NAME OF PROVIDER OR SUPPLIER STREE TADDRESS, CITY STRE JP CODE LLANFAR HOUSE CARE & REHABILITATION CENTER STREE TADDRESS, CITY STRE JP CODE YMID SUMMARY STATEMENT OF DEFICIENCES In PREVX TVG SUMMARY STATEMENT OF DEFICIENCES In WID SUMMARY STATEMENT OF DEFICIENCES In RECOLLATORY OR LSC DENTIFYING INFORMATION In PROVIDER'S PARA OF CORRECTION K 000 INITIAL COMMENTS K 000 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Oratico on 10/27/22 and 10/28/22, was found to be in onocompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 433.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy K 222 This facility is a 3-story building that was built in 70%, it is composed of Type I fire resistant construction. The facility is divided into 10-smoke zones. The facility is a divide into 10-smoke zones. The facility is divided into 10-smoke zones. The facility is divided into 10-smoke zones in a required means of egress shall not be quipped 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 K 222 1/20 Where special locking arrangements for the enpid removal of occupants by: remote controid of lo		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION		ATE SURVEY DMPLETED
1140 BLACK OAK RIDGE ROAD WXNE, NJ 07470 Drug ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH COMRESS FLAN OF CORRECTION PREFIX TAG DRV/DER'S FLAN OF CORRECTION (EACH COMRESS FLAN OF CORRECTION RECOULD REPORT AND THE PRECEDED BY FULL RECOULD REPORT AND THE PRECEDED BY FULL RECOULD REPORT AND THE PRECEDED BY FULL RECOULD REPORT AND THE PRECEDED BY FULL DEFICIENCY DO K 000 INITIAL COMMENTS K 000 INITIAL COMMENTS K 000 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/27/22 and 10/28/22, was found to be in noncompliance with the requirements for participation in Medicar/Medicaid at 42 CFR 4439.0(a), Life Safety Code (LSC), Chapter P EXISTING Health Care Occupancy K 000 Initial Safety Code (LSC), Chapter P EXISTING Health Care Occupancy F This facility is a 3-story building that was built in 70's, II is composed of Type fire resistant construction. The facility is divided into 10 - smoke zones. The facility is composed is divided into 10 - smoke zones. The facility is divided into 10 - smoke zones. The facility is divided into 10 - smoke zones. The facility is distat requines the use of a tool or kky from the egreess side unles			315142	B. WING _				11/03/2022
LLAMFAR HOUSE CARE & REHABILITION CENTER WAYNE, NJ 07470 CMUID PREFX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLLL RECULATORY OR LSC IDENTFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) O K 000 INITIAL COMMENTS K 000 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/27/22 and 10/28/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a). Life Safety from Fire, and the 2012 Edition of the National Fire Proteion Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy K 222 This facility is a 3-story building that was built in 70%, it is composed of Type I fire resistant construction. The facility is divided into 10 - smoke zones. The facility has 2 generators 65 KW (Diese) and 75 KW (Natural Gas). K 222 SS=E CER(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 dinical security needs of the patibile means available to the staff at all times.	NAME OF PI	ROVIDER OR SUPPLIER	L		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
PREFIX TAG (EACH CORRECTVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO K 000 INITIAL COMMENTS K 000 K 000 INITIAL COMMENTS K 000 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/27/22 and 10/28/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy K 222 1/20 This facility is a 3-story building that was built in 70%, It is composed of Type I fire resistant construction. The facility is divided into 10- smoke zones. The facility has 2 generators 65 KW (Diesei) and 75 KW (Natural Gas). K 222 1/20 SSEE CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a lath 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 K 222 1/20 Where special locking arrangements for the clinical security needs of the partited an eused, only one locking device shall be permitted on each door and provisions shall be meant adit interes. Interest of the sub-reliable means available to the staft at all times.	LLANFAIR	HOUSE CARE & REHA	BILITATION CENTER					
A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/27/22 and 10/28/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This facility is a 3-story building that was built in 70's, It is composed of Type I fire resistant construction. The facility is divided into 10-smoke zones. The facility advided into 10-smoke zones. The facility advide into 10-smoke zones. 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 premitted 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.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
New Jersey Department of Health, Health Facility Survey and Field Operations on 10/27/22 and 10/28/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This facility is a 3-story building that was built in 70's, it is composed of Type I fire resistant construction. The facility is divided into 10- smoke zones. The facility has 2 generators 66 KW (Diee)) and 75 KW (Natural Gas). K 222 SS=E CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equiped 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	K 000	INITIAL COMMENTS	1	ĸ	000			
SPECIAL NEEDS LOCKING ARRANGEMENTS		New Jersey Departm Survey and Field Ope 10/28/22, was found the requirements for p Medicare/Medicaid at Safety from Fire, and National Fire Protecti Life Safety Code (LS) Health Care Occupar This facility is a 3-sto 70's, It is composed of construction. The fac zones. The facility ha (Diesel) and 75 KW (Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required m equipped with a latch use of a tool or key fr using one of the follow arrangements: CLINICAL NEEDS Of LOCKING Where special locking clinical security needs only one locking devi- each door and provis rapid removal of occu locks; keying of all loc all times; or other suc to the staff at all times 18.2.2.2.5.1, 18.2.2.2	ent of Health, Health Facility erations on 10/27/22 and to be in noncompliance with participation in t 42 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING ncy ry building that was built in of Type I fire resistant ility is divided into 10- smoke s 2 generators 65 KW Natural Gas). heans of egress shall not be or a lock that requires the om the egress side unless wing special locking R SECURITY THREAT g arrangements for the s of the patient are used, ce shall be permitted on ions shall be made for the upants by: remote control of cks or keys carried by staff at ch reliable means available s. 2.6, 19.2.2.2.5.1, 19.2.2.2.6	κz	222			1/20/23
								(X6) DATE

