STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING **01** B. WING _____	**10/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	**85 HARRETON ROAD** **ALLENDALE, NJ 07401**

(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 10/11/22 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This building is a 1-story LTC facility that was opened in 2006, It is composed of Type I fire resistant construction. The facility is divided into 9- smoke zones. The generator does approximately 60 % of the facility. No elevators are involved in the long term care side of the building. The assisted living section of the building has 2-stories and 1-elevator. The fire sprinkler system is supplied by city pressure.	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 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	K 222		11/4/22

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

Electronically Signed | 10/28/2022

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K 222	Continued From page 1 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 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	K 222		

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K 222	Continued From page 2 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 observation and interview, in the presence of Maintenance Director (MD) and Regional Plant Operations Director (RPOD) on 10/11/22, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 for 2 of 2 sets of exterior exit/egress doors observed. This deficient practice was identified for 3 of 3 sets of doors and was evidenced as follows: 1. At 9:30 AM, the Surveyor, MD and RPOD observed two sets of glass sliding doors located at the front entrance of the facility, the interior set of sliding glass doors indicated with a red strip sign approximately 3" x 20" that "IN AN EMERGENCY PUSH TO OPEN". The doors were observed to not have the ability to push to open in the event of an emergency due to the inside of both sets of doors having a keyed latch that if locked, would prevent the door from opening in the event of an emergency. The current evacuation plan indicated that the front doors were designated an exit/egress route. 2. At 12:18 PM, the Surveyor, MD and RPOD observed outside the Long Term Care unit, a set of exit/egress doors were designated as an	K 222	K222 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The keyed latches were removed from both doors at Exit #8. How the facility will identify other residents having the potential to be affected by the same deficient practice: All exit/egress doors in the facility were inspected and all are free of keyed latches and all are able to be pushed open in the event of an emergency. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct an inspection monthly for 3 months to verify that all exit/egress doors in the facility are free of keyed latches and are able to be pushed open in the event of an emergency. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility□s Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are	

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K 222	Continued From page 3 exit/egress route on the facility evacuation plan. The exit/egress door marked #8 was equipped with a red door latch located on the upper left door. The red door latch was in the locked position and required a red string to be pulled down to open the door in the event of an emergency. The MD and RPOD both confirmed the findings during the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 10/11/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	present and determine if any further action is needed to maintain compliance.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/11/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 1 of 1 transfer switches and was evidenced by the following:	K 291	K291 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: A battery back-up emergency light above the ATS-1 emergency generator transfer switch was installed in boiler room. How the facility will identify other residents having the potential to be affected by the same deficient practice:	11/4/22

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K 291	Continued From page 4 At 01:07 PM, the surveyor observed in the boiler room where the generator transfer was located, that the ATS-1 transfer switch was not equipped with battery back-up emergency lighting. The Maintenance Director and Regional Plant Operations Director, both confirmed the findings at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit on 10/11/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	All areas in the facility requiring a battery back-up emergency light were inspected to ensure that there is a battery back-up emergency light installed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility instituted a monthly test of the battery back-up emergency light above the ATS-1 emergency generator transfer switch to ensure it is working. The test will be performed by the Maintenance Director or designee. The Maintenance Director or designee will conduct an inspection monthly for 3 months to verify all areas in the facility requiring a battery back-up emergency light have one installed and it is working. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility's Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to	K 341		11/4/22

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K 341	Continued From page 5 provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/11/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: At 12:38 PM, the surveyor, MD and RPOD observed in the enclosed courtyard, that no evidence of a fire alarm notification (horn/strobe) was located. An interview was conducted during the observation and the surveyor asked the MD and RPOD, if there was a horn/strobe, tied into the fire alarm system within the above enclosed courtyard. The MD and RPOD both confirmed	K 341	K341 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: A fire alarm notification (horn/strobe) was installed in the enclosed courtyard and is connected to the facility fire alarm system. How the facility will identify other residents having the potential to be affected by the same deficient practice: A facility inspection was conducted to ensure that all areas requiring a fire alarm notification (horn/strobe) have one installed and that they are connected to the facility fire alarm system. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct an inspection monthly for 3 months to verify that all that all areas in	

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K 341	Continued From page 6 that currently there are no horn/strobe devices tied into the fire alarm system in the enclosed courtyard observed. The Administrator was notified of the findings at the Life Safety Code exit conference on 10/11/2022. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	the facility requiring a fire alarm notification (horn/strobe) have one installed and that they are connected to the facility fire alarm system. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility□s Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 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,	K 351		11/25/22

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K 351	Continued From page 7 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/11/22 in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the facility failed to a.) provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment and b.) to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in these areas. At 01:25 PM, the surveyor, MD, and RPOD observed in the occupied sun room (approximately 7' x 20'), that no fire sprinkler heads were observed. The glass and metal sunroom was observed to covered in combustible wood framing and fabric covered over the ceiling glass panels. The sunroom contained combustible furniture. An interview was conducted with the MD and RPOD at the time of the observation, both confirmed the facility's sun room did not have any fire sprinkler coverage. The Administrator was informed of the findings at the Life Safety Code exit conference on 10/11/22. NJAC 8:39-31.2(e)	K 351	K351 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Two sprinkler heads were installed in the sunroom and were connected to the facility□s sprinkler system. How the facility will identify other residents having the potential to be affected by the same deficient practice: A facility inspection was conducted to ensure that all areas requiring sprinkler coverage have sprinklers installed and that they are connected to the facility sprinkler system. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct an inspection monthly for 3 months to verify that all that all areas in the facility requiring sprinkler coverage have sprinklers installed and that they are connected to the facility sprinkler system. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility□s Quality	

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K 351	Continued From page 8	K 351	Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
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 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.	K 363		11/4/22

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K 363	Continued From page 9 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/11/22 in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was further identified in 5 of 25 residents' room doors observed and was evidenced by the following: During the building tour from 9:15 AM to 3:00 PM, the surveyor, MD and RPOD toured the facility and observed: Resident Room # [redacted] the door hits the door frame. Resident Room # [redacted] the door gets caught on the floor Resident Room # [redacted] the door hits the door frame. Resident Room # [redacted] the door rubbed on the door frame not closing properly. Resident Room # [redacted] the door would not latch into its frame.	K 363	K363 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Doors in rooms numbered [redacted] and [redacted] were all repaired and all close completely to properly confine fire and smoke products and to properly defend occupants in place. How the facility will identify other residents having the potential to be affected by the same deficient practice: All doors in the facility were inspected to ensure that they all close completely. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct an inspection of all doors in the facility monthly for 3 months to verify that all doors close completely. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be	

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K 363	Continued From page 10 At the time of observations, the surveyor interviewed the MD and RPOD, who both confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 10/11/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	reviewed by the facility□s Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/11/22, in the presence of the facility Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to ensure resident bathroom ventilation system's for 11 of 30 resident rooms, were adequately maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following:	K 521	K521 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Motor that powers the exhaust fans in the bathrooms of Resident Room numbers EX. Order 26.(4) B1 [redacted], and [redacted] was replaced. Ventilation is now present via the exhaust fans in all of these bathrooms. How the facility will identify other residents	11/4/22

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ALLENDALE REHABILITATION AND HEALTHCARE CENTER	**85 HARRETON ROAD** **ALLENDALE, NJ 07401**

(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 521	Continued From page 11 Starting from 11:00 AM to 3:00 PM, the surveyor observed that the ventilation in the following resident room bathrooms did not function: EX. Order 26.(4) B1 [redacted], and [redacted] The surveyor requested that the Maintenance Director, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Maintenance Director and Regional Plant Operations Director, who both stated and confirmed the ventilation in the resident room bathrooms was not working at the time of the observations. The Maintenance Director indicated a roof top motor seems to be malfunctioning. The Administrator was informed of the findings at the Life safety code exit conference on 10/11/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1	K 521	having the potential to be affected by the same deficient practice: All bathrooms in all resident rooms were inspected to ensure that ventilation systems are functioning properly in all of them. All motors powering exhaust fans in the facility were inspected to ensure they are functioning properly. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct a random inspection of 3 resident rooms weekly for 3 weeks and monthly for 3 months thereafter to verify that the bathroom ventilation systems are fully functioning. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility□s Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
K 918 SS=F	NJAC 8:39-31.2(e) Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		11/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING **01** B. WING _____	**10/11/2022**

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K 918	Continued From page 12 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 observations, interview, and review of facility documents on 10/11/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to a.) certify the time needed by their generator to transfer power	K 918	K918 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: A load test was performed and power was	

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K 918	Continued From page 13 to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems and b.) ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 1-generator log provided by the RPOD by the following: a). At 09:30 AM, a review of the generator records for the previous twelve months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the monthly load test document provided by the RPOD indicated that on the following dates no transfer time was being logged: 9/9/22, 8/5/22, 7/7/22, 6/6/22, 5/30/22, 4/28/22, 3/25/22, 2/12/22, 1/11/22, 12/10/22, 11/12/22, and 10/2/22. The RPOD then provided documentation from the facility Direct Supply TELS system. The dates on the provided documents indicated on 8/26/22 and 9/02/22 that the diesel generator tested under load were 15-seconds for transfer time to emergency power. It was also noted that the load test date's from the TELS system were different from the first generator load test log provided by the RPOD. An interview was conducted with the RPOD at the time of record review, who confirmed no transfer times were currently on the facility log's provided. He then confirmed that the TELS load test	K 918	verified to transfer to the building in less than 10 seconds. A remote manual stop station to prevent inadvertent or unintentional operation was installed remote of the enclosure housing the prime mover of the generator. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will perform a quarterly audit for one year of monthly generator load tests, to ensure that power is transferred to the building in less than 10 seconds. The Maintenance Director or designee will perform a monthly inspection of the generator for one year to verify that remote manual stop station is correctly installed. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the audits and inspections will be reviewed by the facility's Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	

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K 918	Continued From page 14 documents indicated 15- seconds to transfer time to emergency power. b). At 12:40 PM, the surveyor, MD, and RPOD, observed that the facility's generator did have a remote shutoff. An interview was conducted during the observation with the MD and RPOD, who stated that they were aware that the generator did not have a remote manual stop station to prevent inadvertent or unintentional operation located (remote) of the enclosure housing the prime mover. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 10/11/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		