STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**03/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 03/21/22 and 03/22/22 and Rehab at River's Edge 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. Rehab at River's Edge is a single (1) story, Type II Protected building that was built in October 1972. The facility is divided into 8 smoke zones.	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/21/2022, in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with	K 291	1. The emergency light in the generator was checked for function by the Director of Environmental Services (DEVS). It was determined that this exit light was indeed the correct light as required in accordance with NFPA 101:2012 □ 7.9 19.2.9.1 The emergency light included the required	5/3/22

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

Electronically Signed | 04/08/2022

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 291	Continued From page 1 NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 03/21/2022 starting at 9:29 AM with the facility's Administrator (Admin) and Director of Environmental Services (DEVS), a tour of the building was conducted. During the tour at 11:55 AM, an inspection inside the Generator room where the emergency generator's transfer switch is located was performed. The surveyor observed, inside the room, a combination Illuminated exit sign/ emergency light located above the door. At this time, a request was made to the DEVS to conduct a test of the battery back battery back up system of the exit sign/ emergency light. The DEVS looked at the sign and said to the surveyor there is no test button, its tied into the generator. When the generator comes on, the light comes on. The findings were verified and confirmed by the Admin and DEVS during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 03/22/2022 at 10:39 AM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	backup battery. At the time of this inspection the DEVS and the Administrator could not locate the battery test button. The button to test the emergency light was located on the top left corner of the fixture. The light was tested and functioned properly by the DEVS. 2. All Residents and staff have the potential to be affected by the identified deficient practice. Safety checks were conducted for all residents by the DEVS, and none were found to be affected. 3. The emergency lighting test button was marked to indicate where the test button is to ensure the backup battery functions properly and is clearly visible. A sign was also placed in the generator room near the emergency light indicating where the test button is located. The Administrator educated the DEVS to ensure that a battery back-up emergency light above the emergency generator transfer switch is always functioning. The DEVS will check and change the battery monthly. 4. The emergency light in the generator room will be tested weekly X 3 months then monthly X 3 months by the DEVS or the Administrator and tested for functionality. Findings will be reviewed at the Monthly Quality Assurance meeting and addressed accordingly.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		5/3/22

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K 321	Continued From page 2 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 interview on 03/21/2022, in the presence of facility management, it was determined that the facility failed to provide fire barriers with a one-hour fire resistance rating to hazardous areas 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.	K 321	K321 1. The missing ceiling tiles were replaced in the boiler room on Wing [redacted] by the Director of Environmental Services (DEVS). The penetration where the two copper pipes make a 90-degree turn were patched with smoke resistant caulk above the drop ceiling tile by the DEVS to ensure	

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K 321	Continued From page 3 This deficient practiced was evidenced by the following: On 03/21/2022 starting at 9:29 AM with the facility's Administrator (Admin) and Director of Environmental Services (DEVS), a tour of the building was conducted. During the tour at 11:10 AM, an inspection inside the boiler room on Unit [redacted] was performed. The surveyor observed inside the room, that one ceiling tile was missing and had two (2) copper pipes that were running upward and made a 90 degree turn to run through an approximately 20 inch by 10 inch penetration through the rooms one-hour fire rated wall that was above the drop ceiling grid. At this time a request was made to the Admin, when were the two copper pipes installed. The Admin told the surveyor, it's been a while. This condition would allow fire, smoke and poisonous gases to pass from the Boiler room into the exit access corridor in the event of a fire. The findings were verified and confirmed by the Admin and DEVS during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 03/22/2022 at 10:39 AM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	that no fire, smoke, or poisonous gases passes from the boiler room into the exit access corridor in the event of a fire. 2. Resident safety checks were conducted by the DEVS, no residents were affected. All Residents and staff have the potential to be affected by the identified deficient practice. All rooms in the facility were checked above the ceiling tiles by the DEVS to ensure there was no penetration gaps, no other deficient areas were identified. 3. The Administrator educated the DEVS on the importance of not having any penetration through any areas of the smoke walls throughout the facility. 4. All areas of the facility will be checked for penetration gaps monthly by the DEVS or Administrator X 3 months, then semi-annually. Any findings will be addressed and discussed at the monthly Quality Assurance meeting and addressed accordingly.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation	K 341		5/3/22

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K 341	Continued From page 4 A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/21/2022, in the presence of facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 enclosed courtyard in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 03/21/2022 starting at 9:29 AM with the facility's Administrator (Admin) and Director of Environmental Services (DEVS), a tour of the building was conducted. During the tour at 10:42 AM, an inspection of the outside enclosed center [redacted], located between Units [redacted], Unit [redacted] and Unit [redacted] was performed.	K 341	K341 1. A work order was placed with the fire safety company on 3/16/2022 by the Administrator to install the horn and strobe in the enclosed [redacted] per NFPA 101. Fire safety company installed he horn/strobe per NFPA 101 on 4/7/2022. The enclosed outdoor [redacted] is currently not used by staff/residents at this time. 2. Resident safety checks were conducted by the Administrator, no residents were affected. All Residents and staff have the potential to be affected by the identified deficient practice in the event of a fire in the outdoor enclosed [redacted]. 3. The Director of Environmental Services Director (DEVS) was educated	

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K 341	Continued From page 5 The surveyor observed no evidence of a fire alarm notification (horn/ strobe) in the enclosed courtyard area. At this time, the surveyor asked the Admin if there was a horn/strobe for the fire alarm system. The Admin said, no there is an alarm inside the building. The findings were verified and confirmed by the Admin and DEVS during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 03/22/2022 at 10:39 AM. NJAC 8:39-31.2(a)	K 341	by the Administrator on the regulation in accordance with NFPA 70, National Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the facility and, to maintain the fire alarm notification system in all areas of the facility by audible and visible signals including the enclosed outdoor [redacted]. 4. The DEVS or Administrator will perform monthly audits to check for placement and functionality of audible and visible fire alarm signal. This audit will be conducted for 3 months, then semi-annually. The findings of these audits will be reported at the monthly Quality Assurance meeting and addressed accordingly.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations on 03/21/2022, it was	K 372	K372	5/3/22

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K 372	Continued From page 6 determined that the facility failed to maintain the integrity of smoke barrier partitions for six (6) of eight (8) smoke barrier walls as evidenced by the following: On 03/21/2022 starting at 9:29 AM with the facility's Administrator (Admin) and Director of Environmental Services (DEVS), a tour of the building was conducted. During the building tour the surveyor observed penetrations through smoke barrier walls ranging from 3/8 of an inch up to 10 inches in the following locations: 1. At 9:57 AM, above the double smoke doors between the Human Resources Dept. and the Activities office had an approximately 6 inch penetration through the smoke barrier wall with a pipe and wires running the the opening. 2. At 10:14 AM, Unit [redacted] above the double smoke doors next to Resident room [redacted] had an approximately 3/8 gap around a pipe through the smoke barrier wall with wires running through the opening. 3. At 10:24 AM, Unit [redacted] above the double smoke doors next to Resident room [redacted] had an approximately 2 inch penetration through the smoke barrier wall with wires running through the opening. 4. At 10:37 AM, Unit [redacted] above the double smoke doors next to Resident room [redacted] had an approximately 4 inch penetration through the smoke barrier wall with 3 pipes and wires running through the opening. 5. At 11:07 AM, Unit [redacted] above the double smoke doors next to Resident room [redacted] had an	K 372	1. The smoke barrier walls were inspected for the integrity of the required by NFPA 19.3.7.3.8.6.7 The penetrations found at the Human Resources Dept./Activities Office, on Unit [redacted] above the double smoke doors next to resident room #[redacted], on Unit [redacted] above the double smoke doors next to room [redacted], on unit [redacted] above the double smoke doors next to room #[redacted] on Unit [redacted] above the double smoke doors next to room [redacted], on Unit [redacted] above the double smoke doors next to room #[redacted] were all sealed with fire caulk by the Director of Environmental Services (DEVS). 2. Resident safety checks were conducted by the DEVS, no residents were affected. All staff and residents have the potential to be affected by this deficient practice in the event of a fire. 3. All smoke barrier doors were checked by the DEVS to ensure there was no penetration through the barrier. No additional penetrations were found. The DEVS was educated by the Administrator on the importance of maintaining the integrity of smoke barrier walls to prevent smoke, fumes, and fire from passing through to the other smoke compartments in the event of a fire. 4. All smoke compartment barrier doors will be inspected monthly by the DEVS or Administrator to ensure there is no penetrations. This audit will be conducted for 6 months, then semi-annually. All findings will be reported at the monthly Quality Assurance Meeting and addressed accordingly.	

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K 372	Continued From page 7 approximately 10 inch penetration through the smoke barrier wall with 3 pipes and wires running through the opening. 6. At 11:28 AM, Unit [redacted] above the double smoke doors next to Resident room [redacted] had a 3/8 inch gap around a pipe running through the smoke barrier wall. These penetrations were observed on both sides through the smoke barrier walls, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The findings were verified and confirmed by the Admin and DEVS during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 03/22/2022 at 10:39 AM.	K 372		
K 918 SS=E	NJAC 8:39-31.2(e) Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		5/3/22

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K 918	Continued From page 8 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 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and review of facility provided documentation on 3/21/2022, in the presence of facility management, it was determined that the facility failed to a) Certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems, and b) Exercise the emergency electrical generator 12 times each year for 12 of 12 monthly load tests in accordance with NFPA 99. This deficient practice was evidenced for 1 of 1 generator logs provided by the Director of Environmental Services (DEVS).	K 918	K918 1. The generator was run on the full load by the Director of Environmental Services (DEVS) as required by NFPA 111 on 3/22/2022 post the NJDOH Surveyor exiting. The Transfer time for the switch of the generator was less than 10 seconds per the requirement of NFPA 110. 2. Resident safety checks were conducted by the DEVS, no residents were affected. All staff and residents have the potential to be affected by this deficient practice in the event of a power failure. 3. The DEVS was educated by the	

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K 918	Continued From page 9 During the survey entrance on 03/21/2022 at 9:13 AM, a request was made to the Director of Environmental Services does the facility have an emergency generator, how often does the facility transfer the load of the building onto the generator and do they keep a log book. The DEVS said yes they do a monthly load test and have a log book. Later a review of the generator records for the previous twelve months, revealed that the dates were not documented when the generator was under load for the month and did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. The findings were verified and confirmed by the during the review. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 03/22/2022 at 10:39 AM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	Administrator on the correct procedure of maintaining the documented certification that the generator would start and transfer power to the building within ten seconds. The generator test log was changed to reflect the load and switch time. 4. The DEVS or Administrator will monitor the load type and switch time and record the certification documentation on the test log weekly X 3 months then monthly X 3 months to ensure compliance. The logs will be reviewed at the monthly Quality Assurance meeting and discussed for follow up and addressed accordingly.	