STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315178	A. BUILDING **01** B. WING _____	**02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

(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 from 2/01/22 to 2/03/22,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 The facility is a 3- building that was built in 80's, It is composed of Type II unprotected construction. The facility is divided into 14- smoke zones. The generator does 100% of the building. The building has a ground floor and a partial basement. The facility utilized 1135 waivers allowing for regulatory flexibility during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibility did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 215 certified beds. At the time of	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/22/2022

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K 000	Continued From page 1 the survey the census was 166.	K 000		
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/01/22, in the presence of the Maintenance Director, it was determined that the facility failed to provide two acceptable exits from each floor as evidenced by the following: At 10:00 AM, the surveyor and the facility's Maintenance Director, observed that the basement area was provided with only one exit. The exit was a stairway to the first floor. The basement level was used only for mechanical space, maintenance office and laundry. No residents were allowed into the basement and residents do not have access to this level. At the time, the surveyor interviewed the Maintenance Director who acknowledged there were not two exits in the basement area. At the time of observation there were three laundry staff and one assistant maintenance staff member working in the area.	K 252	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: This deficiency has the potential to affect any employee who works in the maintenance and laundry area in the basement; no residents have the potential of being affected by this deficient practice. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All remainder of the Facility areas meet the requirements of this regulation. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC	5/12/22

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COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

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K 252	Continued From page 2 An interview was conducted with the Administrator and Maintenance Director and they confirmed that the project for the basement exit was to be completed by Windsor Gardens and at this time the project was not started. The facility was given a time-limited waiver that expired on 10/31/2021, but did not complete the work. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e)	K 252	CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Visitors do not have access to this area additional exit signs are in place to guide staff to appropriate additional exit signs. Maintenance Director or Supervisor will monitor the area for safety daily. The facility respectfully requests a time limited waiver to fix the issue. A waiver request form was completed on 5/12/2022 to complete the work that is required in the basement to correct this issue. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR.I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Facility respectfully requested a time limited waiver dated 11/23/23 to allow time to correct the deficient practice by way of installing an exit. Project Plan to be reviewed at monthly QAPI x12.	
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual	K 281		4/13/22

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K 281	Continued From page 3 intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 2/01/22 to 2/03/22, the facility failed to provide automatic emergency illumination, that would operate automatically along the means of egress, and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.8, 7.8.1.1, 7.8.1.2, 7.8.1.4. The deficient practice was evidenced by the following: At 10:38 AM, the surveyor and Maintenance Director observed in the smoking courtyard at the egress/discharge gate with a keypad and keyed-lockset, that there was no emergency lighting at the lock or beyond the gate to the public way. The findings were verified by the Maintenance Director at the times of the observation. The Administrator was informed of the findings at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e)	K 281	K281: ILLUMINATION OF MEANS OF EGGRESS 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO This deficient practice has the potential to affect any Resident or Staff in the area. This deficiency can affect all residents who smoke. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All other Facility areas currently meet this requirement. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Facility installed emergency lighting to the smoking courtyard completed on February 22, 2022. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance will audit lighting function weekly x 4 weeks, then monthly x 2	

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K 281	Continued From page 4	K 281	months and lastly quarterly x3 quarters. Findings will be reported to the Administrator and/or designee at the facility's QAPI meeting monthly.	
K 291 SS=D	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 from 2/01/22 to 2/03/22, it was determined that the facility failed to provide an operational battery backup emergency light above the emergency generator's transfer switches, 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 observed for 2 of 2 transfer switches and was evidenced by the following: At 10:04 AM, the surveyor and Maintenance Director, observed in the ground floor physical therapy room, where the generator transfer switch's were located, that no emergency lighting was provided at each of the 2-ATS switches. This finding was verified by the Maintenance Director, at the time of the observation's. The Administrator was notified of the above findings at the Life Safety Code exit conference on 2/03/22.	K 291	K291: EMERGENCY LIGHTING 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: This deficient practice has the potential to affect any Resident or Staff in the area. This deficiency can affect all residents in the event of power outage. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents or staff members have been affected by this deficiency. 3 WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEM CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIEN PRCTICE WILL NOT RECUR: On 2/17/22 Maintenance director installed 2 emergency lights on the generator transfer switch closet .	4/8/22

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K 291	Continued From page 5 NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	These emergency lights has been added to facility weekly emergency lights switch maintenance log. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Emergency light will be tested on a weekly by the maintenance department or designee schedule, and will be brought to the QA meeting monthly x 12 months	
K 321 SS=D	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 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)	K 321		4/13/22

