STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. BUILDING **01** B. WING _____	**10/05/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	**275 JOHN T O'LEARY BOULEVARD** **SOUTH AMBOY, NJ 08879**

(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 10/04/22 and 10/05/22, 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 The facility is a four-story building that was built in 2015. It is composed of Type II protected construction. The facility is divided into 9-smoke zones. The generator covers 100% of the facility.	K 000		
K 211 SS=F	Means of Egress - General 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, interview and documentation review on 10/04/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice occurred for 14 of 14 fire doors observed, and was evidenced by the following:	K 211	1, Maintenance developed a log for all fire doors to be monitored for proper function. All fire doors were assessed for proper function on 11/15. 2. All residents and staff can be affected by this deficient practice.	11/16/22

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

Electronically Signed | 10/29/2022

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	Continued From page 1 From approximately 10:00 AM to 2:00 PM, the surveyor reviewed all documentation provided from the MD and RPOD. The annual fire door inspection documentation was not provided for the facility's fire door assemblies. An interview was conducted with the MD and RPOD, during the document review. They stated that currently they could not provide any documentation for the last 12-months as identified in the S&C 17-38-LSC documentation. The Administrator was informed of the finding's at the Life Safety Code exit conference held on 10/05/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	3.Maintenance Director and/or designee developed an audit tool for all fire doors to be monitored for proper function 11/15. All fire doors will be checked weekly and reported to the Administrator if any issue arise. 4.Maintenance Directors and/or designee developed an audit tool for all fire doors to be monitored for proper function 11/15. All fire doors will be checked weekly for one month and then monthly. Audits will be reported to the Administrator if any issue arise. All findings will be communicated to the entire team at the quarterly Quality Assurance Performance Improvement (QAPI) meeting.	
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	K 321		12/21/22

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K 321	Continued From page 2 and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 10/04/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 1 of 6 Hazardous storage rooms as evidenced by the following: At 10:18 AM, the surveyor, MD and RPOD observed that the double steel doors to the	K 321	1. Maintenance Director called vendor to schedule to replace the steel door and door will be replaced. All fire doors were checked for proper functioning. All other fire doors were functioning properly on 10/5. 2. All residents and staff can be affected by this deficient practice. 3.Maintenance Director called vendor to schedule to replace the steel door 10/22. Maintenance Director and/or designee will audit all fire doors functionality so fire, smoke, and poisonous gases cannot pass through.	

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K 321	Continued From page 3 kitchen were compromised from closing and latching. One of the two doors did not fully close due to the top right-side door hitting the top edge of the closed door. This would allow fire, smoke and poisonous gasses to pass into the exit corridor in the event of a fire. An interview was conducted with the MD and RPOD during the observations, where they confirmed the finding's. The Administrator was informed of the finding's at the life safety code exit conference on 10/05/22. NJAC 8:39-31.2 (e) Life Safety Code 101- 2012 edition	K 321	All staff and vendors were in serviced on proper door functionality and doors cannot propped open by Maintenance Director by 10/28. 4.Maintenance Director called vendor to schedule to replace the steel door on 10/22. Vendor will came in on 10/26 to access door. Quote received on 10/31. Maintenance Director and/or designee will call vendor weekly to follow up on date of service. Door has been replaced and working functionally as of 12/21/22. Maintenance Director and/or designee will audit all fire doors on a weekly basis for proper function so doors close properly in which fire, smoke, and poisonous gases cannot pass through. All findings will be communicated to the Administrator. All findings will be communicated to the entire team at the quarterly Quality Assurance Performance Improvement (QAPI) meeting.	
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.	K 918		1/3/23

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K 918	Continued From page 4 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 on 10/04/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 1:05 PM, the surveyor, MD, and RPOD	K 918	1. Regional Maintenance Director called vendor to schedule the installation of the remote manual stop for the generator located outside on 10/21. Generator stop button installed on 1/3/23. 2. All residents and staff can be affected by this deficient practice. 3. Regional Maintenance Director called vendor to schedule the installation of the	

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K 918	Continued From page 5 observed the exterior generator. There was not a remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator observed remotely outside the enclosure housing the prime mover. An interview was conducted during the time of the observation with the MD and RPOD, who both confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation located remotely outside the enclosure housing the prime mover. The Administrator was informed of the finding's at the Life Safety Code exit conference held on 10/05/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	remote manual stop for the generator located outside on 10/21. Electrician was on site on 10/25 to assess and will give date on when project will be completed. Generator stop button installed on 1/3/23. 4. Regional Maintenance and Maintenance Director will schedule the installation of the remote manual stop for the generator. Maintenance Director will ensure the completion of the installation of the remote manual stop. Maintenance Director will then communicate to the Administrator that project is completed. An audit will be completed weekly to ensure delivery and installation date of the remote switch by Maintenance Director. Once installed, Director of Maintenance and/or designee will monitor functionality of remote switch weekly. All findings will be communicated to the entire team at the quarterly Quality Assurance Performance Improvement (QAPI) meeting.	
K 927 SS=E	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care	K 927		11/4/22

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K 927	Continued From page 6 rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility did not store and trans fill liquid oxygen in accordance with NFPA 99, 2012 Edition, Section 11.3.3.2 and 11.3.2.7 by ensuring that the room was properly designed and protected. This deficient practice was evidenced for 1 of 1 light fixtures by the following: At approximately 10:08 AM, the Surveyor, MD, and RPOD, observed on the ground floor oxygen storage and trans filling room, that a non-explosion proof ceiling mounted two-bulb fluorescent light fixture was observed. The room wall light switch was observed to be explosion proof. The room contained six-large industrial grade liquid oxygen cylinders, six-filled H-cylinders and 24 portable oxygen cylinders. An interview was conducted during the observation with the MD and RPOD, who both stated and confirmed that the room had a source of ignition, one (1) non-explosion proof light fixture. The Administrator was informed of the finding at the Life Safety Code exit conference on 10/05/22. NJAC 8:39-31.2(e)	K 927	1. Maintenance Director purchased enclosed light fixture and will replace old exposed light fixture. Maintenance Director checked all light fixtures in all oxygen rooms on 10/5. No other issues were reported. 2.All residents and staff can be affected by this deficient practice. 3. Maintenance ordered the proper light fixture on 10/25 and replaced old exposed light fixture on 10/28. Maintenance checked all light fixtures in all oxygen rooms on 10/5. 4.Maintenance ordered enclosed light fixture on 10/25 and replaced old exposed light fixture on 10/28. Maintenance will audit all light fixtures in oxygen rooms to ensure each light fixture is correct on a weekly basis and communicate findings to the Administrator. All findings will be communicated to the entire team at the quarterly Quality	

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K 927	Continued From page 7	K 927	Assurance Performance Improvement (QAPI) meeting.	