STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315142	A. BUILDING **01** 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 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 65 KW (Diesel) and 75 KW (Natural Gas).	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS	K 222		1/20/23

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

Electronically Signed | 12/02/2022

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K 222	Continued From page 1 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 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.	K 222		

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/27/22, 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 2 of 8 egress doors and evidenced by the following: 1. At 10:55 AM, the Surveyor, Maintenance Director and Regional Plant Operations Director, observed that the exit/egress door by resident rooms [redacted] and [redacted], was provided with a delayed egress system. The door was 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 was provided with a push button keypad and opened with the activation of the fire alarm. 2. At 11:18 AM, the Surveyor, Maintenance Director and Regional Plant Operations Director, observed that the exit/egress door by the nurse station [redacted], was provided with a delayed egress system. The door was 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 was provided with a push button keypad and opened with the activation of the fire alarm. The Maintenance Director and Regional Plant Operations Director, confirmed the findings at the time of the observations. The Regional Plant Operations Director, was	K 222	Instructional signage with 1 inch lettering was immediately placed nest to the exit / egress doors near rooms [redacted] and [redacted]. Permanent signage was ordered and will be installed upon receipt. The deficient practice could affect all residents. Facility rounds were conducted to ensure all exit /egress doors have the required signage posted. All other doors were noted to be in compliance. The Maintenance Director or designee will observe exit/egress door signage for compliance once per week for one month, then one time per month thereafter. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least quarterly for 4 quarters.	

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K 222	Continued From page 3 informed of these findings, during the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/28/22, in the presence of the Maintenance Director and Regional Plant Operations Director, the facility failed to provide and maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient condition was evidenced for 1 of 4 exit discharges by the following finding: 1). At 10:29 AM, the Surveyor and Maintenance Director and Regional Plant Operations Director observed outside the physical therapy exit/egress discharge, that the path lead to an approximately 5' x 4' area of a soft grassy area. The facility failed to provide a firm level walking surface, free of all obstructions or impediments to full instant	K 271	11/29/22 Contractor reported to the building to determine the scope of work needed to install a sidewalk on the grassy area and to expand the walkway at the obstruction to ensure a clear exit/egress 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 installed on the grassy area outside of rehabilitation services exit/egress path. The Path obstructed by the metal structure was widened as required to	1/20/23

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K 271	Continued From page 4 use in the case of fire or other emergency. 2). At 12:11 PM, the Surveyor and Maintenance Director and Regional Plant Operations Director observed that the exterior exit/egress concrete path was blocked from full access, due to a metal type structure on the building side approximately 2' out to the exit/egress path. The structure would now only allow approximately 34" for residents to evacuate in that area of the path in the event of an emergency evacuation. The Maintenance Director and Regional Plant Operations Director both stated and confirmed the observation's. The Regional Plant Operations Director was informed of the finding at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.7, 19.2.7	K 271	allow for an unobstructed exit/egress path. The Director of Maintenance or designee will perform walking rounds to observe the discharge exit/egress pathways to ensure that they are level and clear of obstruction every two weeks for one quarter and monthly thereafter. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least quarterly for 4 quarters.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/28/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to provide	K 281	10/31/2022 A solar motion activated lighting device was installed on the wall near the [redacted] floor [redacted] in order to provide emergency illumination without	1/20/23

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K 281	Continued From page 5 emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 2 of 6 exit access areas observed and was evidenced by the following: 1). At approximately 10:37 AM, the facility's [redacted] floor outside exit/egress keyed gate was not provided with any evidence of emergency lighting at the gate or beyond the gate. 2). At approximately 10:50 AM, the surveyor observed that the floor-[redacted] and floor-[redacted] occupied day rooms had no lighting when the wall switches were shut off. The facility's Maintenance Director and Regional Plant Operations Director both confirmed the findings at the time of observations. The Regional Plant Operations Director was informed of these findings at the Life Safety Code survey exit conference. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	the need for manual intervention. Exit/ egress lights in the resident day/dining rooms was modified to ensure continuous illumination of the exit/ egress pathway without the need for manual intervention. The deficient practice could affect all residents. The Director of Maintenance performed walking rounds to ensure that exit /egress illumination is either in continuous operation or capable of automatic operation without manual intervention. All were found to be in compliance. The Director of Maintenance or designee will perform walking rounds to verify that illumination of each means of egress/exit is either in continuous operation or capable of automatic operation without manual intervention weekly for one month, monthly for one quarter and quarterly thereafter. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least quarterly for 4 quarters.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 293		1/20/23