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K 321	Continued From page 6 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 and interview from 2/02/22 to 2/03/22, in the presence of the Maintenance Director, it was determined that the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous area 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 practice was observed in 1 of 10 hazardous storage areas in the facility and was evidenced by the following: On 2/02/22 at 11:28 AM, the surveyor observed on the ground floor Team Member Services/HR room, that 50 plus combustible cardboard boxes were being stored, and the door did not have a self-closing device installed. The room was greater than 50 square feet in size. An interview was conducted with the Maintenance Director during the observation, who stated that hazardous storage areas must have a door with a self-closing device. The Administrator was informed of the finding, at the Life Safety Code exit conference on 2/03/21. NJAC 8:39-31.2(e)	K 321	K321 HAZARDOUS AREAS-ENCLOSURE 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: This deficient practice has the potential to affect all Residents and employees. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No Residents or employees were affected but the potential to be affected is there. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Self-closing closers were installed on the identified door to the Human Resources office on February 22, 2022. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:	

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K 321	Continued From page 7	K 321	Maintenance and/or designee will conduct audits daily to ensure self-closing function to all fire barrier doors are properly working. Audits will be reviewed by the Maintenance Director and/or designees and reviewed at the facility's QAPI monthly meeting through the next 12 months.	
K 345 SS=D	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 observation and interview on 2/03/22, the facility failed to provide and maintain supervised smoke/heat detection in operating condition at all times in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.4.1, 9.6, 4.6.12.1 and NFPA 72. This deficient practice was evidenced in 1 of 30 smoke detectors observed in the following area. On 2/03/22 at approximately 12:48 PM, the surveyor and the Maintenance Director observed in the first floor shower room that 1 of 1 fire alarm smoke/heat detectors, was taped from activation by black electrical tape. An interview was conducted with the Maintenance	K 345	K345 Fire Alarm System- Testing and Maintenance 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Identified fire alarm smoke/heat detector located in the first-floor shower room and removed the black electrical tape which had been inadvertently placed over the device. The alarm was tested and was found to be functioning properly. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE	4/14/22

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K 345	Continued From page 8 Director during the observation and he stated that he was unsure why the detector was blocked with tape to prevent an activation. The Administrator was notified of the finding at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e) NFPA 70,72	K 345	POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents and staff have the potential of being affected by this deficient practice. No Residents were affected by this deficient practice. Maintenance Director conducted a full building audit to ensure all smoke detectors were functioning properly and within proper code. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Maintenance Department and/or designee will conduct weekly rounds to ensure compliance is maintained. 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: 5 The Maintenance Department and/or designee will conduct weekly rounds to ensure compliance is maintained. All findings will be documented on the Maintenance log book and reviewed at the Facility QAPI monthly meeting through the next 12 months.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353		5/11/22

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K 353	Continued From page 9 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 _____ 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 observation and interview on 1/25/22, it was determined that the facility failed to maintain the sprinkler system,1.) by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, 2.) it was determined that the facility failed to inspect the automatic fire sprinkler system quarterly for 3 of 4 inspections in accordance with NFPA 25. Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. 1. From 2/02/22 to 2/03/22, during a building tour from 9:30 AM, to 1:25 PM, the surveyor, and Maintenance Director, observed drop ceiling tiles missing and/or holes in the ceiling tiles (sheetrock) and bad cuts around the fire sprinkler heads in the following areas of the facility: Between resident room 326 and 327 open ceiling	K 353	K353 Sprinkler System- Maintenance and Testing 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: All Residents and Staff have the potential of being affected by this deficient practice. All identified drop ceiling tiles noted by the Life Safety Inspector were replaced and corrected within compliance. All quarterly fire inspection reports were for the year 2021 were received and filed in the Life Safety Facility Book. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents have the potential of being	

