STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315367	A. BUILDING **01** B. WING _____	**01/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATION CENTER	**380 DEMOTT LANE** **SOMERSET, NJ 08873**

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 1/24/2022 and 1/25/2022 and Regency Heritage 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 Occupancies. Regency Heritage is a three (3) story, Type II Protected building that was built in August 1997. The facility is divided into 22 smoke zones.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.	K 321		3/25/22

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

Electronically Signed | 02/10/2022

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

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K 321	Continued From page 1 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 facility documentation on 1/24/2022, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing and shall be 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 practice was evidenced by the following: During the tour of the building at 10:20 AM, in the presence of the facility's Director of Maintenance (DOM), an inspection of the "Leven" unit lower level was performed. At 10:27 AM, the surveyor observed the one-hour fire rated corridor door leading into the Medical records room had no means to self-close.	K 321	K-321 completion date 3/25/22 1.A self-closing device was immediately re-affixed to the medical records room on the Levin unit lower level. All other areas were checked for this deficient practice and were found to be in compliance. 2.All residents may be affected by this deficient practice. 3.All maintenance staff were re-inserviced on the guidelines for when a self-closing device is to be installed and when it is applicable. The maintenance department will conduct weekly environmental rounds to check and ensure that if any self-closing device was removed for repair, it would be immediately replaced. A log will be maintained. 4.The maintenance director will tour the	

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K 321	Continued From page 2 The surveyor observed inside the room contained 800 plus combustible medical records files on 25 filing cabinets with open shelving. The surveyor measured and recorded the room. The room measured 17 feet 3 inches by 15 feet 4 inches. The room measured 264 square feet. The room measured larger than 50 square feet. A review of an evacuation diagram posted in the area identified this room is in the primary exit access path to reach an exit. This condition would allow fire, smoke and poisonous gases to pass from the Medical records room into the exit access corridor in the event of a fire. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference at 1:10 PM on 1/25/2022. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	entire facility monthly for 6 months to complete a standardized audit on the physical environment with an emphasis on room usage and self-closing door devices. A report will be submitted to the quality assurance committee quarterly with a summary of results.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders,	K 341		3/25/22

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K 341	Continued From page 3 and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/25/2022, in the presence of facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 2 of 2 enclosed outdoor resident areas in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. This deficient practice was evidenced by the following: On 1/25/2022 during the building tour starting at 9:58 AM with the facility Director of Maintenance (DOM), the surveyor observed two (2) areas that failed to provide fire alarm visual and audio (horn and strobe) notification in the following locations: 1) At 11:08 AM, an inspection of the [redacted] unit outside enclosed courtyard near Resident room [redacted] was performed. The surveyor observed that the outside Resident patio area did not have any occupant notification devices (horn/strobe tied into the fire alarm system). At that time the surveyor asked the DOM, "Do you have a horn and strobe out here to let residents know there is a fire alarm going on?" The DOM looked around and said "no."	K 341	K-341 completion date 3/25/22 1.All other outdoor patio areas were inspected and found to be in compliance. Our vendor was contacted to install a horn and strobe in the [redacted] enclosed courtyard and the courtyard adjacent to the resident dining room. 2.Any resident in these patio areas has the potential of being affected by this deficient practice. 3.The maintenance department was reinserviced on fire safety code with an emphasis on horn and strobe compliance in the applicable areas.The maintenace department will conduct weekly environmental rounds to ensure compliance and a log will be maintained. 4.The Maintenance Director will tour the entire facility monthly to complete a standardized audit of the physical environment with an emphasis on horn/strobe for 6 months. A quarterly report will be submitted to the quality assurance committee with a summary of results.	

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K 341	Continued From page 4 2) At 11:27 AM, an inspection of the [redacted] outside Resident patio area adjacent to the Resident dining room was performed. The surveyor observed that the outside Resident patio area did not have any occupant notification devices (horn/strobe tied into the fire alarm system). The findings were verified and confirmed by the Director of Maintenance during the observations. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference at 1:10 PM on 1/25/2022. NJAC 8:39-31.2(a)	K 341		
K 351 SS=D	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)	K 351		3/25/22

