of the medical records office, located on the third floor, on 02/28/23 at 8:45 AM revealed the room contained four file cabinets which measured five foot high by three foot wide and were full of records. The room also contained thirty additional records on top of shelves and desks and numerous boxes throughout the room and the door was not equipped with a self-closing device. An observation of a Porter Closet, located near room 344.5 on 02/28/23 at 9:00 AM revealed the room contained one 33 gallon red garbage can used for biohazard trash storage and the door was not equipped with a self-closing device. An interview with the Maintenance Director at the time of each observation confirmed the doors	K 321	Date: 3/14/23 1.The Director of Maintenance immediately identified all (4) areas where self-closing doors would help stop the passage of smoke/fire in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 19.3.2.1.3, and 8.7.1.3. They were: Room 245 which contained a 33-gallon red garbage can used for biohazard trash storage; Room 344.6 which is a soiled linen room on the 3rd floor containing two large containers of soiled linen; Room 345.2 the medical records office which was full of records; and Room 344.5 a Porter□s closet which contained a 33-gallon red garbage can used for biohazard trash storage. Self-closers were immediately installed on all 4 doors by the Maintenance Director, and a metal door sleeve was added over the two pencil-sized doorknob holes above and below the doorknob to block the passage of smoke on the 3rd floor Soiled Utility Room door, on 2/27/23. 2. Every resident has the potential to be affected by these deficient practices. 3. An In-service to all Maintenance employees/groundkeepers was conducted on 2/27/23 by the Regional Administrator, the Administrator, and the Director of Maintenance to ensure that all staff understood and recognized the deficient practice regarding Hazardous Area Enclosures immediately. The (4) self-closing devices and metal door sleeve were immediately located,	

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K 321	Continued From page 8 were not equipped with self-closing devices and the holes in the door to the soiled linen room. He stated the biohazard trash was emptied once a month. NJAC 8:39-31.1(c), 31.2(e) .	K 321	prepared and installed on 2/27/23. Each employee in the Maintenance Department verbally attested that they understood how to avoid these deficient practices in the future. 4. Rounds will be made by the Director of Maintenance/designee on a monthly basis and logged onto the monthly □Doors Inspection□ logs. The Director of Maintenance will continue to meet with his staff to ensure that these practices are being upheld and findings will be reported to the Administrator on a monthly basis in Morning Meeting , and results of all audits will be presented at the Quality Assurance Performance Improvement Meeting, held quarterly for (1) year.	
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 by: . Based on observation, record review and interview, the facility failed to complete a smoke detection sensitivity test for all 88 ionization electric smoke detectors in the past two years in accordance with NFPA 72 National Fire Alarm	K 345	K345 SS=F Fire Alarm System- Testing and Maintenance CFR: NFPA 101	4/19/23

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K 345	Continued From page 9 and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 204 residents. A review of fire safety records from the orange binder titled "Embassy Manor Life Safety Code Book" at the "fire alarm system" tab provided by the Maintenance Director revealed the most recent fire alarm inspections titled "Fire Alarm Inspection and Certification Cover Sheet" respectively on 12/08/22, 06/30/22, 01/03/22, 07/26/21, 12/24/2 did not include a smoke detection sensitivity test. An observation on 02/27/23 and 02/28/23 from 10:15 AM to 1:50 PM and 8:35 AM to 10:55 AM revealed the facility had smoke detection in all corridors every 30 feet. An interview with the Maintenance Director and Regional Operations Director on 02/28/23 at 2:00 PM, confirmed he did not have the sensitivity test from the past two years. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	Date: 4/19/23 1. The Director of Maintenance immediately contacted Oliver Fire Protection & Security to schedule a smoke detection sensitivity test to be conducted on 4/19/23, for all 88 ionization electric smoke detectors in the building to be in accordance with the NPFA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. The sensitivity testing will be completed in-house and all 88 detectors will trigger the Fire Panel to prove their proper function in accordance to each zone. 2. Every resident has the potential to be affected by these deficient practices. 3. An In-service to all Maintenance employees/groundkeepers was conducted on 2/27/23 by the Regional Administrator, the Administrator, and the Director of Maintenance to ensure that they all understood and recognized the deficient practice immediately. Oliver Fire Protection & Security was contacted and scheduled to test and ensure the proper operation of smoke detection sensitivity to ensure the safety of all residents and so that each Maintenance employee would know how to avoid these deficient practices in the future. 4. Rounds will be made by the Director of Maintenance/designee semi-annually and logged onto the 'Semi-Annual Smoke Alarm Inspection Log'. The Director of Maintenance will meet with his staff	

