| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315359 | A. BUILDING **02**<br>B. WING _____ | **09/23/2021** |

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

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| E 000 | Initial Comments<br><br>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<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/22/21 and 09/23/21,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<br><br>Alaris Health at Essex is a 4-story building that was built in 90's, It is composed of Type II protected. The facility is divided into 16- smoke zones. The generator does approximately 50 to 60 % of the building and the facility has an electric fire pump.<br><br>The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities 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. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 10/06/2021 |

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| K 000 | Continued From page 1<br>The facility has 212 certified beds. At the time of the survey the census was 108. Currently floor #4 is closed. | K 000 | | |
| K 222 SS=E | Egress Doors<br>CFR(s): NFPA 101<br><br>Egress Doors<br>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:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 | K 222 | | 10/27/21 |

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| K 222 | Continued From page 2<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview on 9/22/21, in the presence of the Maintenance Director and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that the 15-second delayed egress feature on 3 of 14 exit discharge doors observed would activate when tested.<br><br>This deficient practice was evidenced by the following:<br><br>1. On 9/22/21 at 1:18 PM, the Surveyor, | K 222 | 1. What corrective action will be accomplished for those residents affected by the deficient practice?<br>Egress door by [redacted] was repaired to ensure 15-second delay on 10/6/21<br>Egress door by room #[redacted] was repaired to ensure 15 second delay on 10/6/21<br>Egress door by room #[redacted] was repaired to ensure 15-second delay on 10/6/21<br><br>2. How will the facility identify other residents having the potential to be | |

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| K 222 | Continued From page 3<br>Maintenance Director and Regional Plant Operations Director observed that the delayed 15-second egress feature that was labeled with a sign on the door by resident room #[redacted] did not activate. The doors egress feature was activated 2-times by the Regional Plant Operations Director and did not function. The door was provided with a key pad that opened the door and the fire alarm would open the door when activated, as per the Regional Plant Operations Director.<br><br>2. On 9/22/21 at 1:25 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed that the delayed 15-second egress feature that was labeled with a sign on the door by resident room [redacted] did not activate. The doors egress feature was activated 2-times by the Regional Plant Operations Director and did not function. The door was provided with a key pad that opened the door and the fire alarm would open the door when activated, as per the Regional Plant Operations Director.<br><br>3. On 9/22/21 at 1:35 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed that the delayed 15-second egress feature that was labeled with a sign on the door by resident room [redacted] did not activate. The doors egress feature was activated 2-times by the Regional Plant Operations Director and did not function. The door was provided with a key pad that opened the door and the fire alarm would open the door when activated, as per the Regional Plant Operations Director.<br><br>These findings were verified by the Maintenance Director and Regional Plant Operations Director, during the observations and testing of the doors. | K 222 | affected by the same deficient practice?<br>All residents has the potential to be affected.<br><br>3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?<br>The Maintenance Director or Designee will check daily and document on every Egress Door for proper function to ensure 15 second delay.<br>Any delays or malfunctions will be corrected immediately by the Director of Maintenance.<br><br>4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?<br>Maintenance Director or Designee will audit the Egress door daily and document all findings. These findings will be reported to the Administrator and reported quarterly in the QAPI and Safety Committee meetings. | |

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| K 222 | Continued From page 4<br>The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 9/23/21.<br><br>NJAC 8:39-31.2(e)<br>NFPA 101:2012 - 7.2.1.6.1.1(3)C | K 222 | | |
| K 225 SS=E | Stairways and Smokeproof Enclosures<br>CFR(s): NFPA 101<br><br>Stairways and Smokeproof Enclosures<br>Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.<br>18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 9/22/21, the facility failed to provide stair thread marking stripe applied as a material that is integral with the nosing of each step, each floor landings and handrails with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3. The deficient practice was observed in 4 of 4 stairwells in the facility by the following:<br><br>While touring the facility on 9/22/21 from approximately 9:40 AM, to 2:00 PM, the Surveyor, Maintenance Director and Plant Operations Director, observed that the 4 egress stairwells, revealed that marking stripes were not present on each step, floor landing, and handrails.<br><br>The findings were verified by the Maintenance | K 225 | 1. What corrective action will be accomplished for those residents affected by the deficient practice?<br>Illuminating markings were applied on all 4 egress stairwells, and marking stripes were applied on each step, floor landing, and handrails stairwell steps, handrails, floor landings by 11/1/21<br><br>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>All residents has the potential to be affected.<br><br>3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? | 11/1/21 |

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| K 225 | Continued From page 5<br>Director and Plant Operations Director at the times of the observation.<br><br>The Administrator was informed of this finding during the Life Safety Code survey exit conference on 9/23/21.<br><br>NJAC 8:31.2(e)<br>NFPA 101:2012 - 19.2.2.3, 7.2.2 | K 225 | The Maintenance Director or Designee will monitor all stairwell steps, floor landings and handrails for any defect in the illuminating function on a daily basis. Any issues found will be corrected immediately by the Maintenance Director and reported to the Administrator.<br><br>The Maintenance Director will in-service all staff on the importance of marking stripes in order for staff to be aware of the purpose and importance of these markings.<br><br>4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?<br>The Maintenance Director or Designee will audit daily that stairwells markings are in place and report the findings at the quarterly Safety Committee meetings. | |
| K 291<br>SS=D | Emergency Lighting<br>CFR(s): NFPA 101<br><br>Emergency Lighting<br>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<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and interview from 9/22/21 to 9/23/21, it was determined that the facility failed provide a battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient | K 291 | 1. What corrective action will be accomplished for those residents affected by the deficient practice?<br>Facility provided back up lighting independent of the buildings electrical system and emergency generator above the emergency generator□s transfer | 10/15/21 |

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| K 291 | Continued From page 6<br>practice was evidenced by the following:<br><br>On 9/22/21 at 1:32 PM the Surveyor, Maintenance Director and Plant Operations Director observed in the floor-[redacted] electrical room, where the emergency generator transfer was located, that the room was not equipped with emergency lighting independent of the building's electrical system and emergency generator. This finding was verified by the facility's Maintenance Director and Plant Operations Director at the time of inspection.<br><br>The Administrator was notified of the above findings, at the Life Safety Code exit conference on 9/23/21.<br><br>NJAC 8:39-31.2(e)<br>NFPA 101:2012 - 19.2.9.1, 7.9 | K 291 | switch on 9/29/21.<br><br>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>All Residents has the potential to be affected.<br><br>3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?<br>The Maintenance director and/or designee will monitor the back up lighting daily to ensure proper function. Any issues will be corrected immediately and reported to the Administrator.<br>The Maintenance Director will in-service supervising staff on the back up lighting and emergency generator to check functioning in the absence of the Maintenance Director.<br><br>4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?<br>The Maintenance Director or designee will audit the daily findings to be presented quarterly at the Safety Committee Meetings. | |
| K 353 SS=E | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire | K 353 | | 10/22/21 |

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| K 353 | Continued From page 7<br>Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 9/22/21, it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, 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.<br><br>The deficient practice was identified for 15 of 30 areas of the facility observed, checked for smoke resistance during the building tour with the Maintenance Director and Plant Operations Director and was evidenced by the following:<br><br>1. At 12:24 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed in [redacted] stairwell that approximately three 4'x2' ceiling tiles were missing. The missing ceiling tiles could delay the activation of the fire alarm and fire sprinkler heads until the void above the ceiling filled with heat and smoke. | K 353 | 1. What corrective action will be accomplished for those residents affected by the deficient practice?<br>The facility ensured and changed the ceiling tile was smoke resistant in stairwell #[redacted], room[redacted], floor #[redacted] soiled utility room, stairwell #[redacted], floor #[redacted] outside room [redacted], Floor #[redacted] dining rooms, floor #[redacted] dining room, floor #2 physical therapy bathroom, floor [redacted] by room [redacted], floor #1 boiler room, floor [redacted] corridor outside room [redacted] and [redacted] on 10/6/21. Floor #[redacted] fire panel and [redacted] floor outside fire pump room by 10/22/21.<br>The escutcheon plate was placed on floor #4 soiled utility room, floor #[redacted] in central bath and shower room and floor [redacted] physical therapy room on 10/06/21.<br><br>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>All Residents has the potential to be | |

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| K 353 | Continued From page 8<br>2. At 12:28 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed in unoccupied resident room [redacted], that approximately a 6" x 4' ceiling tile were missing. The missing ceiling tile could delay the activation of the fire alarm and fire sprinkler heads until the void above the ceiling filled with heat and smoke.<br><br>3. At 12:38 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed in the floor # [redacted] soiled utility room, that the fire sprinkler head was missing an escutcheon plate. The missing escutcheon plate gap around the ceiling tile, could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>4. At 12:40 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed in stairwell # [redacted], that the pipe chase into the ceiling tile was observed to have gaps, that could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>5. At 1:00 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on floor # [redacted] outside resident room [redacted] that a bad ceiling tile cut could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>6. At 1:10 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on floor # [redacted] that 1 of 4 fire sprinkler heads, were missing the escutcheon plate in the central bath/shower room. The missing | K 353 | affected<br><br>3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?<br>The Maintenance Director or Designee will monitor and inspect the ceiling tiles and escutcheon plates daily throughout the facility to ensure proper function. Any identified issues with the tiles or escutcheon plates will be addressed immediately.<br>The Director of Maintenance will in-service staff to assist and identify missing tiles or escutcheon plates and report immediately to the Maintenance Director for correction.<br><br>4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?<br>The Maintenance Director or Designee will audit the tile placement and escutcheon plates daily and all findings will be reviewed at the quarterly Safety Committee meeting. | |

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| K 353 | Continued From page 9<br>escuteheon plate could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>7. At 1:12 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed in the floor # [redacted] dining room that an approximately 2' x 2" piece of ceiling tile was missing. The missing ceiling tile could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>8. At 1:22 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on the floor # [redacted] at the fire alarm panel pipe chase, that the ceiling tile was cut square and left gaps into the ceiling that could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>9. At 1:30 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on the floor # [redacted] staff dining room, that an approximately 2' x 4' ceiling tile was missing by the exit door, that could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>10. At 1:42 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on the floor # [redacted] physical Therapy room bathroom that the fire sprinkler head was missing an escutcheon plate leaving an approximately 1/2" gap around the ceiling tile, that could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke. | K 353 | | |

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| K 353 | Continued From page 10<br><br>11. At 1:52 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on floor #[redacted] that in the corridor by resident room [redacted], a 1/2 opening in the ceiling tile that could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>12. At 2:08 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on floor #1, that in the boiler room, the pipe chase along with a wire chase around the drop ceiling tiles, were cut square, leaving a gap that could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>13. At 2:10 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on floor #1, that in the corridor outside resident rooms [redacted] and [redacted] that the ceiling tile around the fire smoke alarm left a gap approximately 1" that could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>14. At 2:28 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on floor [redacted], that in the corridor outside resident rooms [redacted] and [redacted] that the ceiling tile around the fire smoke alarm left a gap approximately 1" that could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>15. At 2:28 PM, the Surveyor, Maintenance Director and Regional Plant Operations Director observed on floor [redacted], that the fire sprinkler head | K 353 | | |

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|---|---|---|---|
| | 315359 | A. BUILDING **02** B. WING _____ | **09/23/2021** |

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| K 353 | Continued From page 11<br>in the corridor, outside the fire pump room, had a bad ceiling tile cut, leaving an approximately 3/4 opening, that could delay the activation of the fire alarm and fire sprinkler heads, until the void above the ceiling filled with heat and smoke.<br><br>The Maintenance Director and Regional Plant Operations Director stated and confirmed the observations stated above.<br><br>The facility administration was notified of the findings at the Life Safety Code exit conference on 9/23/21.<br><br>NJAC 8:39-31.2(e) | K 353 | | |
| K 521 SS=E | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 9/22/21, in the presence of the facility Maintenance Director and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure resident bathroom ventilation systems for [redacted] of [redacted] units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient | K 521 | 1. What corrective action will be accomplished for those residents affected by the deficient practice?<br>Resident bathroom ventilation system was repaired and operating properly for rooms, [redacted] on 10/5/21 [redacted] and [redacted] by 10/22/21 | 11/1/21 |

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| K 521 | Continued From page 12<br>practice was evidenced by the following:<br><br>From 9:30 AM to 2:12 PM, the surveyor observed that the ventilation in the following resident room bathrooms did not function: [redacted] and [redacted]<br><br>The surveyor requested that the Maintenance Director and RPOD, 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.<br><br>At that time, the surveyor interviewed the Maintenance Director and RPOD, who confirmed that the approximately 6" x 6" exhaust vents in the above resident room bathrooms were not functioning when tested.<br><br>The Administrator was informed of this deficiency at the Life Safety Code exit conference on 9/23/21.<br><br>NFPA 90 A<br>NFPA 101-2012 -19.5.2.1 section 9.2.2<br>NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 | K 521 | 2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>All residents has the potential to be affected<br><br>3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?<br>The Maintenance Director or Designee will monitor the resident bathroom ventilation system daily to ensure proper functioning. All issues will be addressed immediately.<br>The Maintenance Director will in-service the maintenance staff on the resident bathroom ventilation system and check functioning in the absence of the Maintenance Director.<br><br>4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?<br>The Maintenance Director or Designee will audit the ventilation system in the resident's bathroom and report the finding quarterly at the Safety Committee meeting. | |
| K 923 SS=E | NJAC 8:39-31.2(e)<br>Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet | K 923 | | 10/6/21 |

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| K 923 | Continued From page 13<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>This deficiency was also cited in 2019 at the last recertification survey. | K 923 | 1. What corrective action will be accomplished for those residents affected by the deficient practice? | |

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| K 923 | Continued From page 14<br><br>Based on observations and interview from 9/22/21 to 9/23/21, in the presence of the Maintenance Director, Regional Plant Operations Director and Administrator, it was determined that the facility failed to store a cylinder of compressed Oxygen gas in a safe manner to prevent tipping and rupture in accordance with NFPA 99. This deficient practice was evidenced for 1 of 11 portable oxygen tanks by the following:<br><br>On 9/22/21 at 1:48 PM, the surveyor observed in the floor-[redacted] oxygen storage closet by the MDS coordinator office and resident room [redacted] that a portable filled oxygen tank was stored unsecured and the valve was not fully closed. The oxygen air outlet was hissing at the time of the observation. The oxygen storage closet contained 4-full and 7-empty tanks.<br><br>On that same date and time, an interview was conducted during the observations with the Maintenance Director and Regional Plant Operations Director and they both confirmed the portable oxygen tank was stored unsecured and hissing at the time of the observation.<br><br>The Administrator was informed of the deficiency at the Life Safety Code exit conference on 9/23/21.<br><br>NJAC 8:39-31.2(e)<br>NFPA 99 | K 923 | All cylinders of compressed oxygen gas in the floor [redacted] oxygen storage room was immediately stored in a secure holder on 9/22/21.<br>One cylinder of compressed oxygen gas in the floor [redacted] oxygen storage room that had a valve that was not fully closed and hissing was sent back to supplier on 9/22/21.<br><br>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>All residents has the potential to be affected.<br><br>3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?<br>All staff were in-serviced on the proper secure storage of full and empty compressed oxygen gas cylinders to prevent tipping and rupture on 10/06/21<br>All staff were in-serviced on 10/06/21 notifying the maintenance department for any defective compressed oxygen gas cylinders to ensure proper functioning and safety.<br><br>4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?<br>Maintenance Director or designee will audit daily the proper secure storage of compressed oxygen gas cylinders along with any defective cylinders and report those finding in quarterly QAPI meeting and Safety Committee meeting. | |

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