STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. BUILDING **01** B. WING _____	**02/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	**527 RIVER AVENUE** **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 The nursing home building construction was stated to be 90's with no current major renovations or noted additions. It is a one- story building Type II (000) unprotected construction with no basement and is fully sprinklered. The inside 54 KW natural gas generator does approximately 60% of the building. The building has 7-smoke zones and an updated fire alarm system. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life 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 123 certified beds. At the time of the survey the census was 100. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222	Egress Doors	K 222		2/27/23

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

Electronically Signed | 03/08/2023

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K 222 SS=F	Continued From page 1 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 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	K 222		

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K 222	Continued From page 2 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 on 02/23/2023, it was determined that the facility failed to ensure that exit doors locked with a delayed egress device were provided with instructional signage as per the requirements of NFPA 101:2012 - Chapter 7.2.1.6.1.1(4). This deficient practice was identified in 5 of 5 egress doors and evidenced by the following: From approximately 9:30 AM to 1:45 PM, the Surveyor and Maintenance Director (MD), observed that 5 of 5 the exit/egress fire door's in the facility were not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door's opened in 15-seconds	K 222	1. All exit/egress doors now have visible signs reading "Push until the alarm sounds, door can be opened in 15 seconds" posted. 2. An audit was completed with all exit/egress doors in the facility to ensure proper visible signs with the correct verbiage are posted by each door. All residents have the potential to be affected by the deficient practice. Maintenance Director was in-serviced regarding proper visible signs and verbiage by all exit/egress doors in facility. 3. Administrator or designee will make	

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K 222	Continued From page 3 and the MD indicated the doors opened with the activation of the fire alarm. The Maintenance Director, confirmed the findings at the time of the observations. The Administrator was informed of these findings during the Life Safety Code survey exit conference on 02/23/2023. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222	weekly rounds for the next 6 months to ensure correct signs are posted by all exit/egress doors. Administrator will share his findings quarterly with QAPI committee.	
K 321 SS=F	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)	K 321		3/29/23

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K 321	Continued From page 4 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 02/23/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled 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 identified in 6 of 18 hazardous area storage room doors and was evidenced by the following: 1). At 1:40 PM, the Personal Protective Equipment storage room was observed to have approximately 100 plus combustible cardboard boxes, greater than 50 square feet in size and requires an auto close device installed on the door. 2). At 11:49 AM, the kitchen door was observed with a 90 minute fire rating label, but the wooden door was compromised with two 1/2" holes through the door. 3). At 11:54 AM, the right-side kitchen door was observed with a rated 45 minute fire rating label, but the top of the wooden door was compromised with four 1/4" holes through the door and when the door was opened, it remained open due to the	K 321	K321 1.Auto close device was installed on PPE room door. Holes on kitchen door were filled with fire barrier caulk. Kitchen and storage room Door no longer stick to the floor as obstruction underneath was removed. Hardware(door knob assembly) has been added to the wooden laundry door. Door actuator in service corridor wooden doors has been fixed and doors have been replaced so doors can close properly. 2. An audit was completed throughout the facility to ensure all doors have the required fire resistance rating, are free from any holes and close properly. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding required fire resistance ratings for all doors, to be free of holes and close properly.	

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K 321	Continued From page 5 door sticking to the floor. 4). At 11:58 AM, the general storage room was observed to have 2-doors, 1 of the 2 doors remained open due to the door sticking to the floor. 5). At 12:04 PM, the wooden laundry room door was missing hardware (door knob assembly) leaving an approximately 4" opening through the door. 6). At 12:10 PM, the service corridor set of wooden doors would not close properly, due to the door actuator (the component in any machine that enables movement) not functioning properly. The Maintenance Director confirmed the finding's during the observations. The Administrator was informed of the finding's at the Life Safety exit conference on 02/23/2023. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321	4. Administrator or designee will make weekly rounds for the next 6 months to ensure all doors have correct fire resistance rating, are free of holes and close properly. Administrator will share his findings quarterly with QAPI committee.	
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,	K 341		3/31/23

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K 341	Continued From page 6 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 and interview on 02/23/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 3 of 3 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: From approximately 9:30 AM. to 1:30 PM. the surveyor and the MD, observed in the enclosed courtyards, no evidence of a fire alarm notification (horn/strobe) device in the following enclosed courtyards: 1). Buckingham 2). Fountain 3). Fireside An interview was conducted during the observation's and the surveyor asked the MD, if there was a horn/strobe, tied into the fire alarm system within court yard's: (Buckingham, Fountain and Fireside). The MD confirmed that currently there are no horn/strobe devices tied	K 341	1. Horn/Strobes for all 3 enclosed courtyards have been ordered and to be installed by March 31. 2. An audit was completed in all 3 enclosed courtyards to ensure proper fire alarm notification devices are placed there. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding the requirement of proper fire alarm notification devices in all enclosed courtyards. 4. Administrator or designee will make weekly rounds of all 3 enclosed courtyards for the next 6 months to ensure fire alarm notification devices are properly installed and working. Administrator will share his findings quarterly with QAPI committee.	

