STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315359	A. BUILDING **02** B. WING _____	**11/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	**155 40TH STREET** **IRVINGTON, NJ 07111**

(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 11/16/2022 and 11/17/2022 and Alliance Care Rehabilitation and Nursing Center 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. Alliance Care Rehabilitation and Nursing Center is a four-story, Type II Protected building that was built in June 1991. The facility is divided into 10 smoke zones.	K 000		
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 observations and review of facility documentation on 11/16/2022 and 11/17/2022 in the presence of facility Management it was determined that the facility failed to ensure that 3	K 311	I: Immediately Action 1. Smoke door closure adjustments were made in stairwell #4 next to resident	12/23/22

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

Electronically Signed | 12/23/2022

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K 311	Continued From page 1 of 14 exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 11/16/2022 during the survey entrance at 9:07 AM, a request was made to the Director of Nursing and Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are four floors in the facility. On 11/16/2022 starting at 9:49 AM and continued on 11/17/2022 in the presence of the facility's DOM a tour of the building was performed. Along the tour in the presence of the facility's DOM the surveyor performed a closure test of the fourteen (14) 1-1/2 hour fire rated doors leading into the stairwells, three (3) 1-1/2 hour fire rated doors did not positive latch into their frame as required by code to maintain the fire rated construction in the following location, 1. At 11:01 AM, on the third floor during a closure test of the exit access stairwell #4 next to Resident room [redacted] leading into the stairwell when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. 2. At 11:35 AM, on the second floor during a closure test of the exit access stairwell door #3 near to Resident room [redacted] leading into the stairwell when tested and allowed to self-close into its frame, the door did not positive latch into	K 311	room [redacted] and has positive latch completed on 12/2/2022 2. (Immediately) Smoke door closure adjustments were made by stairwell #3 near resident room [redacted] and have a positive latch 3. [redacted]-floor exit access stairwell Smoke door closure adjustments were made keeper installed for stairwell room [redacted] leading to the stairwell was completed on 12/2/2022. positive latch into the frame was completed on 12/2/2022. II: Identification of others: 4. The facility respectfully submits All residents have the potential to be affected by this III: System Changes: All other DOORS have been checked and confirmed and shown to Positively latch smoke doors were reviewed by the Administrator and Maintenance Director, and no revision needed was necessary. Date It was completed 12/23/22. IV: Quality Assurance 1. Smoke door audits will be conducted by the maintenance director or designee weekly x4, monthly X 4 quarterly thereafter 2. (All negative findings will be reported to the administrator and Maintenance director for immediate correction.) All findings will be brought to QAPI and chaired by the administrator and	

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K 311	Continued From page 2 its frame. This test was repeated two additional times with the same results. 3. At 12:15 PM, on the second floor during a closure test of the exit access stairwell door #4 near to Resident room [redacted] leading into the stairwell when tested and allowed to self-close into its frame, the door did not positive latch into its frame. The surveyor observed that the door had no evidence of a "Keeper" (latching device) on door's frame to positive latch the door into the frame. This test was repeated two additional times with the same results. The stairwell doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The DOM confirmed the findings at the time of observations. The Regional Administrator and DOM was notified of the deficiency at the Life Safety Code exit conference on 11/17/2022 at approximately 1:45 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311	reported quarterly in the Safety Committee meetings proper functioning all issues will be addressed immediately. V: Responsible Person: Director of Maintenance	
K 341 SS=E	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,	K 341		12/23/22

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K 341	Continued From page 3 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. 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, interview and review of facility provided documentation on 11/16/2022, in the presence of facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 enclosed outside patio area in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6, 9.6.1.8, and NFPA 72, 2010 Edition. The deficient practice was evidenced by the following: On 11/16/2022 during the survey entrance at 9:07 AM, a request was made to the Director of Nursing and Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are four floors in the facility. Starting at 9:49 AM in the presence of the facility's DOM a tour of the building was conducted. Along the tour at 11:20 AM, an	K 341	I: Immediate Action 1. Vendor was contracted to install an Audio and Visual (Horn and Strobe) alarm in the outside patio area. It was completed on 12/27/2022. 2. II: Identification of others: 1. The facility respectfully submits that all residents have the potential to be affected by this practice. III: System Changes 1. Audits will be conducted on the horn/strobe system monthly by the maintenance director or designee. 2. All negative findings will be reported to the administrator and the vendor for immediate correction. IV: Quality Assurance 1. Fire alarm audits will be conducted by the maintenance director or designee weekly x4, monthly x2, and quarterly	

