STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**05/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(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 05/02/2023 and 05/03/2023 and Leisure Chateau 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Leisure Chateau is a Two-story, Type I Fire Resistant building that was built in January 1977. The facility is divided into 9 smoke zones. The facility has one 500 KW Diesel emergency generator.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 05/02/2023 and 05/03/2023 in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency lights above two (2) of two (2) emergency generator's transfer switch locations, 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 evidenced by the following:	K 291	1) On June 15, 2023 a battery backup emergency light was installed above the emergency generator switch in the basement level electrical/ boiler room and above the second emergency generator transfer switches (Main service and Future Vent Unit) located in the other basement level Boiler room. 2) All residents can be affected by this deficient practice	6/27/23

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

Electronically Signed | 06/02/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 291	Continued From page 1 On 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) whether the facility had an Emergency Generator. The Maintenance Director told the surveyor, "yes we have a 500 KW Diesel Generator." Starting at approximately 9:58 AM on 05/02/2023 in the presence of the facility's MD, a tour of the facility was conducted. During the tour, the surveyor observed the following: 1) At approximately 10:22 AM, an inspection in the basement level electrical/ boiler room area identified one (1) emergency generator transfer switch. The surveyor observed no evidence of a battery back up emergency light for the generator transfer switch. At this time, the MD told the surveyor, "We have the battery back up emergency lights, we have not installed them yet." 2) At approximately 10:31 AM, an inspection inside a second basement level Boiler room identified two (2) emergency generator transfer switches (Main service and Future Vent Unit). The surveyor observed no evidence of a battery back up emergency light for the two transfer switches. The MD confirmed the findings at the time of observation. On 05/03/2023 during the survey exit at approximately 1:05 PM, the surveyor informed the Administrator of the deficiency.	K 291	3) On June 23, 2023 the administrator inserviced the maintenance director and on June 26, 2023 The maintenance director inserviced the entire maintenance department about the requirement of installing and maintaining the emergency backup lights in these locations. 4) the Maintenance Director or his designee will audit monthly for 6 months to make sure that the lights are in place and functioning and submit his findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting for the 3rd and 4th quarters of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 291	Continued From page 2 NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 05/02/2023 and 05/03/2023 in the presence of facility management, it was determined that the facility failed to 1.) provide six (6) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door and 2.) maintain three (3) illuminated exit signs in proper working order. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants.	K 293	1) On June 15, 2023 a certified electrician, "affiliated electric" installed new Exit signs that are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system in the following locatons: a. inside the exit stairwell next to the basement level Medical records storage area. b. on the basement level next to the boiler room, where the corridor makes two 90 degree turns, two (2) illuminated exit signs with direction arrows to identify the exit access route will be installed c. in the "Small" enclosed outside courtyard two (2) illuminated exit signs.	6/27/23

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K 293	Continued From page 3 NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code. 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) 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	K 293	One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. d. in the "Large" enclosed outside courtyard two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. e. inside the Administrative Office corridor, two (2) illuminated exit signs. 2) all residents can be affected by this deficient practice 3) On June 23, 2023 The administrator onducted an inservice with the maintenance director and on June 26, 2023 the Maintenance Director inserviced the entire maintenance department about the illuminated exit signs requirement & to stress the importance of compliance with exit signs. 4) The maintenance director or his designee will conduct a monthly audit for 6 months of all exit signs to ensure complaince and submit results of the audits to the Administrator on a aquarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting for the 3rd and 4th quarters of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 293	Continued From page 4 the facility as a two-story building with a basement. There are two enclosed (surrounded by the building) center courtyards. Starting at approximately 9:58 AM on 05/02/2023 and continued on 05/03/2023 in the presence of the facility's MD, a tour of the facility was conducted. Along the two (2) day tour, the surveyor observed six (6) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit and failed to maintain three (3) illuminated exit signs in proper working condition in the following locations. On 05/02/2023: 1) At approximately 10:15 AM, inside the exit stairwell next to the basement level Medical records storage area, one (1) illuminated exit sign was not illuminated. 2) At approximately 10:52 AM, on the basement level next to the boiler room, where the corridor makes two 90 degree turns, the facility failed to have two (2) illuminated exit signs with direction arrows to identify the exit access route. On 05/03/2023: 3) At approximately 10:53 AM, the surveyor observed in the "Small" enclosed outside courtyard that the facility failed to have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit.	K 293		

