STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING **01** B. WING _____	**10/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	**1433 RINGWOOD AVE** **HASKELL, NJ 07420**

(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 10/17/2023, 10/18/2023 and 10/19/2023, Phonex 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 Occupancy Phonex Center is a four-story building that was built in the 1980's. It is composed of Type II protected construction. The facility is divided into 17 smoke zones. The facility has a small Natural Gas generator and a 300 KW Diesel generator.	K 000		
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	K 321		12/8/23

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

Electronically Signed | 11/08/2023

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K 321	Continued From page 1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 10/17/2023, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas 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 practiced was evidenced by the following: During the survey entrance on 10/17/2023 at 9:31 AM a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified there are two (2) buildings that are connected together, the Long Term Care building and the Pediatric building. Starting on 10/17/2023 in the presence of the	K 321	IMMEDIATE ACTION On 10/17/2023, Maintenance added enclosure to the corridor door in room [redacted] and [redacted] floor treatment room to ensure the door self-closes into its frame. IDENTIFY OTHERS: On 10/26/2023 Director of Maintenance/designee reviewed all hazardous area to ensure all doors had self-enclosure. No negative findings. INSERVICES: On 10/26/2023 Director of Maintenance/designee initiated in services to all maintenance staff to ensure all hazardous area has a door that self-closes into its frame. QAPI: Director of Maintenance/designee will perform monthly audits to ensure all hazardous areas has a door that self-closes into its frame for the first 3	

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K 321	Continued From page 2 facility's DOM a tour of the building was conducted. During the building tour the surveyor observed the following hazardous area that failed to have smoke resisting doors, On 10/17/2023: 1) At approximately 11:34 AM, an inspection inside the [redacted] floor Resident room [redacted] was performed. The surveyor observed that the room was utilized as a Medical Records storage room. The surveyor observed inside the room over 50 Banker size boxes filled with combustible Medical records and 9 six shelf racks filled with combustible Medical Records. The surveyor observed the corridor door had no means to self-close the door into its frame. This left an approximately 38 inch opening to the corridor. The surveyor measured and recorded the room which is 11 feet by 16 feet (176 square feet) which is larger than 50 square feet. With this corridor door not closing into its frame all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 12:15 PM, an inspection inside the [redacted].) floor Treatment room was performed. The surveyor observed that the Treatment room was utilized as a Medical Records storage room. The surveyor observed inside the room [redacted] Banker size boxes filled with combustible Medical records and 16 two feet long by twelve inch boxes filled with combustible Medical Records. The surveyor observed that the corridor door had no means to self-close the door into its frame.	K 321	months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Director of Maintenance and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Maintenance and will be ongoing until 100 percent compliant attained.	

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K 321	Continued From page 3 This left an approximately 36 inch opening to the corridor. The surveyor measured and recorded the room. The room was 9 feet by 6 feet which is 54 square feet. With this corridor door not closing into its frame all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted in the area identified to pass the Resident room #324 and Treatment room is the primary and/ or secondary egress route in the event of a fire. The DOM confirmed the findings at the time of observations. On 10/19/2023 during the survey exit at approximately 11:47 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
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 and review of facility documentation on 10/17/2023, 10/18/2023 and	K 355	IMMEDIATE ACTION On 10/17/2023, Maintenance replaced the	12/8/23

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K 355	Continued From page 4 10/19/2023 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 2 of 38 portable fire extinguishers, 2) Replace 1 of 38 portable fire extinguishers when discharged, as required by National Fire Protection Association 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. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 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. - 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. The findings include the following,	K 355	fire extinguisher on the [redacted] floor resident's day room. On 10/18/2023, Maintenance performed monthly inspection and documented on the two fire extinguishers in the maintenance shop. IDENTIFY OTHERS: On 10/26/2023 Director of Maintenance/designee reviewed all fire extinguishers to ensure all were inspected and documented. Any negative findings were corrected. INSERVICES: On 10/26/2023 Director of Maintenance/designee initiated in services to all maintenance staff to ensure all fire extinguishers in the facility including maintenance shop will have monthly inspection performed and documented. QAPI: Director of Maintenance/designee will perform monthly audits to ensure all fire extinguishers in the facility are inspected and documented for the first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Director of Maintenance and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Maintenance and will be ongoing until 100 percent compliant attained.	

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K 355	Continued From page 5 On 10/17/2023 during the survey entrance at approximately 09:21 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified there are two (2) buildings that are connected together, the Long Term Care building and the Pediatric building. Starting at approximately 09:59 AM on 10/17/2023 and continued on 10/18, 19/2023 in the presence of the facility's DOM a tour of the building was conducted. Along the three (3) day tour the surveyor observed and inspected thirty-eight (38) fire extinguishers in various locations that were last annually inspected March 2023 with the following issues that were identified: On 10/17/2023: 1) At approximately 12:01 PM, the surveyor observed One (1) "ABC-Type" fire extinguisher inside the [redacted] floor Residents [redacted] pressure indicating needle was in the RED discharge zone on the gauge. At this time the surveyor asked the DOM if the facility had a spare fire extinguisher and could he replace this fire extinguisher. The DOM told the surveyor yes we have a couple spare fire extinguishers. The DOM complied with the request to replace the fire extinguisher. On 10/18/2023: 2) At approximately 11:42 AM, the surveyor observed two (2) ABC-Type fire extinguisher inside the [redacted] floor Maintenance shop. At this time the surveyor asked the DOM, are these	K 355		

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K 355	Continued From page 6 spare fire extinguisher. The DOM said, yes. The surveyor observed on the tags attached to the extinguishers were last annually inspected Maintenance Shop was last annually inspected March 2023. There was no evidence of monthly visual examination performed and documented for August and September 2023. The DOM confirmed the finding at the time of observations. On 10/19/2023 during the survey exit at approximately 11:47 AM, the surveyor informed the Administrator of the deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 372 SS=E	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 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 observations and review of facility provided documentation, it was determined that	K 372	IMMEDIATE ACTION On 10/19/2023, Maintenance sealed the	12/8/23

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K 372	Continued From page 7 the facility failed to maintain the integrity of smoke barrier partitions for two (2) of eleven (11) smoke barrier walls as evidenced by the following: During the survey entrance on 10/17/2023 at 9:31 AM a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified there are two (2) buildings that are connected together, the Long Term Care building and the Pediatric building. There are eleven (11) smoke barrier walls and one (1) two hour fire rated wall in the facility. Starting on 10/17/2023 and continued on 10/18 and 19/2023 in the presence of the facility's DOM an inspection above the corridor ceiling tiles of 9 fire/ smoke barrier walls was performed. The surveyor observed the following smoke barrier walls failed to maintain the 1/2 hour fire rated construction as required by code in the following locations, 1. On 10/19/2023 at approximately 9:40 AM, in the Pediatric building near Resident room [redacted] the surveyor observed above the ceiling tiles of the corridor double smoke doors, one (1) approximately 1" by 2-1/2" , one approximately 2" hole with 2 gray wires and 1 BX electrical cable and one approximately 3" by 6" hole with one orange cable and 4 white wires 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.	K 372	hole that was found above the ceiling tiles of the corridor double smoke doors next to resident room [redacted] and #[redacted] IDENTIFY OTHERS: On 10/26/2023, Director of Maintenance/designee reviewed all smoke barrier partitions for all smoke barrier walls to ensure no other areas failed to maintain the 1/2 hour fire rated construction as required by code. No negative findings. INSERVICES: On 10/26/2023 Director of Maintenance/designee initiated in services to all maintenance staff to ensure facility maintain the integrity of smoke barrier partitions in all areas and will be ongoing until all staff are educated. QAPI: Director of Maintenance/designee will perform monthly audits to ensure all fire/smoke barrier walls have no openings above the ceiling tiles for first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Director of Maintenance and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Maintenance and will be ongoing until 100 percent compliant attained.	

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K 372	Continued From page 8 2. On 10/19/2023 at approximately 9:51 AM, in the Pediatric building near Resident room [redacted] the surveyor observed above the ceiling tiles of the corridor double smoke doors, two (2) approximately 1/2" , with 3 blue wires 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 DOM confirmed the findings at the time of observations. On 10/19/2023 during the survey exit at approximately 11:47 AM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	K 374		12/8/23

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K 374	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 10/17/2023, 10/18/2023 and 10/19/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 2 of 11 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. During the survey entrance on 10/17/2023 at 9:31 AM a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified there are two (2) buildings that are connected together, the [redacted] Care building and the Pediatric building. There are eleven (11) smoke barrier walls and one (1) two hour fire rated wall in the facility. Starting on 10/17/2023 and continued on 10/18 and 19/2023 in the presence of the facility's DOM an inspection and inspection of the building was conducted Along the three (3) day tour the surveyor performed a closure test of eleven (11) smoke	K 374	IMMEDIATE ACTION On 10/23/2023, Maintenance ordered door sweeps to add to the bottom of the smoke barrier doors on the double smoke doors by resident room [redacted] and [redacted] and smoke doors by resident room [redacted] and [redacted] to ensure there will be no more than ¿ of an inch gap from the bottom of the door to the floor. IDENTIFY OTHERS: On 10/26/2023, Director of Maintenance/designee reviewed all smoke barrier doors to ensure the doors can resist the transfer of smoke by ensuring there is ¿ of an inch gap from the bottom of the door to the floor. No negative findings. INSERVICES: On 10/26/2023 Director of Maintenance/designee initiated in services to all maintenance staff to ensure the doors can resist the transfer of smoke by ensuring there is ¿ of an inch gap from the bottom of the door to the floor and will be ongoing until all staff are educated. QAPI: Director of Maintenance/designee will perform monthly audits to ensure the doors can resist the transfer of smoke by ensuring doors shall be a maximum of ¿ inch from the floor for first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Director of Maintenance and	

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K 374	Continued From page 10 barrier sets of double smoke doors in the corridors with the following results, On 10/17/2023: 1) At approximately 10:38 AM, during a closure test of the double smoke doors on the [redacted]. floor next to Resident room [redacted] and [redacted] when the doors were release from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measure a 1-1/8 inch gap along the bottom edge of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. 2) At approximately 10:50 AM, during a closure test of the double smoke doors on the 4th. floor next to Resident room [redacted] and [redacted]4 when the doors were release from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measure a 1-1/8 inch gap along the bottom edge of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The DOM confirmed the findings at the time of observations. On 10/19/2023 during the survey exit at approximately 11:47 AM, the surveyor informed the Administrator of the deficiency. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374	reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Maintenance and will be ongoing until 100 percent compliant attained.	

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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 observations, interview and review of facility provided documentation on 10/17/2023, 10/18/2023 and 10/19/2023 in the presence of facility management, it was determined that the facility failed to : 1) Ensure that the facility's ventilation systems were being properly maintained for 5 of 20 bathroom exhaust systems. 2) Provide an exhaust system for 2 of 20 Resident Shower bathrooms, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 10/17/2023 (day one of survey) during the survey entrance at approximately 09:21 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked how many Resident sleeping rooms are in the facility. The DOM told the surveyor that there are 126	K 521	IMMEDIATE ACTION On 10/17/2023, Maintenance repaired the exhaust systems in the 5 bathroom locations (NJ EX Order. 264b1, Staff bathroom) and 2 resident shower bathrooms on the 3rd floor and 2nd floor. The two roof exhaust motors were repaired by maintenance on 10/18/2023. IDENTIFY OTHERS: On 10/26/2023, Director of Maintenance/designee reviewed all exhaust system at the facility to ensure ventilation. Any negative findings were corrected. INSERVICES: On 10/26/2023 Director of Maintenance/designee initiated in services to all maintenance staff to ensure all exhaust system is properly maintained will be ongoing until all staff are educated. QAPI: Director of Maintenance/designee will	12/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING **01** B. WING _____	**10/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	**1433 RINGWOOD AVE** **HASKELL, NJ 07420**

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K 521	Continued From page 12 Resident sleeping rooms. A review of the facility provided lay-out identified there are two (2) buildings that are connected together, the Long Term Care building and the Pediatric building. The Long Term Care building has, - There are 31 Resident sleeping rooms, common areas and a Resident shower room on the [redacted]. floor. - There are 31 Resident sleeping rooms, common areas and a Resident shower room on the [redacted] floor. - There are 31 Resident sleeping rooms, common areas and a Resident shower room on the [redacted]. floor. - There are common areas, Kitchen, Physical Therapy,Mechanical rooms and Offices on the [redacted] floor. The Pediatric building has, - There are 37 Resident sleeping rooms (4 rooms under cosmetic renovation), [redacted] and [redacted] area. Starting on 10/17/2023 and continued on 10/18 and 19/2023 in the presence of the facility's DOM a tour of the building was conducted. During the Three (3) day building tour the surveyor inspected inside sixteen (16) Resident sleeping rooms and three (3) Resident shower bathrooms. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 5 of 20 bathrooms and no	K 521	perform monthly audits to ensure all exhaust system are working properly for first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Director of Maintenance and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Maintenance and will be ongoing until 100 percent compliant attained.	