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K 341	Continued From page 4 inspection of the [redacted]. floor outside Residents smoking patio was performed. The patio area was fenced-in with a locked gate that lead to other parts of the facility's 2nd. floor roof. The surveyor observed no evidence of an Audio and Visual (Horn and Strobe) alarm that is tied into buildings fire alarm and detection system. At this time the surveyor asked DOM, do you have an audio and visual alarm in the Resident smoking patio area. The DOM looked around the area and said, no I don't see one. The DOM confirmed the findings at the time of observations. The Regional Administrator and DOM was notified of the deficiency at the Life Safety Code exit conference on 11/17/2022 at approximately 1:45 PM. Fire Safety Hazard. NJAC 8:39 -31.2(a)	K 341	thereafter. 2. All negative findings will be reported to the administrator and maintenance director for immediate correction. 3. Results of all audits will be brought to the QAPI committee x4 quarters. V. Person responsible: Director of Maintenance	
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	K 351		12/23/22

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K 351	Continued From page 5 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 11/16/2022 and 11/17/2022, it was determined that the 1) Facility failed to properly install sprinklers 2) Facility failed to provide proper fire sprinkler coverage to all areas of the facility, 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 11/16/2022 during the survey entrance at 9:07 AM, a request was made to the Director of Nursing and Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are four floors in the facility. Starting on 11/16/2022 at 9:49 AM and continued on 11/17/2022, in the presence of the facility's DOM a tour of the facility was conducted. Along the tour, the surveyor observed that the	K 351	K351 Sprinkler System - Installation SS=E I. Immediate Action 1. Fire sprinkler escheon cap was replaced by the vendor in the fourth-floor resident's dining area. It was completed on 1/12/2022. 2. Missing tile in room [EX. Order?] was replaced. It was completed on 1/12/2022. 3. Fire sprinkler escheon cap was replaced by the vendor in the [EX. Ord]-floor nurses' station. It was completed on 1/12/2022sectionn sprinkler escheon cap was replaced by the vendor in the [EX. Ord]-floor soiled linen room. It was completed on 1/12/2022. 4. Fire sprinkler escheon cap was replaced by the vendor in the kitchen's dishwashing machine area. It was completed on 1/12/2022. 5. Fire sprinkler escheon cap was replaced by the vendor in the kitchen's broom area. It was completed on 1/12/2022. 6. A second fire sprinkler was installed in the [EXEX. Order 26.(4) B] room to cover all areas of the room. It was completed on 1/12/22. 7. DOM (ensured) audited all sprinkler heads to confirm that there are no openings in the ceilings around fire	