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K 293	Continued From page 5 2. At approximately 11:19 AM, the surveyor observed in the "Large" enclosed outside courtyard that the facility failed to have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. 3. At approximately 12:02 PM, the surveyor observed inside the Administrative Office corridor, two (2) illuminated exit signs were not illuminated. The MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c)	K 293		
K 311 SS=F	NFPA Life Safety Code 101 2012 -7.7 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.	K 311		7/7/23

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K 311	Continued From page 6 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 05/02/2023 and 05/03/2023, in the presence of facility Management it was determined that the facility failed to ensure that 5 of 8 exit access stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction. This was evidenced by the following: On 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) 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 the facility as a two-story building with a basement. There are three (3) exit stairways. Starting at approximately 9:58 AM on 05/02/2023 and continued on 05/03/2023 in the presence of the facility's MD, a tour of the facility was conducted. Along the two (2) day tour, the surveyor performed a closure test of eight (8) corridor exit access doors leading into exit stairways with the following results. On 05/02/2023:	K 311	Leisure Chateau will continue to ensure 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. To address survey concerns we will do the following: 1) The corridor doors on the second floor by rooms, 125, 110, recreation/smoke room area and on the first floor by rooms 91 and room 78 will be configured to be latched even at such times that the magnetic lock is released. 2) all residents can be affected by this deficient practice 3) the administrator in-serviced the maintenance director, the maintenance director inserviced the entire maintanance department about vertical openings being secured with a latching device on June 26, 2023. 4) the maintenance director or his/her designee will audit all vertical openings between floors monthly for 3 months for	

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K 311	Continued From page 7 1. At approximately 11:13 AM, during a closure test of the second (2nd.) floor stairway (next to Resident room #125) corridor exit access door, the door did not positively latch into its frame. The surveyor observed the door had no means to positively latch into its frame. 2. At approximately 11:30 AM, during a closure test of the second (2nd.) floor stairway (next to Resident room #110) corridor exit access door, the door did not positively latch into its frame. The surveyor observed the door had no means to positively latch into its frame. 3. At approximately 11:38 AM, during a closure test of the second (2nd.) floor Recreation room stairway exit access door, the door did not positively latch into its frame. The surveyor observed the door had no means to positively latch into its frame. On 05/03/2023: 4. At approximately 9:55 AM, during a closure test of the first (1st.) floor stairway (next to Resident room #91) corridor exit access door, the door did not positively latch into its frame. The surveyor observed the door had no means to positively latch into its frame. 5. At approximately 10:17 AM, during a closure test of the first (1st.) floor stairway (next to Resident room #78) corridor exit access door, the door did not positively latch into its frame.	K 311	compliance and will report findings to the Administrator. The Administrator will submit audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 311	Continued From page 8 The surveyor observed the door had no means to positively latch into its frame. The stairwell doors would need to positively 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 MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		6/27/23

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K 321	Continued From page 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 on 05/02/2023 and 05/03/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions 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 practiced was evidenced by the following: On 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) 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 the facility as a two-story building with a basement.	K 321	1) A self closing device was installed on the corridor door leading into the Medical Records storage room on the California Unit on June 1, 2023. 2) all residents can be affected by this deficient practice 3) On June 15, 2023, the assistant administrator together with the Maintenance Director conducted a review of all hazardous areas to ensure that they 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 will be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors will be checked that they are self-closing or automatic-closing.	

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K 321	Continued From page 10 Starting at approximately 9:58 AM on 05/02/2023 and continued on 05/03/2023 in the presence of the facility's MD, a tour of the facility was conducted. Along the two (2) day tour of the facility the surveyor observed the following hazardous area that failed to have smoke resisting doors. 1) On 05/03/2023 at approximately 11:35 AM, an inspection of the Medical records storage room was performed. During a closure test of the corridor door leading into the Medical Records storage room, the door did not self-close into its frame. The surveyor observed evidence that the corridor door leading into the room had no means to self-close. The surveyor observed 6 filing cabinet filled with combustible medical records and multiple combustible paper medical records around the room. At this time, the surveyor recorded the measurements of the room. The room was seven feet six inches by sixteen feet (120 square feet) which is larger than 50 square feet. With this corridor door not self-closing, this would allow fire, smoke, and poisonous gases to pass into the exit access corridor in the event of a fire. The MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. NJAC 8:39-31.2 (e)	K 321	On June 23, 2023, the administrator inserviced the Maintenance Director and on June 26, 2023 the Maintenance Director Inserviced the entire maintenance department about the protection of hazardous areas with a fire barrier and that doors must be self or automatic closing and that the self or auto Closure device must be in working order. 4) the maintenance director will conduct an audit on a monthly basis x 6 months of the self or auto closing doors for compliance and will submit results to the administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly QAPI committee meeting for the 3RD & 4TH quarters of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 321	Continued From page 11	K 321		
	Life Safety Code 101			
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. 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 05/02/2023 and 05/03/2023, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 2 of 2 outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following:	K 341	Leisure Chateau will continue to ensure that A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. To address survey concerns, Leisure Chateau will do the following:	6/27/23

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	315190	A. BUILDING **01** B. WING _____	**05/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(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 341	Continued From page 12 On 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) 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 the facility as a two-story building with a basement. There are two (2) outside enclosed (surrounded by the building) center courtyards in the facility. Starting at approximately 9:58 AM on 05/02/2023 and continued on 05/03/2023 in the presence of the facility's MD, a tour of the facility was conducted. On 05/03/2023 (day 2 of survey), the surveyor observed the following: 1. At approximately 10:53 AM, the surveyor observed in the "Small" enclosed outside courtyard that the facility failed to have an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the buildings fire alarm system. At this time, the surveyor asked the MD whether the facility had an audio and visual alarm tied into the buildings fire alarm system. The MD looked around and told the surveyor, "no". 2. At approximately 11:19 AM, the surveyor observed in the "Large" enclosed outside courtyard that the facility failed to have an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the buildings fire alarm system.	K 341	1) On June 15, 2023 An audio/visual alarm was installed in both the "small" and "large" courtyards by a certified electrician with experience in Fire alarms "Affiliated Electrical" to notify Resident, Staff and Visitors of an activation of the buildings fire alarm system on. 2) All residents can be affected by this deficient practice 3) The administrator inserviced the Maintenance Director and the maintenance director inserviced the Entire Maintenance Department on June 26, 2023 about the requirement to provide fire alarm notification by audible and visible signals in all areas in the building which includes the courtyards. 4) The Maintenance Director or his designee will audit the placement of the Audio/Visual Probes monthly for 3 months and report same to the Administrator for a review at the 3rd Quarterly QAPI meeting of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 341	Continued From page 13 At this time, the surveyor asked the MD whether the facility had an audio and visual alarm tied into the buildings fire alarm system. The MD looked around and told the surveyor, "no". The MD confirmed the findings at the time of observation. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341		
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	K 351		6/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 351	Continued From page 14 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 review of facility provided documentation on 05/02/2023 and 05/03/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, 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 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) 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 the facility as a two-story building with a basement. Starting at approximately 9:58 AM on 05/02/2023 and continued on 05/03/2023 in the presence of the facility's MD, a tour of the facility was conducted. Along the two (2) day tour, the surveyor observed the following locations that	K 351	Leisure Chateau will ensure that the nursing is continuposly protected with a properly installed sprinkler system as required. To Address survey concerns, the facility will do the following: 1) all ceiling tiles that were missing have been replaced. this refers to the basement level elevator mechanical room, basement level Medical records storage room, basement level Kitchen storage room basement level Electrical room, basement level Employee break room by laundry. 2) All residents can be affected by this deficient practice 3) On June 23, 2023 The administrator in-serviced the Maintenance Director and on June 26, 2023 the Maintenance Dirctor inserviced the entire Maintenance Department about the requirement of proper sprnkler installation and the importance of ensuring that all ceiling tiles are in place. 4) The maintenance director or his designee will conduct monthly audits for 6 months to ensure compliance and will submit findings to the Administrator on a quarterly basis. The administrator will submit the audit results to the Quarterly	

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K 351	Continued From page 15 failed to provide proper fire sprinkler coverage: On 05/02/2023, 1) At approximately 10:01 AM, inside the basement level elevator mechanical room, the drop ceiling was missing one 2' by 2' ceiling tile from the grid. 2) At approximately 10:05 AM, inside the basement level Kitchen storage room, the drop ceiling was missing two (2) ceiling tiles from the grid. 3) At approximately 10:29 AM, inside the basement level Medical records storage room, the drop ceiling was missing three (3) ceiling tiles from the grid. 4) At approximately 10:36 AM, inside the basement level Electrical room, the drop ceiling was missing one (1) 2' by 4' ceiling tile from the grid. 5) At approximately 10:47 AM, inside the basement level Employee break room, the drop ceiling was missing four (4) ceiling tiles from the grid. With the opening in the ceilings, in the event of a fire, the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system. The MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM.	K 351	QAPI committee meeting for the 3rd and 4th quarters of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 351	Continued From page 16 Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) 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 observations on 05/02/2023 and 05/03/2023 in the presence of facility management, it was determined that the facility failed to 1.) Install portable fire extinguishers with-in the required height for 14 of 42 fire extinguishers, as required by National Fire Protection Association as required by 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, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire	K 355	Leisure Chateau Care & Rehabilitation Center will continue to ensure that Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. To address survey concerns the facility will do the following: 1) all fire extinguishers have been situated and measured to ensure that they are situated where the height of the fire extinguisher is no higher than 5 feet from the floor to the center of the pressure indicating needle. 2) all residents can be affected by this deficient practice 3) On June 23, 2023 the Administrator in-serviced the maintenance director and	7/7/23

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K 355	Continued From page 17 extinguisher and the floor be less than 4 inches. During the building tour on 05/02/2023 and 05/03/2023 in the presence of the facility's Maintenance Director (MD), the surveyor observed and inspected Forty Two (42) portable fire extinguishers in various locations with the following: On 05/02/2023, 1) At approximately 10:36 AM, one (1) ABC Type fire extinguisher in the basement level corridor next to a stairwell was observed. This fire extinguisher appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 5" to the center of the pressure indicating needle. 2) At approximately 11:30 AM, one (1) ABC type portable fire extinguishers on the 2nd. floor near the clean linen room was observed. The surveyor measured and recorded was mounted 5'- 2-1/2" to the center of the pressure indicating needle. 3) At approximately 11:37 AM, one (1) ABC type portable fire extinguisher on the 2nd. floor outside Resident smoking area was observed. The surveyor measured and recorded was mounted 5'- 7-1/2" to the center of the pressure indicating needle. 4) At approximately 11:39 AM, one (1) ABC type portable fire extinguisher in the 2nd. floor recreation room was observed. The surveyor measured and recorded was mounted 5'- 6" to the center of the pressure indicating needle.	K 355	on June 26, 2023 the maintenance director inserviced the entire maintenance department about the requirement that fire extinguishers are situated where the height of the fire extinguishe is no higher than 5 feet from the floor to the center of the pressure indicating needle. 4)The maintenance director or his/her designee will conduct monthly audits for 3 months to ensure compliance and will submit findings to the Administrator on a quarterly basis. The administrator will report the audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 355	Continued From page 18 5) At approximately 11:50 AM, one (1) ABC type portable fire extinguisher on the 2nd. floor near the Environmental Services Directors office was observed. The surveyor measured and recorded was mounted 5'- 3" to the center of the pressure indicating needle. 6) At approximately 12:05 PM, one (1) ABC type portable fire extinguisher near the 2nd. floor sensory room was observed. The surveyor measured and recorded was mounted 5'- 4" to the center of the pressure indicating needle. 7) At approximately 12:10 PM, one (1) ABC type portable fire extinguisher on the second floor near Resident room #121 was observed. The surveyor measured and recorded was mounted 5'- 3" to the center of the pressure indicating needle. On 05/03/2023, 8) At approximately 10:22 AM, one (1) ABC type portable fire extinguisher on the first floor near Day room was observed. The surveyor measured and recorded was mounted 5'- 3-3/4" to the center of the pressure indicating needle. 9) At approximately 10:42 AM, one (1) ABC type portable fire extinguisher inside the first floor elevator mechanical room was observed. The surveyor measured and recorded was mounted 5'- 2-1/2" to the center of the pressure indicating needle. 10) At approximately 11:11 AM, one (1) ABC type portable fire extinguisher at the Florida Nursing station was observed. The surveyor measured and recorded was mounted 5'- 10-1/2"	K 355		

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K 355	Continued From page 19 to the center of the pressure indicating needle. 11) At approximately 12:05 PM, in the first floor Activity room two (2) ABC type fire extinguishers was observed. The surveyor measured and recorded one (1) was mounted 5'- 4" to the center of the pressure indicating needle and one (1) was mounted 5'- 3-1/2" to the center of the pressure indicating needle. 12) At approximately 12:05 PM, in the first floor Residents Dining room, two (2)ABC type fire extinguishers were observed. The surveyor measured and recorded one (1) was mounted 5'- 10" to the center of the pressure indicating needle and one (1) was mounted 5'- 5-1/2" to the center of the pressure indicating needle. The MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363		6/30/23

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K 363	Continued From page 20 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 on 05/02/2023 and 05/03/2023, in the presence of facility management it was determined that the facility failed to ensure that 2 of 26 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition,	K 363	1)a. Leisure Chateau maintenance department eliminated the 1/2 inch gap along the top of the edge of the corridor door on the second floor room # 123. b. Leisure Chateau maintenance department eliminated the 1/2 inch gap along the door frames latching side lower	

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K 363	Continued From page 21 Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following: On 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) 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 the facility as a two-story building with a basement. There are 117 resident sleeping rooms on the 1st. and 2nd. floors. Starting at approximately 9:58 AM on 05/02/2023 and continued on 05/03/2023 in the presence of the facility's MD, a tour of the facility was performed. During the tour, the surveyor performed closure tests of the twenty six (26) doors in the corridors with the following results: On 05/02/2023 1) At approximately 11:17 AM, on the 2nd. floor resident room #123, during a closure test of the corridor door, there was a 1/2 gap along the top edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. Review of facility posted emergency evacuation diagram identify that you would need to pass resident room #123 as the primary and/ or secondary exit access route to reach an exit. 2) At approximately 12:05 PM, on the second	K 363	edge of the corridor door on the second floor supply room. 2) All residents can be affected by this deficient practice 3) On June 23, 2023 The Administrator in-serviced the Maintenance Director and on June 26, 2023 the Maintenance Director inserviced the entire Maintenance department about the requirement that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. 4) The maintenance director or his designee will conduct monthly audits for 6 months to ensure compliance and will submit findings to the Administrator on a quarterly basis. The administrator will report the audit results to the Quarterly QAPI committee meeting for the 3rd and 4th quarters of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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K 363	Continued From page 22 floor supply room, during a closure test the surveyor observed an approximately 1/2 gap along the door frames latching side lower edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. 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 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. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 374		6/27/23

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	315190	A. BUILDING **01** B. WING _____	**05/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

(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 374	Continued From page 23 Based on observations and review of facility provided documentation on 05/02/2023 and 05/03/2023, 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 11 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 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) 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 the facility as a two-story building with a basement. There are nine (9) smoke zones. Starting at approximately 9:58 AM on 05/02/2023 and continued on 05/03/2023 in the presence of the facility's MD, a tour of the facility was conducted. Along the two (2) day tour, the surveyor performed a closure test of ten (10) sets of double smoke doors in the corridors with the following results: 1) On 05/02/2023 at approximately 11:21 AM, on the second floor between Resident rooms #116 and #117 during a closure test of the double	K 374	Leisure Chateau Care & Rehabilitation Ceneter will continue to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. To address survey concerns the facility will do the following: 1) a. the 1/2 inch wide by 8 inch high gap along the meeting edge of the smoke barrier doors between rooms #116 and #117 was eliminated on June 12, 2023. b. the reference of room 195 should be corrected to room 105. the 40 inch opening at the double smoke doors in the corridor between resident room 105 and the day room when the doors were released from the magnetic hold open device and allowed to self close into their frame was eliminated. A new door closer device was installed on June 12, 2023. 2) all residents can be affected by this deficient practice. 3) On June 23, 2023 The administrator in-serviced the maintenance director and On June 26, 2023 the maintenance director inserviced the entire maintenance department about the requirement to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. 4) The maintenance director or his designee will conduct monthly audits for 6 months to ensure compliance and will submit findings to the Administrator on a quarterly basis. The administrator will report the audit results to the Quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**05/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

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K 374	Continued From page 24 smoke doors in the corridor when the doors were released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measured a 1/2 inch wide by 8 inch high gap along the meeting edge of the doors. This test was repeated two additional times with the same results. 2) On 05/02/2023 at approximately 11:42 AM, on the second floor between Resident room #195 and the day room during a closure test of the double smoke doors in the corridor when the doors were released from the magnetic hold open device and allowed to self close into their frame, one smoke door did not close into its frame. The surveyor observed an approximately 40 inch opening. This test was repeated two additional times with 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 MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. N.B. 8:39-31.1(c), 31.2(e)	K 374	QAPI committee meeting for the 3rd and 4th quarters of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC	K 521		6/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**05/12/2023**

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LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

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K 521	Continued From page 25 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 03/08/2023 and 03/09/2023 in the presence of facility management, it was determined that the facility failed to: 1) Ensure that the facility's ventilation systems were being properly maintained for 3 of 13 Resident bathroom exhaust systems. 2) Provide a bathroom exhaust system for 2 Resident bathrooms, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) 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 the facility as a two-story building with a basement. There are 125 Resident sleeping rooms.	K 521	Leisure Chateau Care & Rehabilitation Center will continue to ensure that Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. To address survey concerns the facility will do the following: 1) a. The ventilation system in Resident Bathroom in Rooms 90, room 85 and in the soiled utility room have have been repaired. The belt on the roof has been replaced. b. a ventilation system has been installed in the 2 bathrooms inside the physical therpay department 2) all residents can be affeceted by this deficie3nt practice 3) On June 23, 2023 The administrator in-serviced the maintenance director and on June 26,2023 The Maintenance Director inserviced the entire Maintenance Department department about the requirement that Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**05/12/2023**

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K 521	Continued From page 26 Starting at approximately 9:58 AM on 05/02/2023 and continued on 05/03/2023 in the presence of the facility's MD, a tour of the facility was conducted. Along the two (2) day tour, the surveyor inspected thirteen (13) Resident sleeping room bathrooms and other storage areas. 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 3 of 13 resident bathrooms in the following locations: On 05/03/2023 1) At approximately 10:07 AM, inside Resident room #90 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the MD that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2) At approximately 10:09 AM, inside Resident room #85 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the MD that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3) At approximately 10:36 AM, inside the first floor soiled linen room, when the rooms exhaust	K 521	manufacturer's specifications. 4) The maintenance director or his designee will conduct monthly audits for 3 months to ensure compliance and will submit findings to the Administrator on a quarterly basis. The administrator will report the audit results to the Quarterly QAPI committee meeting. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

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	315190	A. BUILDING **01** B. WING _____	**05/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

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K 521	Continued From page 27 system was tested did not function properly. At this time, the surveyor informed the MD that the exhaust system did not function properly. This soiled linen room had no window with an area that would open. This bathroom would rely on mechanical ventilation. 4) At approximately 12:21 PM, during an inspection inside the Physical Therapy Department area, the surveyor inspected two (2) Resident bathrooms. There was no evidence of an exhaust system in the two (2) bathrooms. The surveyor asked the MD, whether the facility had an exhaust system in the bathrooms. The MD looked inside both bathrooms and said, " no". The bathrooms had no windows with an area that would open and would rely on mechanical ventilation. The MD confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that	K 911		6/7/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 911	Continued From page 28 are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 05/02/2023 and 05/03/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 5 electrical outlets located next to a water source (with-in 6 feet) was equipped with safe and secured Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) 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 the facility as a two-story building with a basement. Starting at approximately 9:58 AM on 05/02/2023 and continued on 05/03/2023 in the presence of the facility's MD, a tour of the facility was conducted. During the building tour, the surveyor observed and tested five (5) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: 1) On 05/02/2023 at approximately 11:35 AM,	K 911	Leisure Chateau Care & Rehabilitation Center will continue to ensure that all electrical outlets located next to a water source (with-in 6 feet) is equipped with safe and secured Ground-Fault Circuit Interrupter (GFCI) protection. To Address survey concerns the facility will do the following: 1) The one (1) Duplex electrical electrical outlet located 32 inches to the right of the sink in the second floor Recreation room was replaced and tested to ensure that it did in fact de-energize as required by code. 2) all residents can be affected by this deficient practice 3) the administrator In-Serviced the maintenance department about the requirement to ensure that all electrical outlets located next to a water source (with-in 6 feet) is equipped with safe and secured Ground-Fault Circuit Interrupter (GFCI) protection. 4) The maintenance director or his designee will conduct monthly audits for 6 months to ensure compliance and will submit findings to the Administrator on a quarterly basis. The administrator will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	**962 RIVER AVE** **LAKEWOOD, NJ 08701**