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K 353	Continued From page 10 tiles third floor lounge bathroom open ceiling tile Resident room 317 escutcheon plate not in place Resident room 319 ceiling tiles missing Ceiling tiles missing North Stairwell first floor Resident room 305 ceiling tiles missing Resident room 308 ceiling tiles missing Second floor day room conduit into ceiling (bad cuts) Resident room 222 missing ceiling tiles West Stair second floor escutcheon plate missing Rehab exit ceiling tile on floor from ceiling approximately 4' x 2' Resident room 109 ceiling tile missing Resident room 128 ceiling tiles missing Storage access by room 113 missing ceiling tile Resident room 115 ceiling tile (bad cut) Resident room 119 ceiling tile in the bathroom missing 2. From 2/02/22 to 2/03/22 record review indicated that fire sprinkler inspections for each quarter of 2021, were not provided from the Maintenance Director. He stated that due to the previous ownership and the new facility management company and payment issues, the fire sprinkler inspections were done, but the fire sprinkler vendor will not release the inspection documents. The new management company did provide an inspection dated 2/02/22 and there were not current issues with the system. The Maintenance Director stated and confirmed the above findings during the building tour and record review interview from 2/02/22 to 2/03/22. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 2/03/22.	K 353	affected by this deficient practice. Maintenance Director conducted a full building audit with the Administrator to ensure all ceiling tiles are intact and within compliance. A fire sprinkler inspection was conducted on February 2, 2022, with no identified issue with the Facility system. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Maintenance will conduct weekly audits throughout the center to ensure all ceiling tiles are within compliance. Education was also provided to all staff on the importance of documenting any concerns with ceiling tiles in the Maintenance logbook for Maintenance to review. Quarterly sprinkler inspections are pre-scheduled for the remainder of the year. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: facility has a designated contractor to maintain quarterly inspection on the sprinkler system. All audit findings will be reviewed at the Facility QAPI MONTHLY meeting through the next 6 months.	

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K 353	Continued From page 11 NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 353		
K 363 SS=D	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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363		5/11/22

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	315178	A. BUILDING **01** B. WING _____	**02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

(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 363	Continued From page 12 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 from 2/01/22 to 2/03/22, 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 that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 4 of 40 resident room door's and storage areas and was evidenced by the following: From 2/02/22 to 2/03/22, during the building tour from 9:00 AM to 1:00 PM, the surveyor and Maintenance Director, observed that the doors to resident rooms, did not latch into the door frame in the following room numbers: #[redacted] door sticks into frame #[redacted] door does not latch, paper towel folded and stuffed into latch frame [redacted] door will not latch, hardware malfunction Storage room door across from resident room #[redacted] will not latch, hardware malfunction. An interview was conducted with the Maintenance Director, who stated and confirmed that the above resident room doors and storage room, had hardware issues that prevented the doors from latching into there frame's properly.	K 363	K363-Corridors -Doors 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The four rooms identified as not properly latching (#[redacted], Storage room across from RM #[redacted] immediately were corrected to ensure compliance. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents and staff have the potential of being affected by this deficient practice. No Residents were affected by this deficient practice. Maintenance Director conducted a full building audit to ensure all further Facility room doors were securely latching and closing. No further findings currently noted. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: the facility will ensure that all corridor doors can resist the passage of smoke in accordance with the requirements of	

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K 363	Continued From page 13 The Administrator was informed of the finding at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.1(c), 31.2(e)	K 363	NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. by performing daily rounds conducted by Maintenance director or designee. This practice will Ensure that all room doors will close, and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance Department and/or designee will conduct daily rounds to ensure compliance is maintained. All findings will be documented on the Maintenance logbook and reviewed at the Facility QAPI Monthly meeting through the next 12 months.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of	K 374		4/18/22

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COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

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K 374	Continued From page 14 egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 2/03/22 in the presence of the Maintenance Director, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 9 smoke barrier door sets observed and was evidenced by the following: At 1:14 PM, the surveyor observed that 1 of 2 smoke barrier doors by resident room 234 were blocked from fully closing by a stored linen cart. The linen cart was directly in front of the right-side door by resident room 234, when released from the electro-magnetic hold open device 1 of 2 doors released and closed and one door remained open due to the linen cart blocking the door. The Maintenance Director, confirmed the findings above during the observation. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference on 2/03/22. NJAC 8:39-31.1(c), 31.2(e)	K 374	K374 Subdivision of Building Spaces-Smoke Barrier 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The linen cart was immediately removed from blocking the smoke barrier door. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents, Staff and Visitors have the potential of being affected by this deficient practice. No other areas were found to be blocked or improperly latching. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: In-services were conducted by the Maintenance Director and Nursing supervisor on February 3, 2022, and February 17, 2022, to all employees on	

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K 374	Continued From page 15	K 374	the 3 shifts. The Maintenance Director and/or designee will conduct daily rounds to ensure that doors are properly latching and not blocked by Facility carts. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance Department will conduct weekly audits x 4 weeks, then monthly x 2 months and lastly quarterly x3 quarters. All findings will be documented in the Maintenance logbook and reviewed at the facilitys QAPI MONTHLY meeting.	
K 521 SS=D	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 from 2/02/22 to 2/03/22, in the presence of the facility Maintenance Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 2 of 90 units were adequately maintained, in accordance with the	K 521	K521 HVAC 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE:	4/14/22