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K 351	Continued From page 6 facility failed to provide proper fire sprinkler protection in the following locations: On 11/16/2022, 1) At approximately 9:53 AM, the surveyor observed inside the fourth floor Resident Dining area one (1) fire sprinkler head. This fire sprinkler had no evidence of an escheon cap leaving a 3/4 of an inch gap around the sprinkler head. This would not allow the fire sprinkler in the room function properly in the event of a fire. 2) At approximately 10:02 AM, the surveyor observed inside Resident room [redacted] one 2 feet by 4 feet ceiling tile that was not in place with-in the ceiling grid. This would not allow the fire sprinkler in the room function properly in the event of a fire. On 11/17/2022, 3) At approximately 10:36 AM, the surveyor observed in the [redacted] floor Nurses Station area across from elevators [redacted] and [redacted] one (1) fire sprinkler. This fire sprinkler had no evidence of an escheon cap leaving a 1/2 of an inch gap around the sprinkler head. 4) At approximately 11:06 AM, the surveyor observed inside the [redacted] floor soiled linen room one (1) fire sprinkler. This fire sprinkler had no evidence of an escheon cap leaving a 1/2 of an inch gap around the sprinkler head. 5) At approximately 11:37 AM, the surveyor observed inside the Kitchen's dish washing machine are one (1) fire sprinkler.	K 351	sprinklers to ensure proper activation in the event of a fire. II. Identification of others: All residents have the ability to be affected. 1. An audit was completed for all fire sprinklers in the facility to ensure proper installation. It was completed on 1/12/2022. 2. Ceiling tiles were checked to ensure all tiles are in place with no openings. 3. All negative findings will be reported to the Administrator and DOM for immediate correction. III. System Changes 1. All ceiling and fire sprinklers were reviewed, and no revision was necessary. It was completed on 1/12/2022. 2. Vendor conducts monthly audits of all fire sprinklers to ensure they are in compliance with regulations. IV. Quality Assurance 1. An audit will be conducted of all fire sprinklers to ensure compliance by DOM or designee to ensure compliance monthly x3, and quarterly x4 quarters. 2. An audit of ceiling tiles will be done by DOM or the designee to ensure all tiles are in place monthly x3, and quarterly x4 quarters. 3. All negative findings will be brought to QAPI every quarter. The QAPI is chaired by the Administrator, and the proper functioning of all issues will be addressed	

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K 351	Continued From page 7 This fire sprinkler had no evidence of an escheon cap leaving a 1/2 of an inch gap around the sprinkler head. 6) At 11:39 AM, the surveyor observed inside the Kitchen's broom area one (1) fire sprinkler. This fire sprinkler had no evidence of an escheon cap leaving a one (1) inch gap around the sprinkler head. 7) At approximately 12:01 PM, an inspection inside the [redacted] floor Oxygen storage room area was performed. The surveyor observed the oxygen storage room was located with in a larger room. Further inspection identified that the room was in the shape of an [redacted] At this time the surveyor observed no evidence of fire sprinkler protection in the 7 feet 6 inch deep by 4 feet 6 inch wide section of the room. At this time the surveyor asked the DOM do you see a fire sprinkler in this area. The DOM look around and said, no. The surveyor observed that the one fire sprinkler in the room would not reach around the corner. With the opening's in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the room and not activate the fire sprinkler system. The DOM confirmed the findings at the time of observations. The Regional Administrator and DOM was notified of the deficiency at the Life Safety Code exit conference on 11/17/2022 at approximately 1:45 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e)	K 351	immediately. V. Person responsible: Director of Maintenance.	

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K 351	Continued From page 8 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 observation and review of facility documentation on 10/06/2022 in the presence of facility management, it was determined that the facility failed to: 1) Perform and document on the tag attached to the fire extinguisher a monthly visual examination for 10 of 19 fire extinguishers, 2) Maintain one (1) portable fire extinguishers in proper working condition, in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 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. 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	K 355	I. Immediate Action 1. Visual examination was conducted on all portable fire extinguishers. 2. One wet chemical fire extinguisher was replaced by the vendor. 3. Inservice was conducted with all maintenance staff to reinforce monthly fire extinguisher inspections. II. Identification of others: 1. The facility respectfully submits that all residents have the potential to be affected. III. System Changes a) The Policies and Procedures on Fire extinguishers were reviewed and found to be in compliance with the regulations, with no revision necessary. It was completed on 1/12/2023 IV: Quality Assurance 1. An audit of all fire extinguishers will be conducted by the Maintenance Director to ensure that the problem does not reoccur and that we maintain compliance they are	12/23/22