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K 341	Continued From page 7 into the fire alarm system in the enclosed courtyard's observed. The Administrator was notified of the findings at the Life Safety Code exit conference on 02/23/2023. 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 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview and document review on 02/22/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to conduct in-house fire drills with varying activation types and specific simulation of emergency fire conditions and predictable times, in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was evidenced by the following:	K 712	1. Fire drill was conducted to specify the simulation of the emergency fire conditions. 2. An audit was conducted to note that nature of emergencies are specified and that times of emergency drills vary according to the regulation. All residents have the potential to be affected by the deficient practice.	3/22/23

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K 712	Continued From page 8 The facility fire drill reports revealed method for the simulation of emergency fire conditions for 6 of 12 drills, were not documented: Date: Type of alarm transmission: Pull, Smoke or Page Shift: 7-3 3-11 11-7 - 02/13/23 Type: N/A 04:52 PM - 01/16/23 Type: pull 12:49 PM - 12/05/22 Type: N/A 12:58 AM - 11/21/22 Type: pull 07:55 PM - 10/18/22 Type: smoke 01:09 PM - 09/14/22 Type: N/A 02:01 AM - 08/28/22 Type: smoke 04:55 PM - 07/12/22 Type: smoke 01:10 PM - 06/09/22 Type: N/A 01:44 AM - 05/06/22 Type: pull 04:42 PM - 04/14/22 Type: N/A 11:10 AM - 03/07/22 Type: N/A 02:20 AM 7-3 shift 3 of 4 drills within 1-hour 3-11 shift 3 of 4 drills within 1-hour 11-7 shift 3 of 4 drills within 1-hour The fire drills had identified locations, but were not specific as to what caused the simulation of emergency fire conditions. The MD confirmed the time's were to close for 3 of 3 shifts completed and indicated the simulation of emergency fire conditions were not specific in the identified areas on the reports.	K 712	3. In service conducted with Maintenance Director to ensure emergency drills occur at the appropriate times, frequencies and conditions to be included and noted for each drill. Contracted fire safety vendor notified to ensure to include these considerations when scheduling and conducting future drills. 4. On a quarterly basis, Administrator or designee will review the fire drills to ensure the times of the drill are appropriate and the conditions are specified. Administrator will share his findings quarterly with the QAPI committee.	

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K 712	Continued From page 9 The Administrator was informed of the finding at the Life Safety Code exit conference on 02/23/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by:	K 741		2/27/23

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K 741	Continued From page 10 Based on observation and interview on 2/23/2023, in the presence of the Maintenance Director (MD) and Administrator (ADM), the facility failed to maintain smoking areas in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. This deficient practice was identified for 2 of 2 smoking areas observed and was evidenced by the following: 1). From approximately 9:30 AM. to1:45 PM., the Surveyor and Maintenance Director observed in the Buckingham smoking enclosed courtyard that 100 plus cigarette butts were in dried leaves and mulch. The area included 1-approved astray for the disposal of cigarette butts. There was no approved self-closing covered metal container in the area for the disposal of cigarette butts and ashes from the approved astray. A plastic composite garbage can was observed to have combustible paper cups, paper plates and various combustible items, including many cigarette butts. 2). From approximately 9:30 AM. to 1:45 PM., the Surveyor and Maintenance Director observed in the Fireside smoking enclosed courtyard that 100 plus cigarette butts were in dried leaves and mulch. The area included 1-approved astray for the disposal of cigarette butts. There was no approved self-closing covered metal container in the area for the disposal of cigarette butts and ashes from the approved astray. A plastic composite garbage can was observed to have combustible paper cups, paper plates and various combustible items, including many cigarette butts. The MD confirmed the finding's during the observations. No further documentation was provided.	K 741	1.All cigarette butts have been cleared and disposed of. A self closing metal container is in every courtyard now. 2. An audit was completed in all courtyards to ensure no cigarette butts are in leaves or mulch and that there are self closing metal containers in all courtyards. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding need to have all courtyards clean of cigarette butts and self closing metal containers to be placed in each courtyard. 4. Administrator or designee will make weekly rounds for the next 6 months to ensure all courtyards are clean from cigarette butts and that self closing metal containers are present. Administrator will share his findings quarterly with QAPI committee.	

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K 741	Continued From page 11 The Administrator was informed of the finding's at the Life Safety Code exit conference on 2/23/2023. NJAC 8:39-31.2(e)	K 741		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 2/23/2023, in the presence of the Maintenance Director (MD), the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. for 1 of 1 generator's. This deficient practice was evidenced by the following: On 2/23/2023 at 12:05 PM, the surveyor and MD reviewed all the facility's generator documentation. The facility currently has an interior 54 KW (kilowatt) natural gas generator. The MD could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all of the	K 911	1. Gas company will provide us a copy of documented reliability letter. 2. An audit was done to ensure there is a documented reliability letter from the natural gas provider for the natural gas generator. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding need for documented reliability letter from the natural gas provider for the natural gas generator. 4. Administrator or designee will inspect quarterly for the next year to ensure documented reliability letter from natural gas provider is in Life Safety binder. Administrator will share his findings quarterly with QAPI committee.	3/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. BUILDING **01** B. WING _____	**02/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	**527 RIVER AVENUE** **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 911	Continued From page 12 following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The MD confirmed there was no reliability letter available from the natural gas provider for the 54 KW natural gas generator for the facility to present to the surveyor. No additional information was received. The Administrator was informed of the findings at the Life Safety Code exit conference on 2/23/2023. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line	K 914		3/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. BUILDING **01** B. WING _____	**02/24/2023**

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FOUNTAIN VIEW CARE CENTER	**527 RIVER AVENUE** **LAKEWOOD, NJ 08701**

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K 914	Continued From page 13 isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 2/23/2023, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 32 of 32 resident rooms and observed by the following: From approximately 9:30 AM, to 1:30 PM, the surveyor and MD observed that the resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The last annual electrical inspection by the facility's electrical vendor was dated 05/18/22. The inspection report indicated: "electrical systems & wiring were safe and in well maintained condition" and did not indicate specific functionally test of electrical receptacles in residents' rooms annually for grounding, polarity,	K 914	1. Electrical inspection of all outlets in resident rooms has been done. 2. An audit was completed throughout the facility for all electrical receptacles that are not hospital grade to ensure annual electrical inspection is done. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding the need for all electrical receptacles that are not hospital grade to get an annual electrical inspection. 4. Administrator or designee will review Life Safety binder for the next year to ensure all electrical receptacles in the facility that are not hospital grade received an annual electrical inspection. Administrator will share his findings quarterly with QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. BUILDING **01** B. WING _____	**02/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	**527 RIVER AVENUE** **LAKEWOOD, NJ 08701**

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K 914	Continued From page 14 and blade tension in accordance with NFPA 99. The MD indicated he was not aware of any non-hospital grade outlet testing procedures that had to be preformed annually. The Administrator was informed of the findings at the Life Safety Code exit conference on 2/23/2023. NJAC 8:39-31.2(e) NFPA 99	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		3/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. BUILDING **01** B. WING _____	**02/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	**527 RIVER AVENUE** **LAKEWOOD, NJ 08701**

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K 918	Continued From page 15 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 observation and interview on 2/23/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure a remote manual stop station for one of one generators and installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 1:05 PM, the surveyor and MD observed the interior 54 KW (kilowatt) natural gas generator. There was no remote manual stop station observed outside the area of the generator location. An interview was conducted during the time of the observation with the MD, who confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover. The Administrator was informed of the findings at the Life Safety Code exit conference on	K 918	1. Manual stop station was installed outside area of generator location. 2. An audit will be done to ensure manual stop station is installed and working properly. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced about need to have manual stop station outside generator area. 4. Administrator or designee will do quarterly rounds to ensure manual stop station is installed and working properly. Administrator will share his findings quarterly with QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. BUILDING **01** B. WING _____	**02/24/2023**

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K 918	Continued From page 16 2/23/2023. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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
315327 Y1	A. Building B. Wing Y2	4/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	527 RIVER AVENUE 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 F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0695	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(i)	Completed
LSC	03/17/2023	LSC	02/27/2023	LSC	03/17/2023
ID Prefix F0812	Correction	ID Prefix F0814	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	02/27/2023	LSC	03/06/2023	LSC	03/17/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
2/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO