STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING **01, 02** B. WING _____	**08/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	**499 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(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 8/4/22, 8/8/22 and 8/9/22, 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 2-story building that was built in 1987, It is composed of Type II protected. The facility is divided into 22- smoke zones. The generator from the Maintenance Director does approximately 35 % of the building. 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. The facility has 547 certified beds.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/4/22, 08/8/22 and 8/9/22, was found to be in noncompliance with the requirements for participation in	K 000		

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

Electronically Signed | 08/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 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 two-story building that was built in 1987, It is composed of Type II protected. The facility is divided into 22- smoke zones. The generator from the Maintenance Director does approximately 35% of the building. 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. The facility has 547 certified beds.	K 000		
K 132 SS=F	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire	K 132		9/15/22

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K 132	Continued From page 2 resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/8/22, the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.3.4. between the Main building and newer Jerry & Dolores Turco (JDT) building. The deficient practice could affect all residents. This deficient practice was evidenced by the following: 1. At 10:50 AM. The surveyor, Maintenance Director and Regional Plant Operations Director, observed that the door separating the floor two main [redacted] building from the [redacted] newer building, had no visible label regarding the fire resistive properties required for an opening in a two-hour rated horizontal separation assembly. 2. At 12:50 PM. The surveyor, Maintenance Director and Regional Plant Operations Director, observed that the kitchen door separating the main [redacted] building from the [redacted] newer building, had no visible label regarding the fire resistive properties required for an opening in a two-hour rated horizontal separation assembly. The findings were verified by the Maintenance Director and Regional Plant Operations Director at the time of both observation's.	K 132	The provider submits the following Plan of Correction in good faith and to comply with federal Law. This Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in in the statement of deficiencies/ 1. Two Hour Fire rated doors will be re-certified or replaced upon inspection from a qualified fire rating inspector. 2 Facility wide fire door rating inspection for August has been completed on August 17th and all existing fire rated doors are functioning as design. 3. Education completed with Maintenance staff to observe fire ratings during rounds. 4. Every month, Maintenance director/Designee will check a random floor of the facility to ensure fire doors and ratings are functioning as design. This information will be documented and presented at the quarterly QAPOI meetings	

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K 132	Continued From page 3 The Maintenance Director and Regional Plant Operations Director were informed of the finding's at the Life Safety Code exit conference on 8/9/22. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.1.3.4.	K 132		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is	K 222		9/15/22

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K 222	Continued From page 4 constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of Maintenance Director, Plant Operations Director on 8/8/22, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in	K 222	The provider submits the following plan of correction in good faith and to comply with Federal Law. This Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies.	

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K 222	Continued From page 5 accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 for 2 of 2 sets of exterior exit/egress doors observed. This deficient practice was identified for 2 of 2 sets of doors and was evidenced as follows: At 11:08 AM, the surveyor, Maintenance Director and Regional Plant Operations Director observed two sets of glass sliding doors located at the front entrance of the facility, the interior set of sliding glass doors and exterior set of sliding glass doors had a lockset that engaged a hook-type deadbolt. The device's on the door could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. At the time of the observation, the surveyor interviewed the Maintenance Director and Regional Plant Operations Director who stated that the lockset (hook type deadbolt) could restrict use of the exit from the egress-side in the event of an emergency. The Maintenance Director and Regional Plant Operation Director were notified of the findings at the Life Safety Code Exit Conference on 8/9/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6.	K 222	It is the practice of the facility to maintain Egress Doors free from all obstructions or impediments to full instant use in case of a fire or other emergencies. 1. The two sets of glass sliding doors and exterior set of sliding doors have had the lockset removed to prevent the possibility of restricting the exit through egress. 2. Facility wide inspection for August was completed on August 17th and all existing doors are functioning as design. 3. Education completed with Maintenance staff to observe fire ratings during rounds. 4. On a monthly basis, the Maintenance Director/Designee will check a random floor of the facility to ensure that all exit doors are functioning as per the design. The information will be entered on a log and will be presented at the quarterly QAPI meeting.	
K 291 SS=F	NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C Emergency Lighting CFR(s): NFPA 101 Emergency Lighting	K 291		9/15/22