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K 355	Continued From page 9 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 11/16/2022 and 11/17/2022 in the presence of the facility Director of Maintenance (DOM) the surveyor observed and inspected on the tags attached to nineteen (19) portable fire extinguishers that were last annually inspected January 2022 in various locations with the following, On 11/16/2022: 1) At approximately 11:23 AM, the surveyor observed on the 3rd. floor Residents outside smoking patio two fire extinguishers. 1. One (1) "ABC- type" fire extinguisher last annually inspected January 2022 with no evidence a monthly examinations being performed and documented on the tag for July, August, September and October 2022. 2. One (1) "ABC- type" fire extinguisher last annually inspected January 2022 with no evidence a monthly examinations being performed and documented on the tag for July, August and September 2022. 2) At approximately 11:52 AM, the surveyor observed inside the [redacted] floor Mechanical room two fire extinguishers. 1. One (1) "ABC- type" fire extinguisher last annually inspected January 2022 with no evidence a monthly examinations being performed and documented on the tag for July, August, September and October 2022. 2. One (1) "Carbon Dioxide" type fire extinguisher last annually inspected January 2022 with no evidence a monthly examinations being	K 355	all inspected as per regulation monthly x3 and quarterly x4 quarters. 2. An audit of all fire extinguishers will be conducted to ensure they are full and in proper working condition monthly x3, and quarterly x4 quarters. 3. All negative findings will be brought to the DOM and administrator for immediate correction. 4. Results of all audits will be brought to the QAPI committee x4 quarters. V. Person responsible: Director of Maintenance	

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K 355	Continued From page 10 performed and documented on the tag for July, August and September 2022. 3) At approximately 11:58 AM, the surveyor observed across from Resident room [redacted] ([redacted] unit) One (1) ABC- type fire extinguisher last annually inspected January 2022 with no evidence a monthly examinations being performed and documented on the tag for July, August and September 2022. 4) At approximately 12:20 PM, the surveyor observed inside the [redacted] floor Physical Therapy electrical closet, One (1) "ABC- type" fire extinguisher last annually inspected January 2022 with no evidence a monthly examinations being performed and documented on the tag for July, August, September and October 2022. On 11/17/2022: 5) At approximately 10:47 AM, the surveyor observed inside the [redacted] floor [redacted] room (next to stairwell #1), One (1) "ABC- type" fire extinguisher last annually inspected January 2022 with no evidence a monthly examination being performed and documented on the tag for September 2022. 6) At approximately 10:54 AM, the surveyor observed on the [redacted] floor in the corridor next to stairwell #1, One (1) "ABC-type" fire extinguisher last annually inspected January 2022 with no evidence a monthly examination being performed and documented on the tag for September 2022. 7) At approximately 11:16 AM, the surveyor observed on the [redacted] floor inside the	K 355		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	**155 40TH STREET** **IRVINGTON, NJ 07111**

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K 355	Continued From page 11 Housekeeping room, One (1) "ABC-type" fire extinguisher last annually inspected January 2022 with no evidence a monthly examination being performed and documented on the tag for September 2022. 8) At approximately 11:35 AM, the surveyor observed two (2) Class K "Wet Chemical" fire extinguishers in the Kitchen. 1. One (1) Wet Chemical fire extinguisher was last annually inspected January 2022 with no evidence monthly examinations being performed and documented on the tag for July and August 2022. 2. One (1) Wet Chemical fire extinguisher pressure indicating needle was in the "RED" discharge zone on the gauge. This extinguisher would not function properly in the event of a fire. The DOM confirmed the findings at the time of observations. The Regional Administrator and DOM was notified of the deficiency at the Life Safety Code exit conference on 11/17/2022 at approximately 1:45 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 374 SS=E	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	K 374		12/23/22

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K 374	Continued From page 12 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 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 and review of facility provided documentation on 11/16/2022 and 11/17/2022, 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 2 of 13 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 11/16/2022 during the survey entrance at 9:07 AM, a request was made to the Director of Nursing and Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are four floors in the facility. A review of the facility provided lay-out identified	K 374	K374 Subdivision of Building Spaces □ Smoke Barrier Doors SS=E I. Immediate Action 1. Identified smoke barrier doors on the [Ex. Orde] floor by Room [Ex. Orde] were repaired to ensure proper closure and functioning. It was completed on 1/12/2022, one set of the double smoke doors in the [EXEX] -floor renovation area that has ½ inch gap between the meeting edges will be repaired. It was completed on 1/12/2022. II. Identification of others: 1. An audit was conducted of all smoke barrier doors to ensure proper closure and functioning. 2. All residents have the potential to be affected by this practice. III. System Changes 1. Monthly maintenance and inspection of the doors will be conducted and will be inspected by the Director of Maintenance. IV: Quality Assurance	