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K 911	Continued From page 29 the surveyor observed in the second floor Recreation room, one (1) Duplex electrical electrical outlet located 32 inches to the right of the sink. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did de-energize as required by code. The Maintenance Director confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	report the audit results to the Quarterly QAPI committee meeting for the 3rd and 4th quarters of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	
K 918 SS=E	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	K 918		6/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. BUILDING **01** B. WING _____	**05/12/2023**

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K 918	Continued From page 30 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 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 interview, document review and facility policy review on 05/02/2023 and 05/03/2023, it was determined the facility failed to: - exercise the emergency generator 12 times each year for at least 30 minutes in 20- to 40-day intervals; and - document the time needed by the generator to transfer power to the building was within the 10-second time frame, accordance National Fire Protection Association (NFPA) 99 and 110. This deficient practice was evidenced by the following: On 05/02/2023 (day one of survey) during the survey entrance at approximately 9:36 AM, a request was made to the Maintenance Director (MD) whether the facility had an emergency generator, and how often do they run the generator.	K 918	1) The Administrator reviewed the October and November 2022 generator testing documentation with the maintenance director and in fact the transfer of power within 10 seconds was not documented. The Maintenance person who was responsible for the testing and documentation of the transfer of power within 10 seconds in 2022 is no longer employed at Leisure Chateau. A review of subsequent Testing and Documentation revealed that the facility was compliant. 2) all residents can be affected by this deficient practice 3) On June 23, 2023 The administrator in-serviced the maintenance director and on June 26, 2023, the mainenace director	

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K 918	Continued From page 31 The MD told the surveyor, "yes we have a 500 KW diesel emergency generator, we run it weekly and run it under load for 30 minutes monthly." The surveyor asked the MD does the facility document the load test and if they do can the facility provide the log for the previous 12 months. Review of a facility policy titled, "Emergency Alternate Energy Policy," reads in part,"The generator is inspected and run weekly. It is tested under load monthly. All inspections and load tests are performed as per the requirements of NFPA 110." A review of the "Emergency Generator Inspection Monthly Log" for the previous 12 months indicated there was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load test was conducted for October and November 2022. The MD acknowledged the findings at the time of observation. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/03/2023 at approximately 1:05 PM. NJAC 8:39-31.2(g)	K 918	inserviced the entire maintenance department about the requirement to exercise the emergency generator 12 times each year for at least 30 minutes in 20- to 40-day intervals; and document the time needed by the generator to transfer power to the building was within the 10-second time frame, accordance National Fire Protection Association (NFPA) 99 and 110. 4) The Administrator or his designee will conduct monthly audits of the generator testing documentation for 6 months to ensure compliance and will submit the audit results to the Quarterly QAPI committee meeting for the 3rd and 4th quarters of 2023. Based on the results of these audits, a decision will be made regarding any adjustments and the need for continued submission and reporting.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315190 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE CHATEAU REHABILITATION	962 RIVER AVE LAKEWOOD, NJ 08701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	06/27/2023	LSC K0293	06/27/2023	LSC K0311	07/07/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	06/27/2023	LSC K0341	06/27/2023	LSC K0351	06/27/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	07/07/2023	LSC K0363	06/30/2023	LSC K0374	06/27/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	06/27/2023	LSC K0911	06/07/2023	LSC K0918	06/27/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO