STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	**685 SALINA ROAD** **SEWELL, NJ 08080**

(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 02/14/23. 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 02/14/23 and 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. Advanced Subacute Rehabilitation Center at Sewell is a one-story building which was built in 1987. It is composed of Type V protected construction. The facility is divided into six smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director. The current occupied beds are 103 of 122.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222		3/17/23

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

Electronically Signed | 03/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be	K 222		

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ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	**685 SALINA ROAD** **SEWELL, NJ 08080**

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K 222	Continued From page 2 permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations, and interviews, the facility failed to ensure exit doors were equipped with a readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that read as follows PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS and located on the door leaf adjacent to the release device in the direction of egress in accordance with NFPA 101 (2012 edition) Life Safety Code, section 7.2.1.6.1.(4). This deficient practice had the potential to affect all 103 residents. Findings include: An observation on 02/14/23 at 2:09 PM revealed the front entrance double doors were 15-second delay egress doors and was equipped with a sign at the top of the door that read PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS and the lettering was 1/4 inch high and less than 1/8-inch stroke width. An observation on 02/14/23 at 2:43 PM revealed the exit door to the courtyard was a 15-second	K 222	Concern K222 SS=F Egress Door Signage Based on observations and interviews, the facility failed to ensure exit doors were equipped with a readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that read as follows PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS and located on the door leaf adjacent to the release device in the direction of egress in accordance with NFPA 101 (2012 edition) Life Safety Code, section 7.2.1.6.1.(4). This deficient practice had the potential to affect all 103 residents. How the corrective action will be accomplished for any resident affected by	

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K 222	Continued From page 3 delay egress door and was not equipped with a sign that read PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. At the time of the observations, the Maintenance Director confirmed that the measurement of the signage on the front entrance doors was smaller than required and the exit door leading to the courtyard had no signage. NJAC 8:39-31.1(c), 31.2(e)	K 222	deficient practice. The Maintenance Director replaced the signage on the front entrance double doors and courtyard door to the required size. No other residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. The Maintenance Department staff was in serviced on the proper measurement of the signage to ensure they are being met for the safety of residents, staff and visitors. The Maintenance Director or designee will check all exit for delayed –egress locking arrangements as part of his rounds daily for 90 days and thereafter and will ensure that the egress signage meets the required size. How the concern will be monitored and title of person responsible for monitoring. Findings or results of daily inspection will be discussed with Administrator for	

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K 222	Continued From page 4	K 222	immediate resolution and this will be discussed in monthly QAPI and will be a part of quarterly Quality Assurance Program. Dates when concern will be completed. March 17, 2023	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure an exit that was obviously and clearly identifiable as an exit, was marked by an approved sign that was readily visible from any direction of exit access and read as follows in plainly legible letters, or other appropriate wording: EXIT in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 7.10.1.2.1 and 7.10.3.1 This deficient practice had the potential to affect 10 residents. Findings include: An observation on 02/14/23 at 2:01 PM revealed the designated exit, located in Therapy, was not marked with an EXIT sign.	K 293	Concern K293 SS=E Exit Signage Based on observation and interviews, the facility failed to ensure an exit that was obviously and clearly identifiable as an exit, was marked by an approved sign that was readily visible from any direction of exit access and read as follows in plainly legible letters, or other appropriate wording: EXIT in accordance with NFPA 101 Life Safety Code (2012 Edition)	3/17/23

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K 293	Continued From page 5 During an interview at the time of the observation, the Maintenance Director confirmed an EXIT sign was missing at the Therapy exit door. He stated he was aware the exit door did not have an EXIT sign, but he had not been able to take care of it. During an interview on 02/14/23 at 5:15 PM, the Administrator stated that during the day, the average number of clients in the Therapy room was 10. NJAC 8:39-31.1(c), 31.2(e)	K 293	Sections 7.10.1.2.1 and 7.10.3.1 This deficient practice had the potential to affect 10 residents. How the corrective action will be accomplished for any resident affected by deficient practice. The missing exit sign over the Therapy Room was immediately corrected. Exit sign was hung visibly from direction of the exit access in an event of emergency. Rehabilitation Department was in serviced regarding the exit access. No other residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern. Maintenance staff was in-serviced regarding exit signage used as signs with continuous illumination, also served by the emergency lighting system. The Maintenance Director or designee will round daily X 90 days to ensure all required exit signs are in place. Corporate Maintenance Director will round	

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K 293	Continued From page 6	K 293	Monthly X 3 months to check that the exit signs are visible and illuminated. How the concern will be monitored and title of person responsible for monitoring. The Maintenance Director's and Corporate Maintenance findings will be discussed with the administrator for immediate resolution. This will be brought and discussed in monthly QAPI and this will be a part of quarterly Quality Assurance Program. Dates when concern will be completed. March 17, 2023	
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 record review and interview, the facility failed to ensure systems and associated equipment for the fire alarm system were tested on a semi-annual basis and a smoke detection sensitivity test was completed for all 242 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code	K 345	Concern K345 SS=F Fire Alarm System – Testing and Maintenance	3/24/23

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K 345	Continued From page 7 (2010 edition), Table 14.4.3.2 and Section 14.4.4.3.2. This deficient practice had the potential to affect 103 residents. Findings include: A review of fire inspection reports from the "State Binder," dated January 2019 through January 2023 and provided by the Maintenance Director, revealed the fire alarm system was tested and inspected on 11/15/22 and 11/05/21 and was not tested on a semi-annual basis. The most recent smoke detection inspection was completed on 11/15/22, but this inspection did not include a smoke detection sensitivity test. During an interview on 02/14/23 at 4:00 PM, the Maintenance Director confirmed the fire alarm system was not tested and inspected on a semi-annual basis and a smoke detector sensitivity test was not completed. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	Based on record review and interview, the facility failed to ensure systems and associated equipment for the fire alarm system were tested on a semi-annual basis and a smoke detection sensitivity test was completed for all 242 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition), Table 14.4.3.2 and Section 14.4.4.3.2. This deficient practice had the potential to affect 103 residents. How the corrective action will be accomplished for any resident affected by deficient practice. The fire alarm and smoke detector sensitivity test have been scheduled for 3/16/23. No other residents were affected of this deficient practice How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern. The Maintenance Director was in-serviced regarding the importance of Fire Alarm Testing and maintenance. Maintenance Director or designee will	

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K 345	Continued From page 8	K 345	schedule the bi-annual fire system and smoke detector sensitivity test on a consistent basis. Administrator or designee will check every 6 months X 1 year to ensure the bi-annual fire system and smoke detector test is done per regulation. How the concern will be monitored and title of person responsible for monitoring. The Maintenance Director will monitor the bi-annual testing schedule for the fire system and smoke detectors and report to the QAPI Committee times 3 months. Dates when concern will be completed. March 24, 2023	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		3/31/23

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K 353	Continued From page 9 _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure deficiencies or impairments found during the inspection, test, and maintenance of the water based sprinkler system were corrected or repaired by qualified maintenance personnel or a qualified contractor in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) Section 4.1.4.1 and 4.1.4.2. This deficient practice had the potential to affect 103 residents. Findings include: A review of water-based sprinkler system inspections from the "State Binder," dated January 2019 through January 2023 and provided by the Maintenance Director, revealed the inspection conducted by the contracted sprinkler company on 01/31/23 had the following uncorrected deficiency: "Need to replace accelerator. Cannot get it to reset." During an interview on 02/14/23 at 4:00 PM, the Maintenance Director confirmed the deficiency had not been corrected or repaired and stated he was unaware of the deficiency. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	Concern K353 SS=F Sprinkler System – Maintenance and Testing Based on record review and interview, the facility failed to ensure deficiencies or impairments found during the inspection, test, and maintenance of the water-based sprinkler system were corrected or repaired by qualified maintenance personnel or a qualified contractor in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of WaterBased Fire Protection Systems (2011 Edition) Section 4.1.4.1 and 4.1.4.2. This deficient practice had the potential to affect 103 residents. How the corrective action will be accomplished for any resident affected by deficient practice. Maintenance Director scheduled site visit for the replacement of the Accelerator and accelerator was replaced on 3/16/23. No residents were affected by this deficient practice.	

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K 353	Continued From page 10	K 353	How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern. Maintenance Director was in-serviced to review all fire system inspections to ensure any deficiencies sited are corrected immediately. Corporate Maintenance Director will review quarterly x one year. Findings will be discussed with the Administrator for immediate resolution. How the concern will be monitored and title of person responsible for monitoring. The Maintenance Director will discuss findings in monthly QAPI and this will be a part of Quarterly Quality Assurance Program. Dates when concern will be completed. 3/31/23	
K 355 SS=F	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.	K 355		3/17/23

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K 355	Continued From page 11 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire extinguishers were provided for the protection of both the building structure and the occupancy hazards contained therein regardless of the presence of any fixed fire suppression systems in accordance with NFPA 10 Standard for Portable Fire Extinguishers (2010 Edition) Section 5.4.2. This deficient practice had the potential to affect all 103 residents. Findings include: An observation on 02/14/23 at 3:10 PM revealed the kitchen did not have a standard complement of a Class A fire extinguisher for building protection, plus an additional Class B or Class C fire extinguisher, or both. During an interview at the time of the observation, the Maintenance Director confirmed a Class A, B, and/or C fire extinguisher was not present in the kitchen and stated he did not know it was a requirement. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355	Concern K355 SS=F Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure fire extinguishers were provided for the protection of both the building structure and the occupancy hazards contained therein regardless of the presence of any fixed fire suppression systems in accordance with NFPA 10 Standard for Portable Fire Extinguishers (2010 Edition) Section 5.4.2. This deficient practice had the potential to affect all 103 residents. How the corrective action will be accomplished for any resident affected by deficient practice. Maintenance Director hung Class A fire extinguisher in the kitchen. This deficient practice was immediately corrected. No other residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice.	

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K 355	Continued From page 12	K 355	Measures to ensure were/will be put into place to assist this area of concern. The Maintenance Director was in-serviced regarding the Portable Fire Extinguishers Classification and purpose in accordance with NFPA 10, Standard for Portable Fire Extinguishers. Administrator or designee will review the fire extinguishers to ensure weekly X 90 days to ensure the appropriate fire extinguishers are hung. How the concern will be monitored and title of person responsible for monitoring. The Maintenance Director will monitor all fire extinguishers weekly X 90 days and report findings to the administrator in morning meeting and issues discussed will be a part of Quarterly QA Program. Dates when concern will be completed. March 17, 2023	
K 363 SS=E	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	K 363		3/17/23

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ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	**685 SALINA ROAD** **SEWELL, NJ 08080**

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K 363	Continued From page 13 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 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 observations and interviews, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were provided with a means for keeping the door closed in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.3. This deficient practice had the potential to affect 62 residents.	K 363	Concern K363 SS=E Corridor Doors Based on observations and interviews, the facility failed to ensure corridor doors	

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K 363	Continued From page 14 Findings include: An observation on 02/14/23 at 2:26 PM revealed the door to Room [redacted] failed to latch when closed. An observation on 02/14/23 at 2:29 PM revealed the door to Room [redacted] failed to latch when closed. An observation on 02/14/23 at 2:42 PM revealed the door to Room [redacted] failed to latch when closed. During an interview at the time of the observation, the Maintenance Director confirmed these doors did not latch when closed. During an interview on 02/14/23 at 2:26 PM, the Maintenance Director stated he does a walk through twice a week and did not notice the doors did not latch. He stated a maintenance binder is located at the nurse stations and if the staff finds a door that does not latch they write the location in the binder. The Maintenance Director went on to state that nursing had not informed him of any doors that would not latch. NJAC 8:39-31-1(c), 31.2(e)	K 363	closed and latched into the frame without impediment and were provided with a means for keeping the door closed in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.3. This deficient practice had the potential to affect 62 residents. How the corrective action will be accomplished for any resident affected by deficient practice. Maintenance Director adjusted Corridor doors [redacted], and [redacted]. This was corrected immediately, the doors closed and latched into the frame. No other residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern. The Maintenance Director was in-serviced with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.3. Corridor doors must latch into the frame properly without obstructions. The Maintenance Director will review the corridor doors daily X 90 days and thereafter, during daily rounds to ensure doors latch properly.	

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K 363	Continued From page 15	K 363	Corporate Maintenance Director will round monthly to test corridor doors to ensure doors latch to the frame when closed. How the concern will be monitored and title of person responsible for monitoring. The Maintenance Director will monitor the corridor doors and report findings to the administrator for resolution and will discuss in morning meeting. This will be a part of quarterly Quality Assurance Program. Dates when concern will be completed. March 17, 2023	
K 741 SS=D	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	K 741		3/24/23

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K 741	Continued From page 16 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 permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure an ashtray of noncombustible material and safe design and a metal container with a self-closing cover device into which an ashtray could be emptied were readily available to the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (5)(6). This deficient practice had the potential to affect one resident who utilized the smoking area. Findings include: An observation on 02/14/23 at 2:20 PM revealed the smoking area had a freestanding plastic cigarette butt receptacle and did not have an ashtray of noncombustible material. The smoking area had a metal container with a self-closing cover device, but it was being used for trash and not to empty the ashtray into. During an interview at the time of the observation, the Maintenance Director confirmed there was not an ashtray of noncombustible material and the metal container with a self-closing cover device was being used for trash. NJAC 8:39-31.2(e)	K 741	Concern K741 SS=D Smoking Regulations Based on observation and interview, the facility failed to ensure an ashtray of noncombustible material and safe design and a metal container with a self-closing cover device into which an ashtray could be emptied were readily available to the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (5)(6). This deficient practice had the potential to affect one resident who utilized the smoking area. How the corrective action will be accomplished for any resident affected by deficient practice. Noncombustible material and safe design and a metal container with a self-closing cover device was placed in the smoking area on 3/6/23.	

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K 741	Continued From page 17	K 741		

The one resident was reeducated regarding safety disposal of cigarette butts to a noncombustible material with self-closing cover and he will be supervised by staff when smoking.

No other residents were affected by this deficient practice.

How we identified other residents/areas that could potentially be affected.

All residents have the potential to be affected by this deficient practice.

Measures to ensure were/will be put into place to assist this area of concern.

The maintenance Director was in-serviced regarding fire safety
(Smoking Regulations)in accordance with NFPA 101 Life Safety Code (2012 Edition) section.
Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.

The Maintenance Director or designee will review the smoking area during rounds daily X 90 days to ensure the non-combustible ashtray remains in place and used properly.

Staff were in serviced the used of Noncombustible Ashtray in the smoking area.

How the concern will be monitored and

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K 741	Continued From page 18	K 741	title of person responsible for monitoring. The Maintenance Director will monitor the noncombustible ashtray. Findings will be discussed with the administrator in morning meeting for immediate resolution. This will be a part of quarterly Quality Assurance. Dates when concern will be completed: March 24, 2023	
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 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	K 918		3/31/23

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K 918	Continued From page 19 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, record review, and interview, the facility failed to ensure the 200 KW (kilowatt) diesel emergency generator had a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building in accordance with NFPA 110 Standard for Emergency and Stand by Power Systems (2010 Edition) Section 5.6.5.6. This deficient practice had the potential to affect all 103 residents. Findings include: A review of the generator reports located in the "State Binder," dated January 2019 through--January 2021 and provided by the Maintenance Director, revealed the generator was inspected on 06/06/21, 09/16/21, and 10/14/21 and there was no documentation of installation of a remote manual stop station. An observation on 02/14/23 at 3:04 PM revealed the 200 KW diesel emergency generator, located outside of the building, did not have a remote	K 918	Concern K918 SS=F Electrical Systems □ Essential Electrical System Based on observation, record review, and interview, the facility failed to ensure the 200 KW (kilowatt) diesel emergency generator had a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building in accordance with NFPA 110 Standard for Emergency and Stand by Power Systems (2010 Edition) Section 5.6.5.6. This deficient practice had the potential to affect all 103 residents. How the corrective action will be accomplished for any resident affected by deficient practice.	

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K 918	Continued From page 20 manual stop station. During an interview at the time of the observation, the Maintenance Director confirmed the generator did not have a remote manual stop station and he stated he did not know it was a requirement. NJAC 8:39-31.2(e) NFPA 99, 110	K 918	A site visit was scheduled by the Maintenance Director with facility□s generator company on 3/6/23 and a proposal was generated and approved. Facility awaiting parts and equipment to complete job. No residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern. The Maintenance Director will ensure the installation of the remote manual stop station. Maintenance Director was in-serviced regarding Essential Electrical System requirement NJAC 8:39-31.2(e). Administrator or designee will check maintenance binder every 3 months x 1 year to ensure the Generator has a functioning remote manual stop station as required. NJAC 8:39-31.2(e). How the concern will be monitored and title of person responsible for monitoring. Administrator will discuss findings in daily morning meeting and this will be a part of Quarterly Assurance.	

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K 918	Continued From page 21	K 918	Dates when concern will be completed. March 31, 2023	