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K 291	Continued From page 6 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 on 8/4/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator's two (2) separate 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 identified for 2 of 2 transfer switches and was evidenced by the following: At 12:05 PM, the surveyor observed in the ATS-1 and ATS-2 emergency generator transfer switch locations, that the area was equipped with battery back-up emergency lighting, ATS-1 room did have an emergency wall mounted light above the transfer switch, but when it was tested the light did not work. The X-building transfer switch emergency light was located in an area of the large room, but would not provide lighting to the area where the transfer switch was located. The Maintenance Director and Regional Plant Operations Director, both confirmed the finding's at the time of the observations. The Regional Plant Operations Director and Maintenance Director were informed of the findings at the Life Safety Code exit on 8/9/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	The provider submits the following Plan of Correction in good faith to comply with Federal Law. This Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1. Battery backup emergency lighting has been installed in the generator automated transfer switch room. 2. Facility wide battery backup lighting inspection for August has been completed on August 17th and all existing battery backup lighting are functioning as per design. 3. Education completed with Maintenance staff to observe during rounds. 4. On a monthly basis, the Maintenance Director/Designee will check a random floor of the facility to ensure battery backup emergency lighting are functioning. This information will be documented on a log and will be presented at the quarterly QAPI meeting	

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K 321	Continued From page 7	K 321		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/8/22, in the presence of the Maintenance Director, Regional Plant Operations Director, it was determined that the facility failed to provide and maintain self-closing devices and hardware on	K 321	The provider submits the following Plan of Correction in good faith and to comply with Federal Law. The Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and	1/11/23

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K 321	Continued From page 8 doors to hazardous areas 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 identified in 4 of 10 hazardous areas and was evidenced by the following: 1. At 1:10 PM. the surveyor observed in the storage room located in the laundry hall, that the door would not close and latch 2. At 1:18 PM. the surveyor observed in the laundry room soiled linen door would not latch into its frame. 3. At 1:22 PM. the surveyor observed in the laundry room that the door to the commercial clothes dryer location did not latch into its frame. 4. At 1:24 PM. the surveyor observed in the washing machine room, that the single door did not latch into its frame. An interview was conducted with the Maintenance Director and Regional Plant Operations Director, who confirmed and stated that hazardous storage areas, must have a door that closes into its frame and latches. The Maintenance Director and Regional Plant Operations Director were informed of the finding, at the Life Safety Code exit conference on 8/8/22. NJAC 8:39-31.2(e)	K 321	conclusions stated in the statement of deficiencies. 1. The storage room, Laundry Room, and Washing Machine room doors will be repaired to provide proper function of the door closing and latching into the frame. 2. Facility wide exit sign inspection for August has been completed on August 17th and all existing doors are functioning as per design. 3. Education completed with Maintenance staff to observe during rounds. 4. On a monthly basis, the Maintenance Director/Designee will check a random floor of the facility to ensure proper door closing and latching function. This information will be entered on a log and will be presented at the quarterly QAPI meeting	
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection	K 347		9/15/22

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K 347	Continued From page 9 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 8/8/22, it was determined that the facility failed to ensure that there was a testing, maintenance, and battery replacement program to ensure proper operation of the battery operated smoke detectors. This deficient practice was evidenced for 100 of 100 observed battery operated smoke detectors and evidenced by the following: A tour of the facility, at 11:15 AM, revealed that the facility resident rooms in the old building, were provided with battery operated smoke detectors and heat detectors. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance program for the testing of the detectors or for battery replacement. In an interview, at 11:55 AM, the facility's Maintenance Director stated that there was no preventative maintenance program for testing the battery operated smoke detectors in resident rooms and could not provide any documentation on the year of installation. He stated that he tested the alarms by pushing the test button periodically and replaced the batteries when the alarms indicated low battery, but he did not record any information on a log. This deficient practice would not ensure the	K 347	The provider submits the following Plan of Correction in good faith and to comply with Federal Law. THe Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to ensure building wide smoke detection present and function and maintained as designed. 1. Proper preventative maintenance program for testing and battery replacement will be completed in the old building. 2. Facility wide battery operated smoke detector inspections will be completed for August. 3. Education completed with Maintenance staff to perform proper preventative maintenance during rounds and to check for proper building wide coverage. 4. On a monthly basis, the Maintenance Director/Designee will check battery operated smoke detector components on a random floor of the facility. This information will be entered on a log and presented at the quarterly QAPI meeting.	