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.

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/21/2023 M APPROVEI D. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315142	B. WING			11	/03/2022
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	R HOUSE CARE & REHA	BILITATION CENTER		114	0 BLACK OAK RIDGE ROAD		
				WA	YNE, NJ 07470		
(X4) ID PREFIX TAG			ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 222	safety needs of the p Clinical or Security Lo being met. In addition electrical locks that fa upon loss of power to protected by a super- system and the locke complete smoke dete constantly monitored within the locked spa and detection system doors upon activation 18.2.2.2.5.2, 19.2.2.2 DELAYED-EGRESS ARRANGEMENTS Approved, listed dela installed in accordance permitted on door ass ordinary hazard conte throughout by an app fire detection system automatic sprinkler st 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROL ARRANGEMENTS Access-Controlled Eg installed in accordance permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY E ARRANGEMENTS Elevator lobby exit ac accordance with 7.2. door assemblies in bu by an approved, super-	g arrangements for the atient are used, all of the ocking requirements are h, the locks must be ail safely so as to release to the device; the building is vised automatic sprinkler d space is protected by a ection system (or is at an attended location ce); and both the sprinkler as are arranged to unlock the h. 2.5.2, TIA 12-4 LOCKING yed-egress locking systems ce with 7.2.1.6.1 shall be semblies serving low and ents in buildings protected proved, supervised automatic or an approved, supervised ystem. LED EGRESS LOCKING gress Door assemblies ce with 7.2.1.6.2 shall be the semblies protected throughout excess door locking in 1.6.3 shall be permitted on uildings protected throughout ervised automatic fire an approved, supervised	K	222			

Facility ID: NJ61611

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	NTERS FOR MEDICARE & MEDICAID SERVICES EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/OPPLIE					NO. 0938-039		
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		ATE SURVEY DMPLETED		
		315142	B. WING			11/03/2022		
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
	HOUSE CARE & REHA			1140 BLACK OAK RIDGE ROAD				
	HOUSE CARE & REHA			WAYNE, NJ 07470				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
K 222	Continued From page	e 2	K 22	22				
	18.2.2.2.4, 19.2.2.2.4							
		+ F is not met as evidenced						
	by:							
		on and interview on 10/27/22,		Instructional signage with	1 inch lettering			
	it was determined that the facility failed to ensure was immediately placed nest							
		d with a delayed egress		egress doors near rooms				
		d with instructional signage		Permanent signage was o	ordered and will			
		nts of NFPA 101:2012 -		be installed upon receipt.				
	was identified in 2 of	 This deficient practice a egress doors and 		The deficient practice cou	ld affect all			
	evidenced by the follo	-		residents. Facility rounds				
				to ensure all exit /egress of				
	1. At 10:55 AM, the S	Surveyor, Maintenance		required signage posted.				
	Director and Regiona	al Plant Operations Director,		were noted to be in comp	liance.			
		it/egress door by resident						
		as provided with a delayed		The Maintenance Director				
		door was not provided with a		observe exit/egress door				
		ith 1-inch letters indicating unds, Door Can Be Opened		compliance once per wee				
		e door was provided with a		then one time per month t	inerealler.			
	push button keypad a	-		Findings will be reported t	o the			
	activation of the fire a			administrator as needed a				
				Quality Management/Perf				
		Surveyor, Maintenance		Improvement Committee				
	-	al Plant Operations Director,		for 4 quarters.				
		it/egress door by the nurse						
		vided with a delayed egress						
		is not provided with a readily						
		ch letters indicating "Push Door Can Be Opened in						
		oor was provided with a push						
		pened with the activation of						
	the fire alarm.							
	The Maintenance Dir	ector and Regional Plant						
	-	confirmed the findings at the						
	time of the observation	ons.						

Facility ID: NJ61611

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				E SURVEY IPLETED
		315142	B. WING			11	/03/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LLANFAIF	R HOUSE CARE & REHA	BILITATION CENTER			140 BLACK OAK RIDGE ROAD VAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 222		dings, during the Life Safety	ĸ	222			
K 271 SS=E	5		к	271			1/20/23
	provides a level walk provisions of 7.1.7 wi elevation and shall be obstructions. Addition be a hard packed all- 18.2.7, 19.2.7 This REQUIREMENT by: Based on observation in the presence of the Regional Plant Opera failed to provide and surface, free of all ob full instant use in the emergency in accord Edition, Section 19.2, 7.7.3.2, 7.1.6, 7.1.6.2 This deficient condition exit discharges by the 1). At 10:29 AM, the 3 Director and Regional observed outside the discharge, that the pa 5' x 4' area of a soft g failed to provide a firm	nged in accordance with 7.7, ing surface meeting the th respect to changes in e maintained free of nally, the exit discharge shall weather travel surface. T is not met as evidenced on and interview on 10/28/22, e Maintenance Director and ations Director, the facility maintain a level walking structions or impediments to case of fire or other ance with NFPA 101, 2012 , 19.2.1, 19.2.7, 7.7, 7.7.1, 2, 7.1.6.3, 7.1.10, 7.1.10.1.			 11/29/22 Contractor reported to the building to determine the scope of wor needed to install a sidewalk on the gra area and to expand the walkway at the obstruction to ensure a clear exit/egres path. The deficient practice could affect all residents. Other discharge exit /egress paths were inspected by the Director of Maintenance to ensure that a level walking surface, free of obstruction is maintained. The other exit paths were found to be in compliance. 1/20/2023 A level concrete pad installe on the grassy area outside of rehabilitation services exit/egress path The Path obstructed by the metal structure was widened as required to 	ssy ss of	

Facility ID: NJ61611

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/21/20 FORM APPROV OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED
		315142	B. WING		11/03/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	· ·
	R HOUSE CARE & REHA	BILITATION CENTER		1140 BLACK OAK RIDGE ROAD	
		BIENATION OENTER	WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETIC
K 271	Continued From page	e 4	K 27	1	
	use in the case of fire			allow for an unobstructed exit/egree	ŝs
	Director and Regional observed that the ext path was blocked from type structure on the 2' out to the exit/egre now only allow appro- evacuate in that area an emergency evacu The Maintenance Dir Operations Director b the observation's. The Regional Plant O informed of the findin exit conference. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.7 Illumination of Means CFR(s): NFPA 101 Illumination of Means Illumination of means discharge, is arrange	ector and Regional Plant both stated and confirmed Operations Director was g at the Life Safety Code , 19.2.7 s of Egress	К 28	The Director of Maintenance or des will perform walking rounds to obse discharge exit/egress pathways to a that they are level and clear of obst every two weeks for one quarter an monthly thereafter. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least qu for 4 quarters.	erve the ensure truction nd
	intervention. 18.2.8, 19.2.8 This REQUIREMENT by: Based on observatio in the presence of the Regional Plant Opera	operation without manual is not met as evidenced an and interview on 10/28/22, Maintenance Director and ations Director, it was acility failed to provide		10/31/2022 A solar motion activate lighting device was installed on the near the second floor second in o provide emergency illumination with	wall order to

Event ID:0SEF21

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · ·	PLETED
		315142	B. WING		11	/03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LLANFAIF	R HOUSE CARE & REHA	BILITATION CENTER		1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
K 281	Continued From page	e 5	К 28	1		
	emergency illumination automatically along the accordance with NFP	on that would operate ne means of egress in A 101, 2012 Edition, Section leficient practice affected 2 s observed and was		the need for manual intervention. egress lights in the resident day/or rooms was modified to ensure co illumination of the exit/ egress pa without the need for manual inter	dining ntinuous thway vention.	
	floor outside e	10:37 AM, the facility's exit/egress keyed gate was evidence of emergency beyond the gate.		The deficient practice could affect residents. The Director of Mainte performed walking rounds to ens exit /egress illumination is either continuous operation or capable automatic operation without man	nance ure that in of	
	observed that the floo	10:50 AM, the surveyor or and floor occupied day when the wall switches		intervention. All were found to be compliance. The Director of Maintenance or d will perform walking rounds to ve	esignee	
	Plant Operations Dire findings at the time of	ance Director and Regional ector both confirmed the observations.		illumination of each means of egr is either in continuous operation capable of automatic operation w manual intervention weekly for or month, monthly for one quarter a	ress/exit or vithout ne	
	survey exit conferenc	lings at the Life Safety Code e. on Life Safety Code: 7.8		quarterly thereafter. Findings will be reported to the administrator as needed and to the		
		of Egress: 7.8.1.3* (2)		Quality Management/Performance Improvement Committee at least for 4 quarters.	e	
K 293 SS=E	Exit Signage CFR(s): NFPA 101		K 29	3		1/20/23
		gns are displayed in with continuous illumination nergency lighting system.				

Facility ID: NJ61611

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	S FOR MEDICARE &					IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING (E CONSTRUCTION		E SURVEY IPLETED
		315142	B. WING		1	1/03/2022
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HOUSE CARE & REHA		1	140 BLACK OAK RIDGE ROAD		
		BENANON OLIVIER	v	VAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
K 293	Continued From page		К 293			
	with less than 30 occt travel is obvious.) This REQUIREMENT by: Based on observatio on 10/28/22, in the pr Director and Regiona it was determined that one (1) exit sign that illumination indicator travel, in every location travel to reach the ne in accordance with NI Section 19.2.10, 19.2 7.10.2.1. The deficier 1 of 28 exit signs obs the following: At 10:00 AM, the survand Regional Plant O in the ground floor kit that a photoluminescent that a photoluminescent exit The findings were ver Director and Regiona at the time of the obs The Regional Plant O	rified by the Maintenance I Plant Operations Director		 11/6/22 the ground floor kitchen exit/egress sign was hard wired in emergency lighting system to provo continuous illumination indicators is the direction of travel to the neares. The deficient practice could affect residents. All exit and directional is were inspected by the Director of Maintenance to ensure they are das required with continuous illumin All were noted to be in compliance. The Director of Mainteneance or Designee will inspect exit and direction is signs to ensure continuous illumin required weekly for one quarter th monthly thereafter. Signs noted to of comliance will be corrected immediately. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least of for 4 quarters. 	vide a howing st exit. all signs isplayed nation. e. ectional ation as an be out	
	NFPA 101, 2012 Editi 19.2.10.1, 7.10.1.2, 7 NJAC 8:39-31.2(e)					

Facility ID: NJ61611

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/21/2023 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315142	B. WING			11/	/03/2022
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				114	0 BLACK OAK RIDGE ROAD		
LLANFAIR	HOUSE CARE & REHA	BILITATION CENTER		WA	YNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
K 321	Continued From page	e 7	к:	321			
K 321 SS=E	Hazardous Areas - E CFR(s): NFPA 101			321			1/20/23
	having 1-hour fire res fire rated doors) or ar system in accordance When the approved a system option is used separated from other partitions and doors i Doors shall be self-cl and permitted to have protective plates that from the bottom of the Describe the floor and	protected by a fire barrier istance rating (with 3/4 hour a automatic fire extinguishing with 8.7.1 or 19.3.5.9. automatic fire extinguishing d, the areas shall be spaces by smoke resisting n accordance with 8.4. osing or automatic-closing e nonrated or field-applied do not exceed 48 inches e door.					
	e. Trash Collection R (exceeding 64 gallons f. Combustible Storag (over 50 square feet) g. Laboratories (if cla Hazard - see K322) This REQUIREMENT by: Based on observation documentation on 10 the Maintenance Direct	ed Heater Rooms han 100 square feet) ce, and Paint Shops ns (exceeding 64 gallons) ooms s) ge Rooms/Spaces ssified as Severe is not met as evidenced n and review of other facility /28/22, in the presence of ector and Regional Plant			Vendor submitted a quote to replace f doors with missing fire rating labels wit 90minute fire rated doors. The quote w	th /as	
	Operations Director,	it was determined that the e that fire-rated doors to			approved and initial deposit forwarded ensure doors were ordered. There is a		