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K 345	Continued From page 10	K 345	semi-annually to ensure that these practices are being upheld and his findings will be reported to the Administrator on a semi-annual basis in Morning Meeting. Results of all audits will be presented at the Quality Assurance Performance Improvement Meeting, held quarterly for (1) year to ensure compliance.	
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure two spaces open to the corridor were protected by smoke detection systems in accordance with NFPA 101 Life Safety Code (2012 edition) Sections 19.3.6.1. (7) to 19.3.4.1. to 9.6. to 9.6.2.1. This deficient practice had the potential to affect 24 residents in two smoke zones on the second floor. Findings include: An observation of room 209, labeled as "Dayroom" on 02/27/23 at 12:00 PM, revealed the room measured 304 square feet, was used for activities and an office area and lacked a corridor door. The room was protected by an automatic sprinkler system and a battery operated smoke detector that sounded an alarm in the immediate	K 347	K347 SS=E Smoke Detection CFR: NFPA 101 Date: 3/30/23 1. The Director of Maintenance Immediately identified □Day Room #209 & the Day Room for 2B□ as spaces that had been converted into Resident Day Lounges and required the furnishing and installation of (2) hardwired conventional Smoke Detectors, as the (2) current systems were only battery operated. The Director of Maintenance notified Oliver Fire Protection & Security to wire and program into the existing zone for each circuit with the building□s fire alarm	3/30/23

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EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE** **EDISON, NJ 08817**

(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 347	Continued From page 11 area. The room was a use area and contained 12 chairs, two tables and a desk and chair for charting. An observation of 2B Dayroom, located near bedroom 278 on 02/27/23 at 1:40 PM, revealed the room measured 301 square feet, was used for activities, and lacked a corridor door. The room was protected by an automatic sprinkler system and no smoke detection. The room was a use area and contained eight chairs and two tables. An interview with the Maintenance Director and Regional Operations Director at the time of each observation verified the doors had been removed prior to the current company acquiring the building or approximately three years ago. NJAC 8:39-31-1(c), 31.2(e) NFPA 70, 72 .	K 347	control panel. The (2) new smoke detectors will be installed and programmed to tie into local zones and will be tested to ensure proper operation after the completion of their installation on 3/30/23. 2. Every resident has the potential to be affected by these deficient practices. 3. An In-service to all Maintenance employees/groundkeepers was conducted on 2/27/23 by the Regional Administrator, the Administrator, and the Director of Maintenance to ensure that all staff understood and recognized the deficient practice immediately. Monthly Fire Drills will be conducted to ensure that smoke detection systems are working and so that employees would know how to avoid these deficient practices in the future. 4. Rounds will be made by the Director of Maintenance/designee semi-annually and logged onto the □Semi-Annual Smoke Alarm Inspection Log□. The Director of Maintenance will complete random audits and meet with his staff on a monthly basis to ensure that these practices are being upheld and his findings will be reported to the Administrator on a monthly basis in Morning Meeting. Results of all audits will be presented at the Quality Assurance Performance Improvement Meeting, held quarterly for (1) year in order to maintain compliance.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101	K 351		3/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. BUILDING **01** B. WING _____	**03/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE** **EDISON, NJ 08817**

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K 351	Continued From page 12 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, 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 interviews, the facility failed to ensure sprinkler coverage was provided under six of six staircase landings in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) Section 8.15.3.2.1. This deficient practice had the potential to affect all 204. Findings include: An observation on 02/27/23 at 10:25 AM of the lower-level exit stairway landing in stairwell C was lacking sprinkler protection. The nearest sprinkler was located at the landing above the lower-level landing and did not cover the lower landing or under the lower landing staircase.	K 351	K351 SS=F Sprinkler System- Installation CFR: NFPA 101 Date: 3/28/23 1. The Director of Maintenance immediately called Oliver Fire Protection & Security to come and evaluate all (6) of the lower level exit stairway landings that were failing to provide sprinkler coverage under staircase: C, C2, B, B-back, A-front, and A-back. On 3/24/23 a service quote was obtained to furnish and install all (6) Sprinkler Systems under the six of six staircase landings. Oliver Fire Protection	