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K 347	Continued From page 10 proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference on 8/8/22. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347		
K 351 SS=E	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 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 8/9/22,	K 351	The provider submits the following Plan	9/8/22

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LINCOLN PARK CARE CENTER	**499 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

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K 351	Continued From page 11 the facility failed to 1.) provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment. 2.) the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in this area. This deficient practice was evidenced by the following: At 11:08 AM, the surveyor, in the presence of the Maintenance Director observed that the HVAC closet approximately four foot by three foot did not have any fire sprinkler coverage. The Maintenance Director took a photo of the ceiling that was blocked by the HVAC unit and the photo revealed no fire sprinkler head was observed. The Maintenance Director was informed of the finding, at the Life Safety Code exit conference on 8/9/22. NJAC 8:39-31.2(e)	K 351	of Correction in good faith and to comply with Federal Law. This Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to ensure building wide sprinkler coverage and can function as designed. 1. The missing sprinkler head in the HVAC closet will be installed. 2. Facility wide sprinkler head inspection has been completed for August on August 17th. 3. Education completed with Maintenance staff to observe sprinklers, ceiling tiles, tamper switches, and sprinkler escutcheons during rounds and check for proper building wide coverage. 4. On a monthly basis, the Maintenance Director/Designee will check sprinkler system components on a random floor of the facility. This information will be entered on a log and will be presented at the quarterly QAPI meeting	
K 363 SS=E	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	K 363		9/15/22

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	315249	A. BUILDING **01, 02** B. WING _____	**08/09/2022**

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K 363	Continued From page 12 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, 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 on 8/8/22, it was determined that 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,	K 363	The provider submits the following Plan of Correction in good faith and to comply with Federal Law. The Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and	

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K 363	Continued From page 13 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 identified in 6 of 150 resident room doors observed and was evidenced by the following: On 8/8/22 during the building tour from 9:15 AM to 2:00 PM, the surveyor, Maintenance Director, and Regional Plant Operations Director toured the facility and observed the following: Resident Room [redacted] the door would not latch due to the door hitting the frame. Resident Room [redacted] the door would not latch due to the door hitting the frame. Resident Room [redacted] the door would not latch due to the door hitting the frame. Resident Room [redacted] the door would not latch due to the door hitting the frame. Resident Room [redacted] the door would not latch due to the door rubbing onto the frame, due to a hardware issue. Resident Room [redacted] the door would not latch due to the door hitting the frame. At the time of observations, the surveyor interviewed the Maintenance Director and Regional Plant Operations Director, who confirmed the above findings. The Maintenance Director and Regional Plant Operations Director were informed of the finding at the Life Safety Code Exit Conference on 8/8/22.	K 363	conclusions stated in the statement of deficiencies. It is the practice of the facility to ensure that corridor doors will close and latch as per design 1. Doors were repaired to allow for closure on August 17, 2022. 2. Doors throughout the facility were checked to allow for closure on August 17, 2022. 3. Education was completed with the Maintenance staff regarding monitoring doors to ensure that they close properly. 4. On a monthly basis, the Maintenance Director/Designee will check random doors throughout the facility to ensure that the doors fully close. This information will be entered on a log and will be presented at the quarterly QAPI meeting.	

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K 363	Continued From page 14 NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 364 SS=F	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/9/22, in the presence of the Maintenance Director, it was determined that the facility failed to maintain doors to hazardous areas in a manner designed to resist the passage of smoke into exit corridors. This deficient practice was identified for 1 of 10 closet doors to (HVAC) units, and was evidenced by the following: At 11:22 AM, the surveyor observed the HVAC closet, located by the front exit/egress corridor	K 364	The provider submits the following Plan of Correctiion in good faith and to comply with Federal Law. The Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to ensure no opening to corridors do not exceed 20 square inches.	9/15/22

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K 364	Continued From page 15 that the door had an approximately 18 inches by 18 inches open transfer grille to the exit/egress corridor. An interview was conducted with the Maintenance Director at the time of the observation, where he confirmed that the open door vent, was not to be used in corridor doors. The Maintenance Director was informed of the finding at the Life Safety Code exit conference on 8/8/22. NFPA 101-2012 edition Life Safety Code 19.3.6.4 Transfer Grilles. 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors. NJAC 8:39-31.2(e)	K 364	1. Louver on HVAC door was sealed to prevent opening into corridor on August 17, 2022. 2. Louvered openings were checked throughout the facility on August 17, 2022. 3. Education completed with Maiontenance staff regarding monitoring louvers to ensure they seal properly. 4. On a monthly basis, the Maintenance Director/Designee will check random doors throughout the facility to ensure proper closure. This information will be entered on a log and will be presented at the quarterly QAPI meting	
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 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.	K 374		9/15/22

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K 374	Continued From page 16 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 8/8/22, in the presence of the Maintenance Director and Regional Plant Operations 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 10 sets of smoke barrier doors observed and was evidenced by the following: At 11:18 AM, the surveyor, Maintenance Director and Regional Plant Operations Director, observed the set of double smoke doors, by resident rooms E202 and E204, that when released from the electro-magnetic hold open device, 1 of 2 doors did not meet fully closed, due to a hardware issue, now leaving a gap approximately two inches. 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 findings were verified and confirmed by the Maintenance Director and Administrator during the observations. The Maintenance Director and Regional Plant Operations Director were informed of the findings at the Life Safety Code survey exit on 8/8/22. NFPA 101- 2012 edition Life Safety Code 19.3.7.6, 19.3.7.8, 19.3.7.9 NJAC 8:39-31.1(c), 31.2(e)	K 374	The provider submits the following Plan of Correction in good faith to comply with Federal Law. The Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies It is the practice of the facility to ensure corridor smoke doors seal when activated to close by the fire alarm. 1. Doors were repaired to allow for closure on August 17, 2022. 2. Doors throughout the facility were checked to allow for closure on August 17, 2022. 3. Education completed with Maintenance staff regarding monitoring doors to ensure they close and seal properly. 4. On a monthly basis, the Maintenance Director/Designee will check random doors throughout the facility to ensure that the doors close and seal properly. This information will be entered on a log and will be presented at the quarterly QAPI meeting	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		9/15/22

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K 511	Continued From page 17 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/8/22, in the presence of the Maintenance Director and Regional Plant Operation's Director, it was determined that the facility failed to maintain electrical panels free of obstructions that would delay access to the panels in an emergency. This deficient practice was evidenced by the following: 1. At 10:52 AM, the surveyor observed in the owner office suite, that combustible cardboard boxes filled with books were blocking electrical panel marked (PI). 2. At 11:10 AM, the surveyor observed in the second floor electrical room that two aluminum ladders were leaning on two-electrical panels. The surveyor interviewed the Maintenance Director and Regional Plant Operation's Director at the time of the observation, who acknowledged and agreed, that the electrical panel must be kept free of any obstructions that would delay shutting	K 511	The provider submits the following PLan of Correction in good faith to comply with Federal Law. The Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to ensure electrical panels are free from obstructions. 1. Electrical panels area was cleaned to allow for free and clear access on August 17, 2022. 2. Electrical panels throughout the facility were checked and are free and clear of obstructions on August 17, 2022. Education completed with the Maintenance staff regarding electrical panel areas to remain free and clear of obstructions.	

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K 511	Continued From page 18 breakers off in the event of an emergency. The Maintenance Director and Regional Plant Operations Director were informed of the deficiency at the Life Safety Code exit on 8/9/22. NJAC 8:39-31.2(e) NFPA 70	K 511	4. On a monthly basis, the Maintenance Director/Designee will check random electrical panels throughout the facility to ensure that the areas are free and clear of obstruction. The information will be entered on a log and will be presented at the quarterly QAPI meeting.	
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, interview, and record review on 8/4/22, it was determined that the facility failed to 1.) ensure that elevators' firefighters service was operated monthly with a written record for 4 of 4 elevator devices, in	K 531	The provider submits the following Plan of Correction in good faith to comply with Federal Law. The Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and	9/15/22