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K 374	Continued From page 13 that there are one (1) set of corridor double smoke doors on the [redacted]. floor, one (1) set of corridor double smoke doors on the 3rd. floor, four (4) sets of corridor double smoke doors on the 2nd. floor and seven (7) sets of corridor double smoke doors on the 1st. (1st.) floor. Starting at 9:49 AM on 11/16/2022 and continued on 11/17/2022, in the presence of the facility's DOM a tour of the building was performed. The surveyor performed closure tests of the thirteen (13) sets of smoke barrier doors in the corridors with the following results, 1) On 11/16/2022 at approximately 11:38 AM, one set of double smoke doors on the second floor next to Resident room [redacted] when both doors were release from their magnetic hold open devices and allowed to self close into their frame, one door moved approximately 5 inches and stopped short from the doors frame. The surveyor observed that the door rubbed on the floor and stopped. The surveyor measure and recorded a 33 inch opening between the left door and meeting edge of the right door. This test was repeated two additional times with the same results. This left a 33 inch and the doors frame. 2) On 11/17/2022 at approximately 12:20 PM, 11:07 AM, one set of double smoke doors in the [redacted]. floor renovations area when both doors were release from their magnetic hold open devices and allowed to self close into their frame, the surveyor observed and measure a 1/2 inch gap between the meeting edges near the bottom of the doors. This test was repeated two additional times with	K 374	1. Audits will be conducted by the Maintenance Director on all smoke barrier doors to ensure proper functioning weekly x4, monthly x2, and quarterly x4 quarters. The Maintenance Director will inspect the smoke barrier doors to ensure the problem does not reoccur and we maintain compliance. 2. All negative findings will be brought to the DOM and administrator for immediate correction. 3. Results of all audits will be brought to the QAPI committee x4 quarters. V. Person responsible: Director of Maintenance	

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K 374	Continued From page 14 the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The DOM confirmed the findings at the time of observations. The Regional Administrator and DOM was notified of the deficiency at the Life Safety Code exit conference on 11/17/2022 at approximately 1:45 PM. N.B. 8:39-31.1(c), 31.2(e)	K 374		
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 observations on 11/16/2022 and 11/17/2022 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 4 of 12 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the	K 521	I. Immediate Action 1. The facility's bathroom ventilation system was repaired to ensure proper operation for rooms [EX. Order 26.(4) B1], and [EX. Order 2], and the Rehabilitation services unisex bathroom. It was completed on 12/1/2022	12/23/22

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K 521	Continued From page 15 following: On 11/16/2022 during the survey entrance at 9:07 AM, a request was made to the Director of Nursing and Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting on 11/16/2022 at 9:49 AM and continued on 11/17/2022, in the presence of the facility's DOM, during the building tour an inspection of 12 Resident bathrooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 4 of 12 resident bathrooms in the following locations: On 11/16/2022, 1. At 12:02 PM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. The surveyor observed that there was air back pressure blowing the tissue inward into the bathroom. At this time, the surveyor informed the DOM that the exhaust system did not function properly. 2. At 12:06 PM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. 3. At 12:12 PM, inside Resident room [redacted] bathroom, when tested the exhaist system did not function properly. On 11/17/2022, 4. At approximately 10:48 AM, on the second	K 521	II. Identification of others: 1. An audit of all bathroom ventilation systems was conducted, and no further malfunctions were identified. III. System Changes 1. Monthly bathroom ventilation system tests will be performed to ensure proper functioning. IV: Quality Assurance 1. Audits and tests will be conducted monthly by the Maintenance Director to ensure that the problem does not reoccur, and we maintain compliance on all bathroom ventilation systems to ensure proper functioning weekly x4, monthly x2, and quarterly thereafter. 2. Maintenance Director will monitor the performance weekly x 4, and monthly x2 to ensure the solution will be sustained and be within compliance 3. All negative findings will be brought to the (DOM and) QAPI quarterly chaired by the administrator for immediate correction. V. Person responsible: Director of Maintenance IV.	