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K 351	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations on 1/25/2022, in the presence of Facility Management it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the Facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. This deficient practice was evidence by the following: Reference #1: N.J.A.C. 5:23 -Uniform Construction Code, Special detailed requirements based on use and occupancy section 407 group I-2, [F] 407.5 Automatic sprinkler system. Smoke compartments containing patient sleeping units shall be equipped throughout with an automatic fire sprinkler system in accordance with Section 903.3.1.1. The smoke compartment shall be equipped with approved quick-response or residential sprinklers in accordance with section 903.3.2. This deficient practice was evidenced by the following: During the survey entrance on 1/24/2022 at 9:36 AM,, the surveyor requested the facility's Administrator (Admin) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identified the various rooms in the facility. During a tour of the building in the presence of the facility DOM, the surveyor observed that the facility failed to provide proper fire sprinkler	K 351	K-351 completion date 3/25/22 1.All other areas were inspected and were found to be in compliance. A service order was placed with the vendor to correct the sprinkler head in the soiled utility room. 2.All residents on [redacted] one may be affected by this deficient practice. 3.The Maintenance staff will be reinserviced on sprinkler head installation guidelines. The maintenance staff will perform monthly sprinkler head inspection rounds and will maintain a log. 4.The Maintenance Director will tour the entire building monthly to complete a standardized audit of the physical environment with an emphasis on sprinkler heads for 6 months. Results will be submitted the quality assurance committee quarterly with a summary of results.	

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K 351	Continued From page 6 protection in the following location: 1. At 11:21 AM, an inspection of the Goldfarb I unit soiled utility room, across from the Physical Therapy area, was conducted. During the inspection, the surveyor observed inside the room one downward pendant sprinkler head. There was an escheon cap installed incorrectly directly above the sprinklers deflector plate, which blocked the fusible link and/or frangible glass head for the fire sprinkler. This would not allow the fire sprinkler to function properly in the event of a fire. The facility DOM confirmed the finding at the time of observation. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference at 1:10 PM on 1/25/2022. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 371 SS=D	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including	K 371		3/25/22

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K 371	Continued From page 7 length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 1/24/2022 in the presence of facility management, it was determined that the facility failed to assure that smoke barriers were maintained smoke, fire and poisonous gas resistant in sleeping areas occupying more than 30 patients. This deficient practice was evident by the following: On 1/24/2022 at 9:36 AM during the survey entrance a request was made to the facility's Director of Maintenance (DOM) to provide a copy of the facility lay-out print which identifies the various rooms and smoke compartments in the facility. The DOM provided the facility lay-out prints of the [redacted] building [redacted], [redacted] and [redacted] floors, and [redacted] building, [redacted] and [redacted] floors, which identified rooms and smoke compartments. Starting at 10:00 AM in the presence of the DOM a tour of the building was conducted. During the tour of [redacted] building on the [redacted] at 11:32 AM, the surveyor observed the Dining room had two (2) doors in the open position. These two doors had no means to self-close into their frames and were opposite of each other with one leading to the corridor near the Resident room [redacted] and the other leading to the corridor near the TV room. The surveyor observed a set of double corridor smoke doors was located between Resident	K 371	K-371 completion date 3/25/22 1.A self-closing device was immediately re-affixed to the dining room door on the [redacted] unit. All other areas were inspected and were found to be in compliance. 2.All residents may be affected on [redacted] unit may be affected by this deficient practice. 3.The Maintenance staff were re-inserviced on smoke barrier guidelines and necessity for self-closing doors where applicable. The Maintenance staff will conduct monthly environmental rounds with an emphasis on smoke barrier door and check to ensure that self-closing devices that were removed for repair, would be immediately replaced. A log will be maintained. 4.The Maintenance Director will tour the entire facility monthly to complete a standardized audit of the physical environment with an emphasis on smoke barrier doors for 6 months. A quarterly report will be submitted to the quality assurance committee with a summary of results.	

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K 371	Continued From page 8 room [redacted] and the TV room. At that time, a review of the facility provided layout was performed. This review identified that one door leads to one smoke compartment and the other door leads to another smoke compartment. There is a set of double smoke doors located between Resident room [redacted] and the TV room. The surveyor observed one dining room door, across from Resident room [redacted] had evidence of a automatic door closure that had been removed. The DOM confirmed the findings at the time of observation. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference at 1:10 PM on 1/25/2022.	K 371		
K 521 SS=E	NJAC 8:39-31.1(d) HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview conducted	K 521	K-521	3/25/22

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K 521	Continued From page 9 on 1/24/2022 and 1/25/2022 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 6 of 12 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During a tour of the building starting at 10:00 AM on 1/24/2022 and continued on 1/25/2022, in the presence of the facility's Director of Maintenance (DOM), an inspection inside of twelve (12) resident bathrooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 6 of 12 resident bathrooms in the following locations: On 1/24/2022: 1. At 11:37 AM, inside Resident room [redacted] bathroom, the exhaust system did not function properly when tested. At that time, the surveyor informed the DOM that the exhaust system did not function properly. 2. At 11:47 AM, inside Resident room [redacted] bathroom, the exhaust system did not function properly when tested. 3. At 11:55 AM, inside Resident room [redacted] bathroom, the exhaust system did not function properly when tested. 4. At 12:14 PM, inside Resident room [redacted] bathroom, the exhaust system did not function	K 521	completion date 3/25/22 1.An order for a part was immediately placed with the vendor to correct the exhaust system affecting rooms #□s [redacted] All other bathroom exhaust fans were inspected and found to be in compliance. 2.All Residents in these rooms may be affected by the deficient practice. 3.The Maintenance staff were reinserviced on exhaust system function and inspection process. The Maintenance department will conduct monthly environmental rounds with an emphasis on the exhaust system function and maintain a log. 4.The Maintenance Director will tour the entire facility monthly for 6 months to complete a standardized audit on the physical environment with an emphasis on exhaust fan function for all areas. A report will be submitted to the quality assurance committee quarterly with a summary of results.	

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K 521	Continued From page 10 properly when tested. The surveyor observed air blowing the tissue inward into the bathroom. 5. At 12:18 PM, inside Resident room [redacted] bathroom, the exhaust system did not function properly when tested. The surveyor observed air blowing the tissue inward into the bathroom. On 1/25/2022: 6. At 11:19 AM, inside Resident room [redacted] bathroom, the exhaust system did not function properly when tested. The DOM confirmed the findings at the time of observations. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference at 1:10 PM on 1/25/2022. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit	K 912		3/25/22

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REGENCY HERITAGE NURSING AND REHABILITATION CENTER	**380 DEMOTT LANE** **SOMERSET, NJ 08873**

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K 912	Continued From page 11 interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations on 1/24/2022 in the presence of facility management, it was determined that the facility failed to ensure that 1.) One (1) of twelve (12) electrical outlets located next to a water source were equipped with Ground-Fault Circuit Interrupter (GFCI) protection and 2) Two (2) of eleven (11) Ground-Fault Circuit Interrupter electrical outlets functioned properly when tested. This deficient practice was evidenced by the following: Starting at 10:00 AM, during the building tour in the presence of the facility Director of Maintenance (DOM), the surveyor conducted an inspection of the Lower level, [redacted] and [redacted] floor common areas, 11 Resident rooms, storage rooms, work areas and offices. The surveyor observed the following electrical outlets located (within 4 feet of a sink) in the following wet locations: 1) At 10:33 AM the surveyor observed one duplex electrical outlet in the Beauty Salon was located 16 inches from a hair washing sink. When tested with a GFCI tester to de-energize, the electrical outlet did not de-energize as required by code for wet locations. 2) At 11:32 AM, the surveyor observed inside Resident room [redacted] bathroom one GFCI electrical outlet. When the surveyor used a GFCI tester to de-energize the electrical outlet, the electrical outlet did not de-energize as required.	K 912	K-912 completion date 3/25/22 1.The GFCI outlet was immediately corrected for the beauty salon and room numbers [redacted]. All other areas were inspected and found to be in compliance. 2.All residents may be affected by this deficient practice. 3.The Maintenance department was inserviced on usage of a GFCI tester. In addition to the annual electrical inspection by an electrical contractor in January , the Maintenance department will inspect each GFCI outlet for proper function annually in June , and a log will be maintained. 4.The Maintenance Director will tour the entire facility monthly for 6 months to complete a standardized audit on the physical environment and will test 5 GFCI outlets on each unit. A report will be submitted to the quality assurance committee quarterly with a summary of results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315367	A. BUILDING **01** B. WING _____	**01/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 912	Continued From page 12 3) At 12:10 PM, the surveyor observed inside Resident room [redacted] bathroom one GFCI electrical outlet. When the surveyor used a GFCI tester to de-energize the electrical outlet, the electrical outlet did not de-energize as required. The DOM confirmed the findings at the time of observation. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference at 1:10 PM on 1/25/2022. NJAC 8:39 -31.2 (e) NFPA 99	K 912		