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K 293	Continued From page 6 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 10/28/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to provide one (1) exit sign that included a continuous illumination indicator showing the direction of travel, in every location, where the direction of travel to reach the nearest exit was not apparent, in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 1 of 28 exit signs observed and was evidenced by the following: At 10:00 AM, the surveyor, Maintenance Director and Regional Plant Operations Director, observed in the ground floor kitchen exit/egress corridor, that a photoluminescent exit sign was provided. The corridor light was approximately 20' away and did not provide enough light to activate the photoluminescent exit sign. The findings were verified by the Maintenance Director and Regional Plant Operations Director at the time of the observations. The Regional Plant Operations Director was informed of the findings at the Life Safety Code exit conference. NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. NJAC 8:39-31.2(e)	K 293	11/6/22 the ground floor kitchen exit/egress sign was hard wired into the emergency lighting system to provide a continuous illumination indicator showing the direction of travel to the nearest exit. The deficient practice could affect all residents. All exit and directional signs were inspected by the Director of Maintenance to ensure they are displayed as required with continuous illumination. All were noted to be in compliance. The Director of Mainteneance or Designee will inspect exit and directional signs to ensure continuous illumination as required weekly for one quarter than monthly thereafter. Signs noted to be out 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 quarterly for 4 quarters.	

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K 321	Continued From page 7	K 321		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of other facility documentation on 10/28/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to ensure that fire-rated doors to	K 321	Vendor submitted a quote to replace fire doors with missing fire rating labels with 90minute fire rated doors. The quote was approved and initial deposit forwarded to ensure doors were ordered. There is an	1/20/23

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K 321	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) 3 of 3 kitchen doors were 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 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	K 321	estimated 10 week turn around time to manufacture the doors. Upon delivery of the 90 minute fire rated doors will be installed. Expected completion date 5/31/2023. The deficient practice could affect all residents. All hazardous areas were inspected to ensure that the doors were labeled to note 3/4 hour fire rating. All were found to be compliant. The Director of Maintenance or designee will inspect all hazardous area doors for required labels and that they are able to close properly during life safety rounds weekly. Director of Maintenance will inservice kitchen, laundry and maintenance staff to make sure that the identified doors are unobstructed and close properly. The identified doors will be sprayed with flame retardant material. Will conduct an additional fire drill monthly specifically related to those areas until the doors are replaced. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee monthly until the doors are replaced and then at least quarterly for 4 quarters.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING	K 347		1/20/23

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K 347	Continued From page 9 Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 8/27/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to ensure that there was a testing, maintenance, and battery replacement program to ensure proper operation of the battery operated smoke detectors as per NFPA 72. This deficient practice was evidenced for 50 of 50 observed battery operated smoke detectors and evidenced by the following: A tour of the facility at 11:15 AM, revealed that the facility resident rooms were provided with battery operated smoke detectors. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance program for the testing of the detectors or for battery replacement. In an interview at 11:55 AM, the facility's Maintenance Director and Regional Plant Operations Director, stated that there was no preventative maintenance documentation for testing the battery operated smoke detectors in resident rooms and could not provide any documentation on the year of installation. He stated that he tested the alarms by pushing the test button periodically and replaced the batteries when the alarms indicated low battery, but he did not record any information on a log.	K 347	100% of resident rooms with battery operated smoke detectors to be replaced with new 10 year life battery operated smoke detectors. The life safety inspection log was revised to include the documentation of systematic smoke detector inspection rounds. 15 pkgs of 6 (90 individual smoke detectors) were ordered, received and installed. The deficient practice could affect all residents. Resident room smoke detectors to be inspected every two weeks to ensure operating as designed for one month then monthly for one quarter and quarterly thereafter. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least quarterly for 4 quarters.	

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K 347	Continued From page 10 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	K 347		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		1/20/23

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K 351	Continued From page 11 by: Based on record review and interview on 10/28/22, in the presence of the facility Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to provide automatic fire sprinkler protection to all areas in accordance with NFPA 13. This deficient practice was evidenced for 2 of 2 elevator shafts and 4 of 4 stairwells, by the following: 1) At 11:58 AM, the facility Maintenance Director and Regional Plant Operations Director, observed on floor [redacted], that when the hydraulic elevator was lowered, it was revealed that the upper shaft was not provided with any fire sprinkler coverage. An interview was conducted with the Maintenance Director and Regional Plant Operations Director during the observations and they confirmed that no fire sprinkler heads were located in the upper or lower shaft of the two elevators. 2) At 12:31 PM, the surveyor, Maintenance Director and Regional Plant Operations Director, observed that there was no fire sprinkler protection provided to the attached outside front entrance combustible blue fabric overhang, that measured approximately 20' x 12' wide. An interview was conducted with the Maintenance Director during the observation where he was asked, if he could provide a flammability rating of the blue awning, but as of 10/28/22 no further documentation was provided. 3) At 1:15 PM, the surveyor, observed that fire	K 351	1/10/23 Sprinkler system vendor was on site to determine scope of work required to extend the automatic sprinkler system into 2 of 2 upper elevator shafts and also into the identified stairwells. 1/17/2023 Quote obtained and approved. Vendor requested a deposit to schedule project. 1/26/2023 Deposit to secure work was sent to vendor (receipt attached). Scheduling of permits by vendor in progress. 2/10/2023 conversation with vendor noted start date anticipated within 10 business day of receipt of deposit or sooner. Projected completion by February ending. The blue fabric awning on the front of the building was coated with flame retardant. Weekly status update to NJDHSS until project completion. The deficient practice could affect all residents. All elevator shafts and stairwells were included in the life safety and vendor inspection. The additional sprinkler heads and the extension of the automatic sprinkler system are added to the quarterly inspection schedule performed by the vendor and the Director of Maintenance. The blue awning will be treated with a fire retardant spray 12/12/2022 and at least annually thereafter. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least quarterly for 4 quarters.	

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	315142	A. BUILDING **01** B. WING _____	**11/03/2022**

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K 351	Continued From page 12 sprinklers were not installed under the first accessible landing for 4 of 4 stairwells observed. An interview was conducted with the Maintenance Director and Regional Plant Operations Director, and they both confirmed that no fire sprinkler heads were observed at the first accessible landing for 4 of 4 stairwells observed. The Regional Plant Operations Director, was notified of the deficiency at the life safety code exit on 10/28/22. NFPA 13, 25 NJAC 8:39-31.1(c) NJAC 8:39-31.2(e)	K 351		
K 364 SS=F	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced	K 364		1/20/23

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K 364	Continued From page 13 by: Based on observation and interview on 10/28/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to maintain doors in a manner designed to resist the passage of smoke into exit corridors. This deficient practice was identified for 1of 8 closet doors and was evidenced by the following: At 11:22 AM, the surveyor observed that the [redacted] floor utility closet had a door with an approximately 2' x 2' open transfer grille to the exit/egress corridor. An interview was conducted with the Maintenance Director and Regional Plant Operations Director at the time of the observation, where they confirmed that the open door vent, was not to be used in corridor doors. The Regional Plant Operations Director, was informed of the finding at the Life Safety Code exit conference. NFPA 101-2012 edition Life Safety Code 19.3.6.4 Transfer Grilles. 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors. NJAC 8:39-31.2(e)	K 364	The ground floor utility closet corridor exit /egress door was observed to have a 2' x 2' open transfer grill which was replaced and sealed with a stainless steel sheet. The deficient practice could affect all residents. All corridor walls and doors where flammable / combustible materials may be found were inspected to ensure that no transfer grills are installed. All noted to be in compliance. Monthly the Director of Maintenace or designee will inspect all corridor openings during life safety rounds to ensure that no transfer grills are installed where flammable or combustibel materials may 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 quarterly for 4 quarters.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99	K 911		1/20/23

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K 911	Continued From page 14 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 10/27/22, 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 2 generator's. This deficient practice could affect all residents and was evidenced by the following: At 12:05 PM, the surveyor, Maintenance Director and Regional Plant Operations Director, reviewed all the facility's generator documentation. The facility currently has an 75 KW natural gas generator and the facility 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 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 finding was verified by the Maintenance	K 911	Our generator vendor provided a statement committing to the designation of a backup generator for the facility as well as the delivery of the backup generator and the required fuel supply in the event of an interruption of the natural gas fuel line to the generator. The deficient practice could affect all residents. The Director of Maintenance or designee 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 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 quarterly for 4 quarters.	

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K 911	Continued From page 15 Director and Regional Plant Operations Director at the time of the observation. On 10/28/22 at 2:30 PM, the Regional Plant Operations Director was informed of the finding at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911		
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 components is established according to manufacturer requirements. Written records of	K 918		1/20/23

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K 918	Continued From page 16 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 10/28/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure a remote manual stop station for 2 of 2 generator's 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, MD, and RPOD observed the exterior generator. There was not a remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator's observed remotely outside the enclosure housing the prime mover. An interview was conducted during the time of the observation with the MD and RPOD, who both confirmed that the exterior generator's did not have a remote manual stop station to prevent inadvertent or unintentional operation located remotely outside the enclosure housing the prime mover. The Regional Plant Operations Director, was informed of the finding's at the Life Safety Code	K 918	11/29/2022 The electrical contractor responded on site to determine the scope of work required to install remote manual stop switches for 2 of 2 generators. A quote for the work was received and approved. 1/27/2023 Generator stop switches were installed. Both were tested and functioning as designed. The deficient practice could affect all residents. The Director of Maintenance or designee will round at least monthly to ensure that the generator stop switches are free of obstruction and appear intact. Semiannually the vendor will inspect the remote manual stop switches to ensure the remote manual stop switch function as designed. Key staff will be educated on the remote manual stop switches function and use after installation, annually and as needed. Findings will be reported to the administrator as needed and to the Quality Management/Performance Improvement Committee at least quarterly	

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K 918	Continued From page 17 exit conference held on 10/28/22. 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	for 4 quarters.	