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K 521	Continued From page 16 floor Rehabilitation Services Unisex bathroom, when tested did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The DOM confirmed the findings at the time of observations. The Regional Administrator and DOM was notified of the deficiency at the Life Safety Code exit conference on 11/17/2022 at approximately 1:45 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 531 SS=E	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.)	K 531		12/23/22

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K 531	Continued From page 17 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 11/16/2022, in the presence of facility management it was determined that the facility failed to maintain elevator emergency communications for 2 of 2 elevators tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: On 11/16/2022 during the survey entrance at 9:07 AM, a request was made to the Director of Nursing and Director of Maintenance (DOM), how many elevators are in the building. The DOM told the surveyor that there are two (2) elevators. On 11/16/2022 during a tour of the building in the presence of the facility DOM at 9:48 AM, a test of elevator [Ex. Order] emergency telephone was performed. When the surveyor tested the emergency communication phone it did not function properly. The emergency communication phone had a Busy signal. This test was repeated a two (2) times with the same result. Later during the tour at 12:24 PM, a test of elevator #[Ex. Ord] emergency telephone was performed. When the surveyor tested the emergency communication phone it did not function properly. The emergency communication phone had a Busy signal. This test was repeated a two (2) times with the same result. The DOM confirmed the findings at the times of observations.	K 531	I. Immediate Action 1. Elevators emergency communication phone was repaired by the vendor. It was completed on 12/8/2022 1. II. Identification of others: 1. The facility respectfully submits that all residents have the potential to be affected by this deficiency. III. System Changes a) Emergency communication phones in the elevators will be tested weekly to ensure proper functioning. IV. Quality Assurance a) An audit and test will be performed by the Maintenance Director to ensure the problem does not reoccur and we maintain compliance on all emergency communication phones in the elevators to ensure their proper functioning weekly x4, monthly x2, and thereafter. b) All negative findings will be brought to the DOM and administrator for immediate correction. c) Results of all audits will be brought to the QAPI committee x4 quarters. Invoice/receipt of the vendor attached. Pls see attached documents. V. Person responsible: Director of Maintenance	

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K 531	Continued From page 18 The Regional Administrator and DOM was notified of the deficiency at the Life Safety Code exit conference on 11/17/2022 at approximately 1:45 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. 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	K 918		12/23/22

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K 918	Continued From page 19 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/16/2022 and 11/17/2022 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 11/16/2022 during the survey entrance at 9:07 AM, a request was made to the Director of Nursing and Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments and if the facility had an emergency generator. The DOM told the surveyor yes there are two (2). One (1) emergency generator is for the EX. Order 26.(4) B1 Home and one (1) is for the EX. Order 26.(4) Unit (another business). During the building tour on 11/17/2022 with the facility DOM at approximately 12:07 PM, an inspection outside of the building where the 125 KW Diesel Emergency Generator is located was performed. At this time the surveyor asked the DOM, where is the remote emergency shut off for the generator. The DOM told the surveyor, There is	K 918	I: Immediately Action 1. Remote manuals stop station for the emergency generator was installed in accordance with the requirements of the NFPA. It was completed on 12/9/22. II: Identification of others: 1. The facility respectfully submits that all residents have the potential to be affected by this practice. III: System changes Generator sets are inspected weekly, exercised under load for 30 minutes 12 times a year in 20–40-day intervals, and once every 36 months for 4 continuous hours. The functionality of the remote stop button will be tested monthly by the Director of Maintenance 2. Audits will be conducted on generators weekly and monthly(basic) by the Maintenance director and Designee 3. All negative findings will be reported to the administrator and vendor immediately IV: Quality Assurance 1. Generator test will be conducted by the maintenance director or designee weekly and monthly 2. All negative findings will be reported to the administrator and maintenance	

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K 918	Continued From page 20 no remote emergency shut off. The surveyor observed that the emergency shut off was located on the generator's control panel. The DOM confirmed the findings at the time of observations. The Regional Administrator and DOM was notified of the deficiency at the Life Safety Code exit conference on 11/17/2022 at approximately 1:45 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	director for immediate correction 3. Result of all audits will be brought up in the QAPI committee x4 quarterly V: Director of Maintenance	