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K 531	Continued From page 19 accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. 2.) the facility failed to test and inspect 4 of 4 elevator's annually with the Authority Having Jurisdiction. This deficient practice was evidenced by the following: 1. During record review with the surveyor, Maintenance Director, and Regional Plant Operations Director on 8/4/22 at 12:50 PM, there was no documented evidence that 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 conformed 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.19.5.3, 9.4.2, 9.4.3. Device #1 Hydraulic Device #2 Hydraulic Device #3 Hydraulic Device #4 Vertical Platform Lift An interview was conducted with the Maintenance Director and Regional Plant Operations Director during the record review and they confirmed currently there is no firefighter's monthly service log. 2. A review of the facility's elevator inspection certificate revealed that 4 of 4 elevator devices, received their last annual inspection with the Department of Community Affairs (DCA) on 12/3/20 and was approved for use until 11/30/21 over 8-months from the expired date to the	K 531	conclusions stated in the statement of deficiencies It is the practice of the facility to ensure Phase 1 and Phase 2 operations of elevators and proper annual inspections from the Department of Community Affairs (DCA) 1. Phase 1 and Phase 2 log has been completed for August on August 17, 2022. The facility has tried on numerous occasions to receive annual inspections from DCA. However, DCA has advised the facility that they are short staffed and will inspect facility elevators when they have adequate staff. Quarterly maintenance is being provided by the facility's contracted elevator maintenance company. 2. Elevators throughout the facility have been inspected on August 17, 2022. 3. Education completed with Maintenance staff regarding reporting Phase 1 and Phase 2. 4. On a monthly basis, the Maintenance Director/Designee will perform Phase 1 and Phase 2 inspection. This information will be entered on a log and will be presented at the quarterly QAPI meeting.	

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K 531	Continued From page 20 current date of 8/9/22. In an interview, at 11:30 AM, the facility's Director of Maintenance and Regional Plant Operations Director, stated they would contact their elevator inspection company,to see why this inspection was not scheduled. The Regional Plant Operations Director was informed of this issue at the Life Safety Code exit conference on 8/9/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	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	K 918		9/15/22

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K 918	Continued From page 21 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 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 observations, interview, and review of facility documents on 8/4/22, it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was evidenced for 1 of 1 generator logs provided by the Maintenance Director by the following: On 8/4/22, a review of the generator records for the previous twelve months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently the Maintenance Director was performing a monthly load test, but he was not recording the required transfer times completely on the testing log. for 7 of 12 documented times. The current monthly dates observed on the provided log:	K 918	The provider submits the following Plan of Correction in good faith and to comply with Federal Law. The Plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to log transfer times during generator testing. 1. Transfer times for August generator testing has been completed on August 17, 2022. 2. A facility wide inspection has been completed on August 17, 2022. 3. Education completed with Maintenance staff regarding logging transfer times. 4. On a monthly basis, the Maintenance Director/Designee will check random	

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K 918	Continued From page 22 Dates: Transfer times: August 21 7-seconds September 21 7-seconds October 21 7-seconds November 21 7- seconds December 21 7-seconds January 22 0-seconds February 22 0-seconds March 22 0-seconds April 22 0-seconds May 22 0-seconds June 22 0-seconds July 22 0-seconds An interview was conducted with the Maintenance Director and Regional Plant Operations Director,where they confirmed 7 of 12 months did not have any documented transfer times. The Maintenance Director and Regional Plant Operations Director were informed of the finding at the LSC exit conference on 8/9/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918	areas of the facility to ensure proper generator testing and transfer times. This information will be entered on a log and presented at the quarterly QAPI meeting.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		9/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING **01, 02** B. WING _____	**08/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	**499 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(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 923	Continued From page 23 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet 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. Less than or equal to 300 cubic feet 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. 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." 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. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/8/22, it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping,	K 923	The provider submits the following Plan of Correction in good faith and to comply with Federal Law. The Plan is not an admission of wrongdoing, nor does it	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING **01, 02** B. WING _____	**08/09/2022**

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K 923	Continued From page 24 rupture and damage in accordance with NFPA 99. This deficient practice was identified for 1 of 8 portable oxygen cylinders and was evidenced by the following: At 11:38 AM, the surveyor observed in the physical therapy room directors office that 1 of 8 full portable oxygen cylinder's were freestanding and not protected against tipping, rupture and damage in accordance with NFPA 99. An interview was conducted with the Maintenance Director and Regional Operations Director, who both stated that the cylinders must be secured from tipping, rupture and damage at all times. The Maintenance Director and Regional Plant Operations Director were informed of the finding at the Life Safety Code exit conference on 8/8/22. NJAC 8:39-31.2(e) NFPA 99	K 923	reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to properly and safely store oxygen cylinders. 1. The oxygen cylinder in the physical therapy room that was freestanding was immediately removed. 2. A facility wide inspection has been completed on August 17, 2022. 3. Education completed with the Maintenance staff on August 17, 2022. 4. On a monthly basis, the Maintenance Director/Designee will check random areas of the facility to ensure proper storage of oxygen cylinders. This information will be entered on a log and will be presented at the quarterly QAPI meeting.	