STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING **01** B. WING _____	**01/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE** **CEDAR GROVE, NJ 07009**

(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 1/17/2023, 1/18/2923 and 1/19/2023 and Alaris Health at Cedar Grove 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Alaris Health at Cedar Grove is a Single-story, Type II Un-Protected building that was built in January 1959. The facility is divided into 9 smoke zones.	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/17/2023 and 01/18/2023, it was determined that the facility failed 1) To provide 1 of 15 exit discharges with a stable, hard packed all-weather travel surface and maintain a level walking surface, free of all obstructions and impediments to reach a public	K 271	The [redacted] Exit from the basement stairwell was paved with a stable, hard packed all -weather surface that was attached to an existing public walkway exiting away from the facility. The [redacted] courtyard gate has a magnetic lock to keep it lock and secure constantly, and a mechanical latch which was	2/23/23

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

Electronically Signed | 02/13/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 271	Continued From page 1 way (street or parking lot) in the case of fire or other emergency 2) To provide unobstructed exit discharges in accordance with National Fire Protection Association (NFPA) 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient practice was evidence by the following: On 01/17/2023 during the survey entrance at approximately 9:27 AM a request was made to the Regional Director of Maintenance (RDM) and 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 lay-out identified this a single story building with a basement. Starting on 01/17/2023 at approximately 10:14 AM and continued on 1/18/2023, a tour of the building with the RDM and DOM was performed. Along the two day tour of the facility the surveyor observed the following, 1) On 01/17/2023 at approximately 11:05 AM, during a tour of the basement, the surveyor observed outside of a designated exit discharge door (illuminated exit sign above the door) that there was no level walking path to reach a public way. The surveyor observed an approximately 30 feet run of unleveled grass. There was no clear and level walking surface to reach a public way. 2) On 01/18/2023 at approximately 1:01 PM, during a tour of the [redacted]) unit's	K 271	removed and a swipe card was installed for a one action means of exit. All residents have the potential to be affected. The Maintenance Director will make monthly rounds to ensure all exit discharges have a stable, all weather travel surface that leads to a public walkway without obstruction for the next 6 months. The Maintenance Director will make monthly rounds on the [redacted] courtyard gate to ensure the gate is locked and working properly for the next 6 months The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters.	

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K 271	Continued From page 2 outside enclosed courtyard the surveyor observed that the gate was locked with a magnetic lock. There was no keypad on the egress side of the gate to unlock the gate in the event of an emergency other then a fire alarm activation. Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." The RMD and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 01/19/2023 at approximately 1:15 PM. Fire Safety Hazard. NJAC 8:39-31.1(e) NFPA 101:2012 - 7.7 NFPA 101:2012- 19.2 Means of Egress Requirements	K 271		
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	K 293		2/23/23

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K 293	Continued From page 3 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 review of facility provided documentation on 01/17/2023 and 01/18/2023 in the presence of facility management, it was determined that the facility failed to: 1) Maintain 2 of 35 illuminated exit signs observed in proper working condition, 2) To provide 2 illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and	K 293	The illuminated Exit Sign located on the "west" unit was replaced with a new illuminated exit sign. A new illuminated exit sign was added to the [redacted] Wing corridor near the Kitchen. The illuminated Exit Sign located above the corridor double smoke doors leading into the wing was replaced with a new illuminated exit sign. A new illuminated exit sign was added to the corridor exiting the Dinning Room near the Kitchen. All residents have the potential to be affected. The Maintenance Director will make monthly rounds to ensure all illuminated exit signs are in working order on a monthly basis. The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters.	

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K 293	Continued From page 4 distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 01/17/2023 during the survey entrance at approximately 9:27 AM a request was made to the Regional Director of Maintenance (RDM) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments and does the facility have a basement. The DOM told the surveyor, yes there is a basement and provided a copy of the facility lay-out. A review of the facility provided lay-out identified that the building is a single story building with with [redacted] units ([redacted] and [redacted] units) in the facility. Starting on 01/17/2023 at approximately 10:14 AM and continued on 1/18/2023, a tour of the building with the RDM and DOM was performed. Along the two day tour of the facility the surveyor observed 2 of 35 illuminated exit signs not functioning properly and two (2) locations that failed to clearly identify the exit access path to reach an exit in the following locations,	K 293		

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K 293	Continued From page 5 1) On 01/18/2023 at 10:17 AM, the surveyor observed one illuminated exit sign above the [redacted]" exit discharge door that was not illuminated. 2) On 01/18/2023 at 11:27 AM, the surveyor observed no evidence of an illuminated exit sign in the corridor leaving the Resident dining room into the "[redacted] wing corridor near the Kitchen. 3) On 01/18/2023 at 12:51 PM, the surveyor observed one illuminated exit sign above the corridor double smoke doors leading into the [redacted] wing was not illuminated. 4) On 01/18/2023 at 1:28 PM, the surveyor observed no evidence of an illuminated exit sign in the corridor leaving the Resident dining room into the "[redacted] wing corridor near the Kitchen. The RMD and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 01/19/2023 at approximately 1:15 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
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	K 321		2/23/23

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K 321	Continued From page 6 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 1/17/2023 and 1/18/2023 in the presence of facility management, 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 evidenced by the	K 321	The supply storage door was fitted with an automatic door closure located near the Physical Therapy room. The Medical Records room was fitted with an automatic door closure located near the Assistant Director of Nursing office. The Central Supply room was fitted with an automatic door closure located near the Salon on the [redacted] Unit. All residents have the potential to be	

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K 321	Continued From page 7 following: On 01/17/2023 during the survey entrance at approximately 9:27 AM a request was made to the Regional Director of Maintenance (RDM) and 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 that the building is a single story building with with [redacted] units [redacted] units) in the facility. Starting on 01/17/2023 at approximately 10:14 AM and continued on 1/18/2023, a tour of the building with the RDM and DOM was performed. Along the two day tour of the facility the surveyor observed the following hazardous areas that failed to have smoke resisting doors, 1) On 1/17/2023 at approximately 11:58 AM, an inspection inside a supply storage room near the Physical Therapy area identified that the storage rooms automatic door closure had evidence that it had been removed. The surveyor observed multipul combustibule paper files and boxes in the room. The surveyor recorded the room to 14'-6" by 8' (116 square feet) which is larger than 50 square feet. 2) On 1/18/2023 at approximately10:56 AM, an inspection of the Medical Records room, near the Assistant Director of Nursing office, was performed. During a closure test of the corridor door leading into the Medical Records storage room the door did not self-close. The surveyor observed the door had no means to self-close and the room was larger than 50 square feet..	K 321	affected. The Maintenance Director will make monthly rounds to ensure all fire rated doors to hazardous areas are equipped with self-closing doors and are in working order. The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters.	

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K 321	Continued From page 8 The surveyor observed in the room 12 large boxes filled with combustibule files, 8 filing cabinets filled with files, 17 milk crates filled with paper files and 6 large racks filled with medical records. 3) At approximately 11:36 AM, an inspection of the Central supply room, located near the Salon was performed. The surveyor observed that the corridor door leading into the supply room had no means to self-close. The surveyor obsered inside the room combustibule boxes and the room was larger that 50 square feet. With these corridor doors not self-closing this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The RMD and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 01/19/2023 at approximately 1:15 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
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.	K 351		2/23/23

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K 351	Continued From page 9 In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/17/2023 and 01/18/2023, it was determined that the Facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 01/17/2023 during the survey entrance at approximately 9:27 AM a request was made to the Regional Director of Maintenance (RDM) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments and does the facility have a basement. The DOM told the surveyor, yes there is a basement and provided a copy of the facility	K 351	Fire sprinklers were installed: Inside the stairwell (located next to the elevator) in the basement. Inside the basement level Medical Supply storage room. Inside the baeement's Main Electrical Room. Inside the [redacted] Wing Attic Motor Access area. Inside the [redacted] Wing Attic Motor Access area. All residents have the potential to be affected. The Maintenance Director will make monthly rounds to ensure all sprinkle heads are in place for the next 6 months. The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2	

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K 351	Continued From page 10 lay-out. A review of the facility provided lay-out identified that the building is a single story building with with [redacted]r units ([redacted] and [redacted] wings) in the facility. Starting on 01/17/2023 at approximately 10:14 AM and continued on 1/18/2023, in the presence of the RDM and DOM a tour of the facility was conducted. Along the tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 01/17/2023, 1) At approximately 10:17 AM, the surveyor observed inside the stairwell (located next to the elevator) leading to the basement had no evidence of fire sprinkler coverage. At this time the surveyor asked the DOM do you see a fire sprinkler. The DOM told the surveyor, no. 2) At approximately 10:45 AM, the surveyor observed inside the basement level Medical supply storage room's approximately four feet seven inch by seven feet seven inch (4'-7" by 7'-7") bathroom had no evidence of fire sprinkler coverage. 3) At approximately 11:20 AM, the surveyor observed no evidence of fire sprinkler coverage inside the approxiamately twenty three feet six inch by fifteen feet six inch (23'-6" by 15'-6") Main Electrical room. On 01/18/2023, 4) At approximately 10:43 AM, the surveyor observed inside the [redacted] wing attic motor access	K 351	quarters.	

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K 351	Continued From page 11 no evidence of fire sprinkler inside the 10' by 6' air handler area. 5) At approximately 1:44 PM, the surveyor observed inside the [redacted] wing attic motor access (units [redacted] no evidence of fire sprinkler inside the 10' by 6' air handler area. The RMD and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 01/19/2023 at approximately 1:15 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=E	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 observations on 01/17/2023 and 01/18/2023 in the presence of facility management, it was determined that the facility failed to failed: 1) To inspect 5 of 38 portable fire extinguishers annually, 2) Install portable fire extinguishers with-in the required height for 2 of 38 fire extinguishers, 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,	K 355	All 5 portable "loaner" fire extinguishers were replaced with current fire extinguisher with an inspected punched tag for 2023. The fire extinguishers located in the basement Records Storage Room and in the basement Main Electrical Room were lowered to regulatory height under 5' high and above 4" above the ground. The 2 portable fire extinguishers swipe	2/23/23

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	315357	A. BUILDING **01** B. WING _____	**01/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE** **CEDAR GROVE, NJ 07009**

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K 355	Continued From page 12 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, - 7.3 Maintenance. - 7.3.1.1 All 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. Reference #2 NFPA 10 - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. According to NFPA 10- 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. During the building tour on 01/17/2023 and 01/18/2023 in the presence of the facility Regional Director of Maintenance (RDM) and Director of Maintenance (DOM) the surveyor observed and inspected Thirty Eight (38) portable fire extinguishers in various locations with the following, 1) Five portable fire extinguishers in various	K 355	lock on the an enclosed cabinets on BHU were removed and a magnetic closure was replaced for all to access. All residents have the potential to be affected. The Maintenance Director will make monthly rounds to ensure all portable fire extinguishers enclosed in a cabinet have magnetic locks, fire extinguishers are at regulatory height and have current inspected extinguishers that are working properly for the next 6 months. The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters.	

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K 355	Continued From page 13 locations had annual inspection tags dated 2021 that read, "Loaner" with no monthly punch or monthly visual examinations documented on the tags attached to the extinguishers. 2) One ABC type portable fire extinguisher located in the basement records storage area. This fire extinguisher appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'-4" to the center of the pressure indicating needle. 3) One BC type poratble fire extinguisher in the main electrical room appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was installed at a height of 5'-6" to the center of the pressure indicating needle. 4) Two portable fire extinguishers on the BHU unit were observed locked in cabinets in the corridor. At this time a request was made to the DOM can you open the cabinet. The DOM used his key swipe card to open and gain access to the extinguishers. The two extinguishers were only accessible to staff with knowledge and a swipe card. The RMD and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 01/19/2023 at approximately 1:15 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 361 SS=F	Corridors - Areas Open to Corridor	K 361		2/23/23

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K 361	Continued From page 14 CFR(s): NFPA 101 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 01/17/2023 and 01/18/2023 in the presence of facility management, it was determined that the facility failed to ensure that an open area to the corridor was not larger than 1,500 square feet in accordance with NFPA 101, 2012 Edition, Section 19.3.6.1. Reference: Life Safety Code 101 2012 Edition 19.3.6.1 (9) Corridor Separation, Group meeting, or multipurpose therapeutic spaces, other than hazardous areas, that are under continuous supervision by facility staff shall be permitted to be open to the corridor provided that all of the following criteria are met: (a) Each area does not exceed 1,500 square feet. (139M-2). On 01/17/2023 during the survey entrance at approximately 9:27 AM a request was made to the Regional Director of Maintenance (RDM) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments and does the facility.	K 361	The opening from the Dining Room into the corridor (leading to the [redacted]) was sealed with a permanent wall. This opening no longer will serve as an entry point into the Dining Area. All residents have the potential to be affected. The Maintenance Director will make monthly rounds to ensure that the corridor remains closed. The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters.	

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K 361	Continued From page 15 A review of the facility provided lay-out identified that the building is a single story building with with [redacted] units [redacted] and [redacted] units) along with a Resident Dining room, Kitchen and Main Entrance lobby area with offices in the center of the facility. Starting on 01/17/2023 at approximately 10:14 AM and continued on 1/18/2023, a tour of the building with the RDM and DOM was performed. Along the two day tour of the facility the surveyor observed the following, 1. On 01/18/2023 at 11:20 AM, an inspection inside the resident dining room was performed. The dining room measured approximately 5,000 sq. ft, there was approximately ten-foot-wide by eight-foot opening from the dining room into the corridor (leading to the main entrance/ lobby area) with a metal roller shutter door that was held open above the ceiling. At this time the surveyor asked if the roller door was tied into the buildings fire alarm system and that it will close with the activation of the fire alarm. The RDM told the surveyor that the roller door is not connected to the fire alarm system. The facility provided floor plan identified a room, that was removed to accommodate the opening into the corridor. The RMD and DOM confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 01/19/2023 at approximately 1:15 PM. NJAC 8:39-31.2(e)	K 361		

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K 361	Continued From page 16 NFPA 101 2012 edition Life Safety Code 19.3.6.1 Corridor Separation	K 361		