Facility ID: NJ61611

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				FORM): 04/21/2023 APPROVED). 0938-0391
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	
	315142	B. WING		11/	03/2022
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
R HOUSE CARE & REHA	BILITATION CENTER		1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
 hazardous areas wer were separated by sr accordance with NFF 19.3.2.1, 19.3.2.1.3, 19.3.6.4, 8.3, 8.3.5.1, This deficient practice hazardous storage ro evidenced by the follo The clothes dryer ra a door that was labeled rating). The Washing Mach with a door that was labeled rating). 3) 3 of 3 kitchen door door that was labeled rating). The boiler room do door that was labeled rating). The boiler room do door that was labeled rating). The Maintenance Dir Operations Director b 	e self-closing, labeled and noke resisting partitions in PA 101, 2012 Edition, Section 19.3.2.1.5, 19.3.6.3.5, , 8.4, 8.5.6.2 and 8.7. ed was identified in 6 of 6, oom doors and was owing: room was not provided with ed with an (3/4 hour fire hine room was not provided abeled with an (3/4 hour fire rs were not provided with a d with an (3/4 hour fire bor was not provided with a d with an (3/4 hour fire bor was not provided with a d with an (3/4 hour fire	К 32	 estimated 10 week turn around manufacture the doors. Upon do the 90 minute fire rated doors winstalled. Expected completion of 5/31/2023. The deficient practice could affer residents. All hazardous areas winspected to ensure that the door labeled to note 3/4 hour fire ratii were found to be compliant. The Director of Maintenance or will inspect all hazardous area or required labels and that they are close properly during life safety weekly. Director of Maintenance staff to make sure identified doors are unobstructed close properly. The identified do sprayed with flame retardant maconduct an additional fire drill manufacture for the safety weekly. 	elivery of ill be date act all vere ors were ng. All designee loors for e able to rounds e will that the d and oors will be aterial. Will onthly	
informed of the findin conference. NJAC 8:39-31.2 (e)	g's at the Life Safety exit	К 34	Quality Management/Performar Improvement Committee month doors are replaced and then at quarterly for 4 quarters.	ice ly until the	1/20/23
	RS FOR MEDICARE & OF DEFICIENCIES PROVIDER OR SUPPLIER R HOUSE CARE & REHA SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page hazardous areas wer were separated by sr accordance with NFF 19.3.2.1, 19.3.2.1.3, 19.3.6.4, 8.3, 8.3.5.1, This deficient practice hazardous storage ro evidenced by the folled 1) The clothes dryer r a door that was labeled rating). 2) The Washing Mach with a door that was labeled rating). 3) 3 of 3 kitchen door door that was labeled rating). 3) 3 of 3 kitchen door door that was labeled rating). 4) The boiler room do door that was labeled rating). 5) The Maintenance Dir Operations Director b during the observatio The Regional Plant C informed of the findin conference. NJAC 8:39-31.2 (e) Life Safety Code 101 Smoke Detection CFR(s): NFPA 101	F CORRECTION IDENTIFICATION NUMBER: 315142 315142 ROVIDER OR SUPPLIER RHOUSE CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 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 6, hazardous storage room doors and was evidenced by the following: 1) The clothes dryer room was not provided with a door that was labeled with an (3/4 hour fire rating). 2) The Washing Machine room was not provided with a door that was labeled with an (3/4 hour fire rating). 3) a of 3 kitchen doors were not provided with a door that was labeled with an (3/4 hour fire rating). A bile room door was not provided with a door that was labeled with an (3/4 hour fire rating). The Maintenance Director and Regional Plant Operations Director both confirmed the finding's during the observations. The Regional Plant Operations Director was informed of the finding's at the Life Safety exit conference. NJAC 8:39-31.2 (e) Life Safety Code 101 Smoke Detection CFR(s): NFPA 101	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 315142 B. WING	SE FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES OF DEFICIENCIES OF DEFICIENCIES IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: A BUILDING 01 STREETADDRESS, CITY, STATE, ZIP CODE 100 SECARE & REHABILITATION CENTER SUMMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 1) The clothes driver room was not provided with a door that was labeled with an (3/4 hour fire rating). 2) The Washing Machine room was not provided with a door that was labeled with an (3/4 hour fire rating). 4) The boiler room doors wan ont provided with a door that was labeled with an (3/4 hour fire rating). 4) The boiler room door was not provided with a door that was labeled with an (3/4 hour fire rating). 4) The boiler room door was not provided with a door that was labeled with an (3/4 hour fire rating). The Regional Plant Operations Director was informed of the finding's at the Life Safety exit conference. NJAC 8:39-31.2 (e) Life Safety Code 101 Smoke Detection CFR(s): NFPA 101	MENT OF HEALTH AND HUMAN SERVICES FORM SFOR MEDICARE & MEDICARE SKENUCEAD SERVICES OMB NC or DEFICIENCIES OMB NC or DEFICIENCIES OMB NC attributed 315142 Image: Comparison of the providence of the prov

Event ID:0SEF21

Facility ID: NJ61611

If continuation sheet Page 9 of 18

TATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION 1	(X3) DAT	<u>O. 0938-039</u> E SURVEY IPLETED
		315142	B. WING			11	/03/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LLANFAIR	HOUSE CARE & REHA	BILITATION CENTER			140 BLACK OAK RIDGE ROAD VAYNE, NJ 07470		
				v			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
K 347	Continued From page	e 9	ĸ	347			
		tems are provided in spaces		011			
	open to corridors as r						
	19.3.4.5.2	. ,					
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
	Based on observatio			100% of resident rooms with battery			
	documentation review	-			operated smoke detectors to be replace	ced	
	presence of the Main Regional Plant Opera			with new 10 year life battery operated smoke detectors. The life safety			
		acility failed to ensure that			inspection log was revised to include t	he	
		naintenance, and battery			documentation of systematic smoke		
		to ensure proper operation			detector inspection rounds. 15 pkgs o	f 6	
		ed smoke detectors as per			(90 individual smoke detectors) were		
	NFPA 72.				ordered, received and installed.		
	•	e was evidenced for 50 of 50			The deficient practice could affect all		
	observed battery ope evidenced by the follo	erated smoke detectors and owing:			residents.		
					Resident room smoke detectors to be		
	-	t 11:15 AM, revealed that the			inspected every two weeks to ensure		
	-	s were provided with battery			operating as designed for one month monthly for one quarter and quarterly	ihen	
	operated smoke dete				thereafter.		
		y's preventative maintenance					
	-	that there was a preventative			Findings will be reported to the		
	detectors or for batte	n for the testing of the			administrator as needed and to the Quality Management/Performance		
					Improvement Committee at least quar	terlv	
	In an interview at 11:	55 AM, the facility's			for 4 quarters.		
	Maintenance Director	· · · · · ·					
		stated that there was no					
		ance documentation for					
		erated smoke detectors in					
	resident rooms and c	e year of installation. He					
		the alarms by pushing the					
		ly and replaced the batteries					
	-	cated low battery, but he did					
	not record any inform				1		1

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NND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 COMPLETE 315142 B. WING 11/03/2 11/03/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/03/2 LLANFAIR HOUSE CARE & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 11/03/2 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OC K 347 Continued From page 10 K 347 K 347 This deficient practice would not ensure the proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. K 347 The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2 Hat be appropriate of the single code application to the state of the safety Code 2012 edition 19.3.6.1,		-	ND HUMAN SERVICES				M APPROVE 0. 0938-039
NME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LLANFAIR HOUSE CARE & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (x) (D) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D K 347 Continued From page 10 K 347 This deficient practice would not ensure the proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. K 347 The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference. K 351 NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2 K 351 Spinkler System - Installation 2012 EXISTING K 351 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler systems in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type 1 and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state				· · ·		(X3) DATE SURVEY COMPLETED	
1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470 (p(x)) 0 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D VAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D VAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C K 347 Continued From page 10 K 347 K 347 Image: Condition prior to the subscitute the proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. K 347 Image: Condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. Image: Condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. Image: Condition prior to the smoke entering the exit conference. Image: Condition prior to the smoke entering the exit conference. Image: Condition prior to the smoke detectors were located. Image: Condition prior to the smoke detectors were located. Image: Condition prior to the smoke detectors were located. Image: Condition prior to the p			315142	B. WING		11	/03/2022
LLAMER HOUSE CARE & REHABILITATION CENTER WAYNE, NJ 07470 (X1)D PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY WIST PRECEDED BY FULL PRETIX TAG D D PRETIX REGULATORY OR LSC IDENTIFYING INFORMATION) D D PRETIX TAG POWDER'S PLAN OF CORRECTIVE (EACH OFFICIENCY WIST BE PRECEDED BY FULL PRETIX TAG D PRETIX CAROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C C CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY C C C C C C C C C C C C C C C C C C C	NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CC K 347 Continued From page 10 K 347 This deficient practice would not ensure the proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. K 347 The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2 K 351 1/2 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state K 351	LLANFAIF	R HOUSE CARE & REHA	BILITATION CENTER				
This deficient practice would not ensure the proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2 Sprinkler System - Installation K 351 SSEF 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 systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE
proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located.The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference.NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2K 351SS=FCFR(s): NFPA 101K 351Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where stateK 351	K 347	Continued From page	e 10	K 347	7		
In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5,		proper operation of the ensure that staff was condition prior to the corridor where perma detectors were locate The Regional Plant C informed of the findin exit conference. NJAC 8:39-31.2(e) NFPA 101 Life Safety 19.3.4.5.2 Sprinkler System - In CFR(s): NFPA 101 Spinkler System - Ins 2012 EXISTING Nursing homes, and construction type, are approved automatic s accordance with NFF Installation of Sprinkle In Type I and II const measures are permitt sprinkler protection ir or local regulations p In hospitals, sprinkler closets of patient slee of the closet does no sprinkler Coverage co required by NFPA 13 Sprinkler Systems.	hese devices and would not signaled of a smoke smoke entering the exit anently wired smoke ed. Operations Director was gs at the Life Safety Code a Code 2012 edition 19.3.6.1, stallation the spitals where required by e protected throughout by an sprinkler system in PA 13, Standard for the er Systems. ruction, alternative protection ted to be substituted for a specific areas where state rohibit sprinklers. 's are not required in clothes eping rooms where the area t exceed 6 square feet and overs the closet footprint as , Standard for Installation of	K 35	1		1/20/23

Facility ID: NJ61611

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 04/21/202 RM APPROVE O. 0938-039	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G 01		DATE SURVEY	
		315142	B. WING		1'	1/03/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				1140 BLACK OAK RIDGE ROAD			
LLANFAIR	HOUSE CARE & REHA	BILITATION CENTER		WAYNE, NJ 07470			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
K 351	Continued From page	e 11	К 3	51			
	by: Based on record rev 10/28/22, in the prese Maintenance Director Operations Director, if facility failed to provid protection to all areas 13. This deficient practice elevator shafts and 4 following: 1) At 11:58 AM, the fa and Regional Plant C on floor , that wher lowered, it was revea not provided with any An interview was con Director and Regional during the observatio no fire sprinkler head or lower shaft of the t 2) At 12:31 PM, the s Director and Regional observed that there w protection provided to entrance combustible measured approximal An interview was con Director during the observation asked, if he could pro-	iew and interview on ence of the facility and Regional Plant it was determined that the le automatic fire sprinkler in accordance with NFPA was evidenced for 2 of 2 of 4 stairwells, by the acility Maintenance Director operations Director, observed in the hydraulic elevator was led that the upper shaft was fire sprinkler coverage. ducted with the Maintenance I Plant Operations Director ns and they confirmed that s were located in the upper wo elevators. surveyor, Maintenance I Plant Operations Director, vas no fire sprinkler o the attached outside front e blue fabric overhang, that		 1/10/23 Sprinkler system vendo site to determine scope of work in to extend the automatic sprinkler into 2 of 2 upper elevator shafts into the identified stairwells. 1/17 Quote obtained and approved. A requested a deposit to schedule 1/26/2023 Deposit to secure wor sent to vendor (receipt attached) Scheduling of permits by vendor progress. 2/10/2023 conversatio vendor noted start date anticipat 10 business day of receipt of dep sooner. Projected completion by ending. The blue fabric awning of front of the building was coated a retardant. Weekly status update NJDHSS until project completion The deficient practice could affeor residents. All elevator shafts and stairwells were included in the lift and vendor inspection. The additional sprinkler heads an extension of the automatic sprint system are added to the quarter inspection schedule performed b vendor and the Director of Maint The blue awning will be treated a retardant spray 12/12/2022 and a annually thereafter. Findings will be reported to the administrator as needed and to the 	required r system and also 7/2023 /endor project. *k was). * in n with red within posit or * February on the with flame to n. ct all d fe safety and the kler ly by the renance. with a fire at least		
	documentation was p			Quality Management/Performand Improvement Committee at least			
	3) At 1:15 PM, the su	rveyor, observed that fire		for 4 quarters.			

Facility ID: NJ61611

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/21/202 MAPPROVE D. 0938-039
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
		315142	B. WING		11/	03/2022
NAME OF P	ROVIDER OR SUPPLIER	l	STF	REET ADDRESS, CITY, STATE, ZIP CODE	•	
LLANFAIF	R HOUSE CARE & REHA	BILITATION CENTER		0 BLACK OAK RIDGE ROAD IYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 351 K 364 SS=F	accessible landing for An interview was com Director and Regional and they both confirm heads were observed landing for 4 of 4 stail The Regional Plant C notified of the deficient exit on 10/28/22. NFPA 13, 25 NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not doors. Auxiliary space flammable or combust to have louvers or be In other than smoke of patient sleeping room are permitted in vision the openings per room inches and are at or the floor to ceiling. In spri per room do not excervision panels in corrie fixed window assemb fully sprinklered smok no restrictions in the a glass and frames.) 18.3.6.5.1, 19.3.6.5.2	stalled under the first r 4 of 4 stairwells observed. ducted with the Maintenance I Plant Operations Director, ned that no fire sprinkler a the first accessible rwells observed. Operations Director, was ney at the life safety code of used in corridor walls or rest that do not contain stible materials are permitted undercut. compartments containing ns, miscellaneous openings in panels or doors, provided m do not exceed 20 square below half the distance from inklered rooms, the openings wed 80 square inches. dor walls or doors shall be blies in approved frames. (In se compartments, there are area and fire resistance of	K 351			1/20/23

Facility ID: NJ61611

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/21/2023 FORM APPROVED OMB NO. 0938-0391
		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315142	B. WING		11/03/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
	R HOUSE CARE & REHA			1140 BLACK OAK RIDGE ROAD	
				WAYNE, NJ 07470	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
K 364	Continued From page	e 13	К 36	54	
K 911 SS=F	in the presence of the Regional Plant Opera determined that the fi doors in a manner de of smoke into exit cor practice was identifie was evidenced by the At 11:22 AM, the surv floor utility clo approximately 2' x 2' exit/egress corridor. An interview was com Director and Regiona at the time of the obs confirmed that the op used in corridor doors The Regional Plant C informed of the findin exit conference. NFPA 101-2012 edition Transfer Grilles. 19.3.6.4.1 Transfer g they are protected by dampers, shall not be doors. NJAC 8:39-31.2(e) Electrical Systems - 0 CFR(s): NFPA 101	d for 1of 8 closet doors and e following: veyor observed that the oset had a door with an open transfer grille to the aducted with the Maintenance al Plant Operations Director servation, where they ben door vent, was not to be s. Operations Director, was g at the Life Safety Code on Life Safety Code 19.3.6.4 rilles, regardless of whether r fusible link-operated e used in corridor walls or Other	K 91	The ground floor utility closet corridor /egress door was observed to have a 2' open transfer grill which was replace and sealed with a stainless steel sheet The deficient practice could affect all residents. All corridor walls and doors where flammable / combustible mater may be found were inspected to ensu- that no transfer grills are installed. All noted to be in compliance. Monthly the Director of Maintenace or designee will inspect all corridor open during life safety rounds to ensure that transfer grills are installed where flammable or combustibel materials in be found. The Director will educate maintenance employees and future contractors of the safety requirement. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least quar for 4 quarters.	2' x ed et. ials re ings it no hay

Facility ID: NJ61611

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01				(X3) DATE SURVEY COMPLETED		
		315142	B. WING				1/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	R HOUSE CARE & REHA	BILITATION CENTER		11	40 BLACK OAK RIDGE ROAD			
				WAYNE, NJ 07470				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
K 911			K	911	Our generator vendor provided a statement committing to the designati of a backup generator for the facility a well as the delivery of the backup generator and the required fuel supply the event of an interruption of the nati gas fuel line to the generator. The deficient practice could affect all residents. The Director of Maintenance or design will ensure the availability of a backup generator and fuel supply remains in effect at all times. The statement of commitment will be reviewed at least	ıs y in ural		
	 the following: 1. A statement of reasonatural gas delivery. 2. A brief description regarding the reliabilition of the net that the interruption of the net 4. A brief description regarding the low pro- 	ere is a low probability of			annually to ensure it is in effect. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least quar for 4 quarters.	terly		

Facility ID: NJ61611

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		MEDICAID SERVICES			OMB NO. 0938	
· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	(
		315142	B. WING		11/03/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LLANFAIR HOUSE CARE & REHABILITATION CENTER				1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	(5) LETIO ATE
K 911	Continued From page 15 Director and Regional Plant Operations Director at the time of the observation.		K 91 ⁻	1		
		PM, the Regional Plant vas informed of the finding at exit conference.				
	NJAC 8:39-31.2(e) NFPA 99, 2012 Edition 2010 Edition, Section	on Chapter 6 and NFPA 110, 5.1.4.				
K 918 SS=F	-	Essential Electric Syste	K 918	8	1/20/2	23
	Maintenance and Tes The generator or oth and associated equip service within 10 sec criterion is not met du process shall be prov capability for the life s Maintenance and tes transfer switches are with NFPA 110. Generator sets are in	er alternate power source ment is capable of supplying onds. If the 10-second uring the monthly test, a ided to annually confirm this safety and critical branches. ting of the generator and performed in accordance spected weekly, exercised				
	day intervals, and exe months for 4 continuo under load conditions simulated cold start a transfer of all EES loa competent personnel stored energy power	nd automatic or manual ads, and are conducted by . Maintenance and testing of sources (Type 3 EES) are in				
	circuit breakers are ir program for periodica components is establ					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/21/20 MAPPROVI D. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315142					CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		B. WING	11/03/2022				
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	HOUSE CARE & REHA			1140 BLACK OAK RIDGE ROAD			
				v	VAYNE, NJ 07470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)			(X5) COMPLETIO DATE
K 918	Continued From page	a 16	K	918			
IX 010			ĸ	910			
		ting are maintained and					
	-	S electrical panels and eadily identifiable, and					
		l power circuits. Minimizing					
		age of the emergency power					
	source is a design co						
	installations.						
	6.4.4, 6.5.4, 6.6.4 (N	FPA 99), NFPA 110, NFPA					
	111, 700.10 (NFPA 70	0)					
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
		on and interview on 10/28/22,			11/29/2022 The electrical contractor		
		e Maintenance Director (MD)			responded on site to determine the so		
		Derations Director (RPOD),			of work required to install remote mar		
	a remote manual stop	at the facility failed to ensure			stop switches for 2 of 2 generators. A quote for the work was received and		
		lled in accordance with the			approved. 1/27/2023 Generator stop		
	- C	A 110, 2010 Edition, Section			switches were installed. Both were te	sted	
		. The deficient practice could			and functioning as designed.	5100	
		id was evidenced by the					
	following:	5			The deficient practice could affect all		
	Ū				residents.		
	At 1:05 PM, the surve	eyor, MD, and RPOD					
		generator. There was not a			The Director of Maintenance or desig		
	- · · ·	station to prevent inadvertent			will round at least monthly to ensure t		
		ation for the emergency			the generator stop switches are free of	of	
	-	I remotely outside the			obstruction and appear intact.	41	
	enclosure housing the	e prime mover.			Semiannually the vendor will inspect		
	An interview was can	ducted during the time of the			remote manual stop switches to ensu the remote manual stop switch function		
		iducted during the time of the MD and RPOD, who both			designed. Key staff will be educated of		
		terior generator's did not			the remote manual stop switches fund		
		al stop station to prevent			and use after installation, annually an		
		ntional operation located			needed.		
		enclosure housing the prime					
	mover.	. .			Findings will be reported to the		
					administrator as needed and to the		
		Operations Director, was			Quality Management/Performance		
	intormed of the findin	g's at the Life Safety Code			Improvement Committee at least qua	rterly	

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		ID HUMAN SERVICES				FORM	APPROVED	
STATEMENT O	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE COI	(X3) DATE	MB NO. 0938-0391 (3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING 01			LETED	
	315142					11/03/2022		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE			
LLANFAIR	HOUSE CARE & REHA	BILITATION CENTER			BLACK OAK RIDGE ROAD NE, NJ 07470			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG			PREFI) TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE	
K 918	Continued From page	e 17	K	918				
	exit conference held	on 10/28/22.		fc	or 4 quarters.			
	NJAC 8:39-31.2(e), 3 NFPA 110, 2010 Editi 5.6.5.6.1.	1.2(g) ion, Section 5.6.5.6 and						

Event ID:0SEF21

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