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K 521	Continued From page 16 National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: While touring the building from 2/02/22 to 2/03/22, from approximately 10:30 AM to 1:30 PM, the surveyor, in the presence of the Maintenance Director, observed that the ventilation in the following resident room bathrooms did not function: # [redacted], [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 who confirmed that the exhaust vents in the above resident room bathrooms, were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference on 2/03/22. 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 NJAC 8:39-31.2(e)	K 521	Residents bathroom ventilation system for rooms [redacted] and [redacted] were replaced and corrected on February 22, 2022. No further concerns noted to these rooms. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents have the potential of being affected by this deficient practice. No further findings noted in any other Resident room/area. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Maintenance Director and/or designee will conduct weekly room inspection to ensure all room ventilation systems are being maintained and properly functioning. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance Director and/or designee will conduct weekly room rounds and document any negative findings in the Maintenance logbook. All findings will be reviewed at the Facility QAPI meeting	

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K 521	Continued From page 17	K 521	monthly x12 months	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/03/21, in the presence of the Maintenance Director, it was determined that the facility failed to maintain elevator emergency communication for 3 of 3 passenger elevator telephones tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: At 11:56 AM, the surveyor had the Maintenance Director conduct a test of the emergency	K 531	K531- Elevators 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Facility immediately contracted a new vendor on 2/4/2022. They serviced Facility Elevators and swapped out the phone lines in order to ensure proper communication between the center and the vendor is in place.	4/18/22

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K 531	Continued From page 18 communication telephone system in the (3) facility passenger elevators. The emergency telephone did function properly, but the vendor that answered the phone indicated that the contract was expired and they would no longer answer any further communication issues and asked the Maintenance Director to remove them from the emergency telephone directory immediately. The Administrator was informed of this finding at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents and staff have the potential of being affected by this deficient practice. No Residents or staff were affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly Elevator emergency phone line inspection will be conducted by our maintenance Director or designee or outside vendor company which included Monthly Phase 2 inspections. 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance Department and/or designee will provide all findings from the monthly inspections to the Facility QAPI monthly meeting through the next 12 months.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101	K 911		4/13/22

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K 911	Continued From page 19 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 2/03/22, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that electrical panels were up to code as per NFPA 99. This deficient practice was evidenced for 1 of 10 electrical panels observed by the following: On 2/03/22 at 10:48 AM, the surveyor and Maintenance Director observed the utility room on the third floor by resident room 313, that the right-side electrical panel's face plate, was not in the proper position exposing the main breaker bar and live electrical wires. The door to the electrical room was locked at the time of the observation. The Maintenance Director confirmed the finding during the observation. The Administrator was informed of the finding at the Life Safety Code exit conference on 2/03/22. NFPA 99 NJAC 8:39-31.2(e)	K 911	K911- Electrical Systems 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: All Residents and staff have the potential of being affected by this deficient practice. The electrical door panel to the identified utility room on the third floor was secured with no further exposed wires. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No Residents or staff were affected by this deficient practice. No further findings were noted throughout the Facility. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Maintenance Director and/or designee will conduct monthly audits to ensure compliance is maintained.	

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K 911	Continued From page 20	K 911	4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: All findings will be documented on the Maintenance logbook and reviewed at the Facility QAPI MONTHLY meeting through the next 6 months.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920		4/13/22

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K 920	Continued From page 21 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/02/22, the facility did not prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was evidenced by the following: At 9:40 AM, the Surveyor and Maintenance Director, observed in resident room 324 (windowside bed), that electronics were plugged into a white household grade extension cord. The extension cord was then plugged into the duplex wall outlet. The finding was verified by the Maintenance Director at the time of the observation. The Administrator was notified of the findings at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e)	K 920	K920 Electrical Equipment- Power Cords and Extension 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: This deficient practice has the potential to affect Residents, Staff, and the Facility. There was no notable injury or negative findings currently due to this practice. The electrical cord was immediately removed on 2/3/2022 from the Residents room with education to the Resident and family. Alternate resources were provided to meet the Residents electronic needs. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The Maintenance Director conducted a full building audit to ensure no further findings were noted. No residents, Staff or Facility was affected. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All employees have been educated on this deficient practice. Residents have been educated during Resident Council as well	

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K 920	Continued From page 22	K 920	on the importance of speaking with Maintenance for any electrical needs in their rooms. Maintenance will round all rooms monthly to ensure compliance. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance director and/or designee will conduct monthly rounds to all center areas and log findings in the maintenance log. All findings will be reviewed at the Facility QAPI MONTHLY meeting through the next 12 months.	