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EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	**10 BRUNSWICK AVENUE** **EDISON, NJ 08817**

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K 351	Continued From page 13 An observation on 02/27/23 at 10:30 AM near bedroom 138 of the lower-level exit stairway landing in stairwell C2 was lacking sprinkler protection. The nearest sprinkler was located at the landing above the lower-level landing and did not cover the lower landing or under the lower landing staircase. An observation on 02/27/23 at 11:00 AM near bedroom 156 of the lower-level exit stairway landing in stairwell B was lacking sprinkler protection. The nearest sprinkler was located at the landing above the lower-level landing and did not cover the lower landing or under the lower landing staircase. An observation on 02/27/23 at 11:10 AM near bedroom 124 of the lower-level exit stairway landing in stairwell A-front was lacking sprinkler protection. The nearest sprinkler was located at the landing above the lower-level landing and did not cover the lower landing or under the lower landing staircase. An observation on 02/27/23 at 11:15 AM near bedroom 101 of the lower-level exit stairway landing in stairwell A-back was lacking sprinkler protection. The nearest sprinkler was located at the landing above the lower-level landing and did not cover the lower landing or under the lower landing staircase. An observation on 02/27/23 at 11:20 AM near the main housekeeping and laundry area of the lower-level exit stairway landing in stairwell B-back was lacking sprinkler protection. The nearest sprinkler was located at the landing above the lower-level landing and did not cover	K 351	& Security is proposing for installation after review of blueprint drawings from local Edison Township are produced, a hydrant flow test is completed and all proper permits are obtained before installation can be complete. On 3/28/23, an Open Public Records Act Request Form, OPRA, was submitted by the Administrator/Maintenance Director to obtain records of original sprinkler blueprints, or “current as built drawings” of our Sprinkler System for the 10 Brunswick Avenue property. Arrival of these documents will subsequently ensure approval for Oliver's installation of (6) sprinkler heads on the 1st floor. Estimated time frame of completion can be 3-6 months as per Authority Having Jurisdiction, AHJ. 2. Every resident has the potential to be affected by these deficient practices. 3. An In-service to all Maintenance employees/groundkeepers was conducted on 2/27/23 by the Regional Administrator, the Administrator, and the Director of Maintenance to ensure that all staff understood and recognized the deficient practice immediately. Installation was contracted by Oliver Fire Protection & Security to ensure that each system is installed and working properly and so that employees will know that these deficient practices are avoided in the future. 4. Rounds will be made by the Director of Maintenance/designee weekly and logged onto the ‘Sprinkler System Rounding	

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K 351	Continued From page 14 the lower landing or under the lower landing staircase. An interview with the Maintenance Director and Regional Operations Director at the time of each observation verified the lack of sprinkler coverage under each stairwell landing. NJAC 8:39-31.1(c), 31.2(e) NJAC 13, 25 .	K 351	Checklist'. The Director of Maintenance will meet with his staff on a weekly basis to ensure that these progresses are being upheld and his findings will be reported to the Administrator on a weekly basis in Morning Meeting. Results of all audits will be presented at the Quality Assurance Performance Improvement Meeting, held quarterly for (1) year.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is	K 741		3/14/23

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K 741	Continued From page 15 permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: . Based on observations, interview, and record review, the facility failed to ensure smoking regulations were enforced in accordance with NFPA 101 Life Safety Code (2012 edition) Section 19.7.4. This deficient practice had the potential to affect 11 smokers. Findings include: An observation of the smoking area, located near the gazebo on 02/27/23 at 1:05 AM, revealed there were no ash trays and no metal self-closing containers in which to empty the ash trays. An observation on 02/27/23 at 1:05 PM revealed four of the eleven smokers were in the designated smoking area smoking cigarettes. Each resident was lacking an ash tray and three of the four were in wheelchairs. The residents were flicking their ashes on the sidewalk. An interview with the Regional Operations Director at the time of the observation revealed he thought the cigarette towers were sufficient for safe smoking. He confirmed all four residents were smoking without ash trays. A review of the facility policy dated 04/05/22 titled "Resident Safe Smoking Policy" provided by the Administrator, revealed the policy lacked references to safety while smoking, such as safe use of ash trays at all times, extinguishing cigarettes in ash trays only, residents assessed	K 741	K741 SS=E Smoking Regulations CFR: NFPA 101 Date: 3/14/23 1(a). A Metal self-closing lid ashtray was purchased for the disposal of ALL extinguished cigarette butts to be discarded in. This container will be emptied daily, at the end of day by the Housekeeping Porter/designee. Two more ashtrays made of non-combustible material and safe design were also purchased and were provided in the smoking gazebo area were smoking is permitted for the proper disposal of all ashes and extinguished butts during and after the residents are finished smoking. 1(b). The Administrator updated the □Resident-Safe Smoking Policy□ to include references to safety while smoking, this included: the safe usage of ashtrays at all times while smoking, extinguishing of cigarettes in ash trays only, inclusion of these functions on the Resident□s Safe Smoker□s Assessment Form, the disposing of all ashes and cigarette butts when finished smoking, how when and where to dispose of the extinguished cigarette butts, and lastly who amongst staff would properly dispose	