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K 521	Continued From page 13 evidence of an exhaust system in 2 Resident Shower bathrooms in the following locations: On 10/17/2023: 1. At approximately 11:46 AM, the surveyor observed no evidence of an exhaust system inside the [redacted] floor Resident shower bathroom. At this time the surveyor asked the DOM, Do you see an exhaust system in the bathroom."inside the third (3rd.) floor Residents shower bathroom, the surveyor observed no evidence of an exhaust system. At this time the surveyor asked the DOM, "Do you see an exhaust system in the bathroom." The DOM looked up and around the bathroom and said, no. The contractor must have not re-connected the exhaust when they renovated the shower room. On 10/18/2023: 2. At approximately 10:29 AM, the surveyor observed no evidence of an exhaust system inside the [redacted] floor Resident shower bathroom. At this time the surveyor asked the DOM, Do you see an exhaust system in the bathroom inside the second (2nd.) floor Residents shower bathroom. The DOM said, no. On 10/19/2023 in the Pediatric building: 3. At approximately 09:41 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 4. At approximately 09:43 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly.	K 521		

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	315229	A. BUILDING **01** B. WING _____	**10/25/2023**

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K 521	Continued From page 14 This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 10:02 AM, inside Staff bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 6. At approximately 10:09 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 7. At approximately 10:17 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. Along the tour the DOM told the surveyor that one of the Mechanics on the roof reported to him that two (2) exhaust motors are not working. The DOM confirmed the finding at the time of observations. On 10/19/2023 during the survey exit at approximately 11:47 AM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 915 SS=C	Electrical Systems - Essential Electric Syste	K 915		6/30/24

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	315229	A. BUILDING **01** B. WING _____	**10/25/2023**

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K 915	Continued From page 15 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: The facility has a Time Limited Waiver which was approved by Center for Medicare and Medicaid Services (CMS) December 21, 2022 that will expire June 30, 2024. The facility has made the progress report dates of 03/01/2023, 06/01/2023 and 09/01/2023. Based on observation, interview and record review on 8/30/22, in the presence of the Maintenance Director, it was determined that, the facility failed to provide a Type 1 Essential Electrical System in accordance with NFPA 99. This deficient practice was evidenced by the following:	K 915	IMMEDIATE ACTION Limited waiver is in place. On November 9, 2022, Phoenix applied for a time limited waiver as to K -915 Electrical Systems for the appropriate design and installation of infrastructure. On December 21, 2023, CMS send the facility a letter stating that its request is approved based on the recommendation of New Jersey Department of Health, Health Facility Survey and Field Operations. The CMS letter also said that the waiver is in place until June 30, 2024. The Facility is continuing to work on the design and installation of the infrastructure pursuant to the existing waiver.	

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K 915	Continued From page 16 At approximately 11:00 AM, the surveyor observed all documents provided by the facility for record review. The provided electrical annual inspection dated: 04/25/22 did not provide any information on "Essential Electrical System Design Standards". The facility currently has a Ventilator (vent) unit that requires a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. At approximately 12:15 PM, the surveyor interviewed the Maintenance Director where he indicated that he was not sure if the current electrical system for the vent unit was a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. At approximately 01:15 PM, while touring the facility, the surveyor, interim Maintenance Director could not locate the required three branch panels that are divided as follows: 1) Life Safety 2) Critical 3) Equipment (Each branch is required to have at least 1-transfer switch) The Administrator was informed of the finding at the Life Safety Code exit conference on 8/31/22. *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. NJAC 8:39-31.2(e)	K 915	INTERIM STEPS WHILE REPAIR COMPLETED: Director of Maintenance/designee is assigned on call 24/7 and present onsite to oversee generator performance during any loss of main power related to the electrical system for the facility. INSERVICES On 10/26/2023, Director of Maintenance/designee initiated RE-services to all pediatric staff to ensure that in the event of power loss on the pediatric unit, staff must disconnect all non-essential electrical item from electrical outlets leaving only critical patient care electrical equipment in place to reduce load on electrical system and generator. In- services will be ongoing until all staff are educated. QAPI: Director of Maintenance/designee will perform monthly audits to ensure all staff are aware of the protocol for power loss in the pediatric unit until electrical system is updated for first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Director of Maintenance and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Maintenance and will be ongoing until 100 percent compliant attained.	

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K 915	Continued From page 17 NFPA 99- 6.7.5.1.1 6.7.5.1.3* Critical Branch 6.7.5.1.4 Equipment Branch 6.7.5.1.2 Life Safety Branch	K 915		

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
315229 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	1433 RINGWOOD AVE HASKELL, NJ 07420

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	K0321	12/08/2023	LSC	K0355	12/08/2023	LSC	K0372	12/08/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0374	12/08/2023	LSC	K0521	12/08/2023	LSC	K0915	12/08/2023
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		
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	
10/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO