STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315435	A. BUILDING **01** B. WING _____	**05/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT MONTCLAIR	**42 NORTH MOUNTAIN AVE** **MONTCLAIR, NJ 07042**

(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 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
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 05/06/2. Family of Caring at Montclair 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 Occupancies. Family of Caring at Montclair is a three story building that was built in 60's. It is composed of Type II construction. The facility is divided into six smoke zones.	K 000		
K 222 SS=E	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	K 222		5/31/21

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

Electronically Signed | 05/21/2021

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K 222	Continued From page 1 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 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	K 222		

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K 222	Continued From page 2 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 on 05/06/21, it was determined that the facility failed to ensure that the building's delayed-egress locking systems was installed in accordance with NFPA 101:2012 - 7.2.1.6.1 as evidenced by the following: At 11:00 AM the surveyor observed, in the presence of the facility's Maintenance Director, two of three exit doors located on the [redacted] floor were locked with a delayed-egress locking system (DELS). The exit doors did not have a posted sign that read, "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS". At 12:14 PM, the same was observed two of three exit doors located on the [redacted] floor. At 12:14 PM, the surveyor observed, in the presence of the facility's Maintenance Director, one of three exit doors on the the [redacted] floor and locked with a DELS failed to open when tested. The exit door located at the end of the corridor by resident room [redacted] had the proper sign that indicated door could be opened in 15 seconds, but door did not open at all when surveyor applied continuous pressure to release the lock. The Maintenance Director acknowledged the above findings in an interview during the surveyor's observation. The facility's Administrator was informed of these	K 222	1. Required signage was posted on egress doors identified. The egress door located by resident room [redacted] was repaired and lock was verified to release with 3 to 5 seconds of pressure. 2. Facility residents may have the potential to be affected by the concern identified. Egress doors throughout the facility were checked to verify that the lock mechanism properly releases with 3 to 5 seconds of pressure and that egress doors have the required signage posted. 3. Maintenance Director was re-educated by the Licensed Nursing Home Administrator regarding the egress doors in reference to proper lock release (with 3 to 5 seconds of pressure) and required signage/postings. 4. The Licensed Nursing Home Administrator will visually observe signage and physically check egress doors weekly for the next twelve weeks to verify proper lock release (with 3 to 5 seconds of pressure) and that required signage is posted. Areas of concern will be addressed. Results of these observations made will be reviewed at the monthly Quality Assurance Performance Improvement meeting monthly for the next three months with follow up provided as needed.	

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K 222	Continued From page 3 findings during the Life Safety Code exit conference at 2:15 PM. NJAC 8;39-31.2(e) NFPA 101:2012 7.2.1.6.1	K 222		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 05/06/21, it was determined that the facility failed to ensure that vertical openings were protected against the spread of fire, smoke and fumes. This deficient practice was evidenced by the following: During a tour of the building from 11:00 AM to 2:00 PM, the surveyor observed that two of three floors had areas with openings in the ceiling caused by penetrating electrical wires which were not sealed closed with a fire rated material. At 12:00 PM the surveyor observed in the presence of the facility's Maintenance Director, the ceiling of a storage room/office located on the [redacted] floor with three openings. The openings	K 311	1. Areas identified with openings in the ceiling caused by penetrating electrical wires were sealed closed with a fire rated material. 2. Ceilings throughout the facility were visually inspected to verify vertical openings are protected against the spread of fire, smoke and fumes. 3. Maintenance Director was re-educated by the Licensed Nursing Home Administrator regarding routine inspection to verify no vertical openings are compromised and that these vertical openings are protected against the spread of fire, smoke and fumes as required.	7/13/21

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K 311	Continued From page 4 were 2-inch x 2-inch, 1-inch x 3-inch and 2-inch x 3-inch. While touring the [redacted] floor at 12:30 PM with the Maintenance Director, the surveyor observed a 3-inch x 6-inch opening in the ceiling of the [redacted] Room. Also, at 12:38 PM the surveyor observed a 8-inch diameter opening in the ceiling of the Dry Storage/Electrical Room located on the 1st floor. These findings were confirmed by the Maintenance Director in an interview during the surveyor's observation. Also, the Maintenance Director stated in the interview that all openings were the result of recent building renovations and acknowledged that they should have been sealed closed with a fire rated material. The facility's Administrator was informed of these findings during the Life Safety Code exit conference at 2:15 PM.	K 311	4. The License Nursing Home Administrator will round with the Maintenance Director to complete visual observations weekly for the next twelve weeks to verify vertical openings are protected against the spread of fire, smoke and fumes. Areas of concern will be addressed. Results of the rounding observations will be reviewed at the monthly Quality Assurance Performance Improvement meeting for the next three months with follow up provided as needed.	
K 341 SS=D	NJAC 8:39-31.2(e) NFPA 101:2012 19.3.1.1 - 19.3.1.6 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 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.	K 341		5/31/21

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K 341	Continued From page 5 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 05/06/21, it was determined that the facility failed to provide alarm occupant notification devices for all areas used by residents as evidenced by the following: At 10:30 AM, the surveyor observed in the presence of the facility's Maintenance Director, the facility's enclosed courtyard was not equipped with alarm occupant notification devices (horn/strobe connected to the fire alarm system). This condition was verified by the facility's Maintenance Director in an interview during the observation. The facility's Administrator was informed of this finding during the Life Safety Code exit conference at 2:15 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.3.4.1, 9.6, 9.6.1.8	K 341	1. An alarm occupant notification device (horn/strobe connected to the fire alarm) was installed in the facility's enclosed courtyard on May 20,2021. 2. Facility residents may have the potential to be affected by the concern identified. 3. Facility installed an alarm occupant notification device (horn/strobe connected to the fire alarm) in the facility's enclosed courtyard on May 20, 2021. Facility staff were educated regarding this installation specifically as it relates to it being connected to the fire alarm and need to respond to the designated area if the alarm sounds. This device is part of the monthly alarm system testing conducted by contracted company to verify that it is properly operating. 4. The Licensed Nursing Home Administrator has verified the installation of an alarm occupant notification device (horn/strobe connected to the fire alarm) in the facility's courtyard on May 20, 2021. The device was tested upon installation and is fully operable. Monthly fire alarm testing will be reviewed at the Quality Assurance Performance Improvement	

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K 341	Continued From page 6	K 341	meeting for the next three months with follow up provided as needed.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 05/06/21, it was determined that the facility failed to ensure that fire drills or staff training for fire response procedures were conducted quarterly for each shift. This deficient practice was evidenced by the following: Facilities were permitted to provide staff training in lieu of fire drills due to the current Covid-19 pandemic. At 10:00 AM, a review of the facility's fire drills and staff training records for the previous 12-month period revealed that the facility did not conduct fire drills or provide staff training for fire response procedures for nine of twelve months. Fire Drills and/or staff training were not conducted from May 2020 to October 2020, December 2020 and from March 2021 to April 2021. This finding was acknowledged by the facility's Maintenance Director in an interview at	K 712	1. The facility cannot retroactively address the concern identified. 2. Facility residents may have the potential to be affected by the concern identified. 3. Maintenance Director was re-educated by the Licensed Nursing Home Administrator regarding requirements for conducting fire drills and required staff education and training related to fire drills/fire safety. 4. The Licensed Nursing Home Administrator will audit fire drill documentation monthly for the next three months to verify that required fire drills and required staff education and training regarding fire drills/fire safety is being conducted at the required intervals.	5/31/21

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K 712	Continued From page 7 10:30 AM. The facility's Administrator informed of this finding during the Life Safety Code exit conference at 2:15 PM. NJAC 31.6(b) NFPA 101:2012 19.7.1.4 - 19.7.1.7	K 712	Areas of concern will be addressed. Results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement meetings for the next three months with follow up provided as needed.	