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K 741	Continued From page 16 as safe smokers, disposing of all ashes and cigarette butts when finished smoking, and how, when, and where to dispose of cigarette butts. The policy also lacked a reference to final disposal of all cigarette butts at the end of the day or a smoking session. NJAC 8:39-31.2(e), 31.6(e) .	K 741	of all daily extinguished cigarette butts, when and where. All Recreation and Housekeeping Staff was provided an in-service by the Administrator, Director of Maintenance, Director of Recreation, and the Director of Nursing, and Director of Housekeeping to ensure that each employee would know how to avoid these deficient practices in the future. 2. Every resident has the potential to be affected by these deficient practices. 3. An in-service to all Recreation, Housekeeping and Maintenance Staff was conducted on 3/10/23 by the Administrator, Director of Maintenance, Director of Recreation, and the Director of Nursing, and Director of Housekeeping to ensure that all staff understood and recognized the deficient practices immediately. 4. Daily rounds will be made by the Director of Housekeeping/designee and the smoking area will be kept clean on a daily basis and monitored during each use by a member of the Recreation Department. Findings will be reported to the Administrator on a monthly basis in Morning Meeting. Results of all audits will be presented at the Quality Assurance Performance Improvement Meeting, held quarterly for (1) year.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		3/14/23

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K 918	Continued From page 17 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and 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 observation and interview, the facility failed to ensure that the transfer switch room was without storage in accordance with NFPA 110	K 918	K918 SS=F Electrical Systems- Essential Electrical Systems	

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K 918	Continued From page 18 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.2.1.2. This deficient practice had the potential to affect all 204 residents. Findings include: An observation of the generator transfer switch room on 02/27/23 at 1:50 PM revealed the room contained three large commercial fertilizer/spreaders, three large wet/dry vacuums, one 50 gallon garbage container with parts and debris and therapy equipment. The storage was blocking a walking path to the transfer switch. AN interview with the Maintenance Director at the time of the observation verified the condition of the room and indicated he could move the equipment out of the room. NJAC 8:39-31.2(e) .	K 918	CFR: NFPA 101 Date: 03/14/23 1. The transfer switch room was immediately freed of the three large commercial fertilizer/spreaders, three large wet/dry vacuums, one 50-gallon garbage container with parts and debris from therapy equipment and the walking path to the generator transfer switch room was cleared in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.2.1.2, on 2/27/23. 2. Every resident has the potential to be affected by these deficient practices. 3. An In-service to all Maintenance employees/groundkeepers was conducted on 2/27/23 by the Regional Administrator, the Administrator, and the Director of Maintenance to ensure that all staff understood and recognized the deficient practice immediately. Nearby resources, like the outside dumpsters and nearby storage rooms were identified as well in order to ensure that each employee would know how to avoid these deficient practices in the future. 4. Daily rounds will be made by the Director of Maintenance/designee and logged onto the □Maintenance Daily Logs□ report sheets. The Director of Maintenance will meet with his staff weekly to ensure that these practices are being upheld and his findings will be	

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K 918	Continued From page 19	K 918	reported to the Administrator on a monthly basis in Morning Meeting. Results of all audits will be presented at the Quality Assurance Performance Improvement Meeting, held quarterly for (1) year.	

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
315279 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	10 BRUNSWICK AVENUE EDISON, NJ 08817

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 K0211	03/14/2023	LSC K0281	03/16/2023	LSC K0291	03/16/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	03/14/2023	LSC K0345	04/19/2023	LSC K0347	03/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	03/28/2023	LSC K0741	03/14/2023	LSC K0918	03/14/2023
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	
3/10/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO