		& MEDICAID SERVICES			-	APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01	COM	PLETED
		335379	B. WING		05/(	04/2021
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
REGO P	E OF PROVIDER OR SUPPLIER         GO PARK NURSING HOME         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         000       INITIAL COMMENTS         A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Cente for Medicare & Medicaid Services (CMS) on Ma 4, 2021 following New York Department of Health, Health Facility Survey and Field Operations survey on April 9, 2021.         At this Comparative Federal Monitoring Survey, Rego Park Nursing Home 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 Associatio (NFPA) 101, Life Safety Code (LSC), Chapter 1 EXISTING Health Care Occupancies.         Rego Park Nursing Home is a six story building that was built in 1974. It is composed of Type II (222) and is partially sprinklered on domestic water. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. Emergency backup power to the building was supplied by a 125 Kw diesel generator outside the facility that is tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases and emergency facility lighting.		11 26 CORONA AVENUE LUSHING, NY 11368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K 000			
	Monitoring Survey for Medicare & Med 4, 2021 following N Health, Health Faci Operations survey At this Comparative Rego Park Nursing noncompliance with participation in Med 483.90(a), Life Safe Edition of the Natio (NFPA) 101, Life Safe Edition of the Natio (NTPA) 101, Life Safe Edition of the Natio (NTPA) 101, Life Safe Edition of the Natio (NTPA) 101, Life Safe Edi	was conducted by the Centers dicaid Services (CMS) on May lew York Department of lity Survey and Field on April 9, 2021. Federal Monitoring Survey, Home was found to be in the requirements for dicare/Medicaid at 42 CFR ety from Fire, and the 2012 nal Fire Protection Association afety Code (LSC), Chapter 19 Care Occupancies. Home is a six story building 74. It is composed of Type II by sprinklered on domestic bervised smoke detection dors, spaces open to the sident rooms. Emergency e building was supplied by a erator outside the facility that arm control panel, cross open devices, exterior door gency facility lighting.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEDARTMENT OF LIEALTH AND LIUMAN CERVICES

TITLE

(X6) DATE

PRINTED: 05/18/2021

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.

		AND HUMAN SERVICES				FORM	05/18/202 APPROVE 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION () 01 - MAIN BUILDING 01		E SURVEY PLETED		
		335379	B. WING			05/	04/2021		
	PROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 111 26 CORONA AVENUE FLUSHING, NY 11368					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE		
K 000	means of egress in alterations or addit	areas of construction, repair, ions. D certified beds. At the time of	K	000					
K 222 SS=F	NOT MET as evide Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required equipped with a lat use of a tool or key using one of the fol arrangements: CLINICAL NEEDS LOCKING Where special lock clinical security nee only one locking de each door and prov rapid removal of oc locks; keying of all at all times; or othe available to the sta 18.2.2.2.5.1, 18.2.2 SPECIAL NEEDS Where special lock safety needs of the Clinical or Security being met. In additi electrical locks that upon loss of power protected by a sup-	I means of egress shall not be ch or a lock that requires the r from the egress side unless llowing special locking OR SECURITY THREAT ing arrangements for the eds of the patient are used, evice shall be permitted on visions shall be made for the ecupants by: remote control of locks or keys carried by staff er such reliable means	K	222	<ol> <li>Plan of Correction for affected areas         <ol> <li>Maintenance staff permanently removed the fabric stop sign attach with Velcro across the Main Dining Room exit access door.</li> <li>The Maintenance staff permanently removed the fabric stop sign attach with Velcro across the 1st Floor Sta exit door.</li> <li>The Maintenance staff permanently removed the delayed egress locking mechanism from the 1st floor Stair I exit door.</li> <li>The Maintenance staff permanently removed the "Stop" sign from the 3 Floor Stair B exit door.</li> <li>The Maintenance staff permanently removed the "Stop" sign from the 3 Floor Stair A exit door.</li> <li>The Maintenance staff permanently removed the "Stop" sign from the 3 Floor Stair A exit door.</li> </ol> </li> <li>The Maintenance staff permanently removed the "Stop" sign from the 6 Floor Stair B exit door.</li> <li>The Maintenance staff permanently removed the "Stop" sign from the 6 Floor Stair B exit door.</li> </ol> <li>The Maintenance staff permanently removed the "Stop" sign from the 6 Floor Stair A exit door.</li> <li>The Maintenance staff permanently removed the "Stop" sign from the 6 Floor Stair A exit door.</li>	ed air B g B rd rd	05/11/2		

If continuation sheet Page 2 of 16

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	IDENTIFICATION NUMBER:				ATE SURVEY MPLETED
	335379	B. WING		0	5/04/2021
R OR SUPPLIER	·	· [	STREET ADDRESS, CITY, STATE, ZIP	CODE	
RSING HOME	E		111 26 CORONA AVENUE FLUSHING, NY 11368		
ACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
ete smoke de antly monitore the locked s etection syste upon activat .2.5.2, 19.2.2 YED-EGRES NGEMENTS ved, listed de ed in accorda ted on door a ry hazard co hout by an a tection syste atic sprinkler .2.4, 19.2.2.2 SS-CONTRO NGEMENTS s-Controlled ed in accorda ted. .2.4, 19.2.2.2 NGEMENTS sor lobby exit dance with 7 ussemblies in hout by an a tection syste vised automa .2.4, 19.2.2.2	etection system (or is ed at an attended location pace); and both the sprinkler ems are arranged to unlock the ion. 2.2.5.2, TIA 12-4 S LOCKING elayed-egress locking systems ance with 7.2.1.6.1 shall be assemblies serving low and ntents in buildings protected pproved, supervised automatic m or an approved, supervised system. 2.4 DLLED EGRESS LOCKING G Egress Door assemblies ance with 7.2.1.6.2 shall be 2.4 Y EXIT ACCESS LOCKING G access door locking in 2.1.6.3 shall be permitted on buildings protected pproved, supervised automatic m and an approved, stic sprinkler system. 2.4		<ul> <li>Plan of Correction to idem areas potentially affected</li> <li>The Maintenance staff com of all exit access and stair obstructions or signage that potentially confuse or prohi instant use of the facility de None were found.</li> <li>Plan of Correction for syst to prevent reoccurrence</li> <li>The Engineer or Designee wexits during environment of and report the findings to the Committee for a period of servironment of care rounds of non-compliance. The Factor Designee will report the audits to the Safety committee for a finder period for the findings for the environment of care rounds of non-compliance. The Factor Designee will report the audits to the Safety committee for the findings for the environment of care rounds of non-compliance. The Factor Designee will report the findings to the Safety committee for the Safety committee for the findings for the environment of care rounds of non-compliance. The Factor Designee will report the findings to the Safety committee for the safety committee for the factor Designee will report the findings for the factor Designee will report the findings for the factor Designee will report the factor Designee will report the findings for the factor prescuence of the factor Designee wi</li></ul>	htify other pleted a survey doors for any at would ibit residents esigned exit. tem measures will monitor all care rounds he Safety six (6) months. nitoring will review s for any cases cilities Manager result of these tee on a	05/11/21
	SUMMARY STA ACH DEFICIENC GULATORY OR L GULATORY OR L SQULATORY OR	ECTION IDENTIFICATION NUMBER: 335379 TROR SUPPLIER JRSING HOME SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL EQULATORY OR LSC IDENTIFYING INFORMATION) Inued From page 2 lete smoke detection system (or is antly monitored at an attended location the locked space); and both the sprinkler etection systems are arranged to unlock the upon activation. 2.2.5.2, 19.2.2.2.5.2, TIA 12-4 YED-EGRESS LOCKING ANGEMENTS oved, listed delayed-egress locking systems led in accordance with 7.2.1.6.1 shall be tted on door assemblies serving low and ary hazard contents in buildings protected ghout by an approved, supervised automatic etection system or an approved, supervised natic sprinkler system. 2.2.4, 19.2.2.2.4 ESS-CONTROLLED EGRESS LOCKING ANGEMENTS as-Controlled Egress Door assemblies led in accordance with 7.2.1.6.2 shall be tted. 2.2.4, 19.2.2.2.4 ATOR LOBBY EXIT ACCESS LOCKING ANGEMENTS tor lobby exit access door locking in dance with 7.2.1.6.3 shall be permitted on assemblies in buildings protected	ECTION       IDENTIFICATION NUMBER:       A. BUILDI         335379       B. WING         IR OR SUPPLIER       JRSING HOME         SUMMARY STATEMENT OF DEFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID         SUMMARY OR LSC IDENTIFYING INFORMATION)       TAG         nued From page 2       K 2:         hued From page 2       K 2:         lete smoke detection system (or is antly monitored at an attended location the locked space); and both the sprinkler etection systems are arranged to unlock the upon activation.       K 2:         2.2.5.2, 19.2.2.5.2, TIA 12-4       YED-EGRESS LOCKING         NNGEMENTS       Development of a mapproved, supervised automatic etection system or an approved, supervised automatic etection system and an approved, supervised automatic etection is buildings protected ghout by an approved, supervised automatic etection system and an approved, vised automatic esprinkler system.         2.2.4, 19.2.2.2.4       SS-CONTROLLED EGRESS LOCKING         NGEMENTS       TACCESS LOCKING     <	ECTION       IDENTIFICATION NUMBER:       A. BUILDING 01 - MAIN BUILDING 01         335379       B. WING         IROR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP         JRSING HOME       STREET ADDRESS, CITY, STATE, ZIP         INCOMPTION TOF DEFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID         GOULATORY OR LSC IDENTIFYING INFORMATION)       ID         Inued From page 2       ID         Iete smoke detection system (or is antly monitored at an attended location the locked space); and both the sprinkler election systems are arranged to unlock the upon activation.       K 222         VED-EGRESS LOCKING       NGEMENTS         NVED, listed delayed-egress locking systems ed in accordance with 7.2.1.6.1 shall be tted on door assemblies serving low and any hazard contents in buildings protected ghout by an approved, supervised automatic stection system or an approved, supervised automatic stection system or an approved, supervised automatic stection system and an approved, supervised automatic stection system and an approved, supervised automatic stection system and an approved, vised automatic stection system and an approved, vised automatic sprinkler system.       Plan of Correction for mo corrective actions         2.2.4, 19.2.2.2.4       The Engineer or Designee + environment of care rounde of non-compliance. The Facily basis, as well as of it warranted.         Responsibility:       Administrator	ECTION       IDENTIFICATION NUMBER:       A BUILDING 01 - MAIN BUILDING 01       CC         335379       B. WING       01         R OR SUPPLIER       JRSING HOME       STREET ADDRESS, CITY, STATE, ZIP CODE       111 26 CORONA AVENUE         FLUSHING, NY 11368       STREET ADDRESS, CITY, STATE, ZIP CODE       111 26 CORONA AVENUE       FLUSHING, NY 11368         SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GRULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-MEFERENCED TO THE APPROPRIATE DEFICIENCY)         nued From page 2       IL       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-MEFERENCED TO THE APPROPRIATE DEFICIENCY)         nued From page 2       K 222       Plan of Correction to identify other areas potentially affected         nued From page 2       K 222       Plan of Correction to identify other areas potentially affected         the locked space); and both the sprinkler det accordance with 7.2.1.6.1 shall be tted on door assemblies serving low and any hazard contents in buildings protected phout by an approved, supervised automatic tacts sprinkler system.       Plan of Correction for monitoring corrective actions         .2.4. 19.2.2.2.4       The Engineer or Designee will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted. <t< td=""></t<>

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	01 - MAIN BUILDING 01	COM	PLETED
		335379	B. WING			05/	04/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REGO P/	ARK NURSING HOME				111 26 CORONA AVENUE		
					FLUSHING, NY 11368		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 222	Continued From pa	ige 3	К 2	222			
	passageways are reall obstructions or in in the case of fire of accordance with the 2012 Edition, Section 7.1.10.1, 7.1.10.2, 1 7.10.1.2.1. The defin of 125 residents, as number of staff and Findings include: Observation on Mar 10:05 AM revealed had fabric "stop" sig with velcro to the do	readily accessible and free of mpediments to full instant use or other emergencies in e requirements of NFPA 101, on 19.2.1, 19.2.2, 19.2.2.2.4, 7.10.1.2.1, 7.2.1, 7.2.1.6 and icient practice could affect 125 s well as an indeterminable d visitors.					
		sidents instant use of the exit in the case of fire or other					
	10:56 AM revealed had fabric "stop" sig with velcro to the do door prohibiting res	y 4, 2021 at approximately first floor stair way B exit door gn across the door, attached oor frame that blocked the sidents instant use of the exit in the case of fire or other					
	10:57 AM revealed did not have a sign	y 4, 2021 at approximately first floor stair way B exit door on the door with a contrasting ing how to operate the king mechanism.					
	11:18 AM revealed	y 4, 2021 at approximately third floor B exit door had loor potentially confusing or					

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		AND HUMAN SERVICES				FORM	05/18/2021 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONST IG <b>01 - MAII</b>	RUCTION N BUILDING 01		E SURVEY PLETED
		335379	B. WING _			05/	04/2021
NAME OF	PROVIDER OR SUPPLIER	•			DDRESS, CITY, STATE, ZIP CODE		
REGO P	ARK NURSING HOME	E			RONA AVENUE IG, NY 11368		
(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 CORRECTION EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 222 K 281 SS=E	<ul> <li>prohibiting resident designated exit in t emergency.</li> <li>Observation on Ma 11:22 AM revealed "stop" sign on the oprohibiting resident designated exit in t emergency.</li> <li>Observation on Ma 11:26 AM revealed "stop" sign on the oprohibiting resident designated exit in t emergency.</li> <li>Observation on Ma 11:32 AM revealed "stop" sign on the oprohibiting resident designated exit in t emergency.</li> <li>Observation on Ma 11:32 AM revealed "stop" sign on the oprohibiting resident designated exit in t emergency.</li> <li>The findings were to Director and House time of the observat Illumination of Mea CFR(s): NFPA 101</li> <li>Illumination of Mea allumination of mea discharge, is arran and shall be either</li> </ul>	ts instant use of the facility he case of fire or other by 4, 2021 at approximately third floor A exit door had door potentially confusing or ts instant use of the facility he case of fire or other by 4, 2021 at approximately sixth floor B exit door had door potentially confusing or ts instant use of the facility he case of fire or other by 4, 2021 at approximately sixth floor A exit door had door potentially confusing or ts instant use of the facility he case of fire or other by 4, 2021 at approximately sixth floor A exit door had door potentially confusing or ts instant use of the facility he case of fire or other by the Maintenance ekeeping Supervisor at the ation. Ins of Egress	К 22	31 Pia	an of Correction for affected ar 1) The facility permanently install light fixture with dual lamps un the canopy at the 1st Floor Re exit discharge above the door.	ed a der hab	08/24/21

If continuation sheet Page 5 of 16

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG <b>(</b>	01 - MAIN BUILDING 01	СОМ	PLETED	
		335379	B. WING _			05/	04/2021	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
REGO P/	ARK NURSING HOME				11 26 CORONA AVENUE LUSHING, NY 11368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE	
K 281	by: Based on observat failed to provide em would operate auto egress and the requilamps energized du accordance with NF Section 19.2.8, 7.8, 7.9.2.1 . The deficite 200 residents, as without 200 residents, as without 200 residents, as without automatic fault 9:55 AM revealed filighting was obstrue no continuous light safety. Observation on Ma 10:24 AM high volta automatic transfer st including the emerge off. There was no continue path of egress to safety. Observation on Ma 10:57 AM revealed there was no continue of egress to safety. The findings were without and the safety.	NT is not met as evidenced tion and interview, the facility hergency illumination that matically along the means of uired illuminance with two uring emergencies in FPA 101, 2012 Edition, 7.8.1.1, 7.8.1.2,7.8.1.4 and ent practice could affect 60 of vell as an indeterminable 1 visitors. y 4, 2021 at approximately irst floor rehab exit door the cted by a canopy, there was ing along the path of egress to y 4, 2021 at approximately age room contained the switch revealed all lighting, gency lights could be powered ontinuous lighting along the afety when the switch was in y 4, 2021 at approximately first floor stairway B exit door nuous lighting along the path	K 28	81	<ul> <li>2) The facility permanently installed a lifixture with dual lamps at the 1st Floor B exit discharge above the door.</li> <li>3) The facility permanently removed the switch in the Main electrical room. The will remain on at all times. The facility a maintains an Emergency Battery Pack the room.</li> <li>Plan of Correction to identify other a potentially affected</li> <li>The Maintenance staff conduct a surverexit discharge. Based on the survey the facility permanently installed a light fixt with dual lamps at the 1st Floor Stair C discharge above the door.</li> <li>Plan of Correction for system measure prevent reoccurrence</li> <li>The Engineer or Designee will monitor lighting during environment of care rou and report the findings to the Safety Committee for a period of six (6) monther of the set of the safety committee on a quarterly as well as correction plan if warranted.</li> <li>Responsibility: Administrator</li> </ul>	Stair e light lights also light in areas ey of all e ure c exit all unds ns. ess of er or audits basis,	08/24/21	
	The findings were verified by the Maintenance Director and Housekeeping Supervisor at the time of the observation.							

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G 01 - MAIN BUILDING 01	CON	IPLETED
		335379	B. WING		05/	04/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REGO P	ARK NURSING HOME			111 26 CORONA AVENUE FLUSHING, NY 11368		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
	Cooking Facilities		K 32	4 Plan of Correction for affected are	as	05/11/21
SS=E	Cooking Facilities Cooking equipment with NFPA 96, Stan and Fire Protection Operations, unless: * residential cooking appliances such as toasters) are used to cooking in accordat * cooking facilities of compartments with with the conditions or * cooking facilities if 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities pr per 9.2.3 are not re hazardous areas, b corridor. 18.3.2.5.1 through 19.3.2.5.5, 9.2.3, T This REQUIREMEN	g equipment (i.e., small microwaves, hot plates, for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, n smoke compartments with s comply with conditions under 5.4. rotected according to NFPA 96 quired to be enclosed as but shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through IA 12-2		<ul> <li>1) The Maintenance staff immediat removed the garbage cart and t telephone charger that obstruct ANSUL manual release mechan Maintenance staff permanently the electrical outlet from below t manual release mechanism.</li> <li>2) 2) The deep-fat fryer was permane separated from the adjacent code equipment in excess of 16".</li> <li>Plan of Correction to identify of areas potentially affected</li> <li>The deep-fat fryer was permane separated from the adjacent code equipment in excess of 16".</li> <li>Plan of Correction for system to prevent reoccurrence</li> <li>All staff will be in-serviced to kee ANSUL manual release mechan obstructions for immediate use. Dietary Director will be responsi- in-service training for all staff. The Engineer or Designee will c environment of care rounds and</li> </ul>	ed the ed the ism. The elocated he ANSUL nently oking other ntly oking measures ep the ism free of The ble for the onduct	
	failed to visually ins suppression manua the requirements N Section 19.3.2.5.1, Sections 10.5, 12.1 deficient practice co	tion and interview, the facility spect and maintain fire al release in accordance with FPA 101, 2012 Edition, 9.2.3, NFPA 96, 2011 Edition, .2.4 and 12.1.2.5. The build affect 30 of 200 s an indeterminable number		findings to the Safety Committee period of six (6) months.	ior a	

If continuation sheet Page 7 of 16

		AND HUMAN SERVICES				FORM	05/18/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Main Building 01		E SURVEY PLETED
		335379	B. WING _			05/	04/2021
NAME OF F	PROVIDER OR SUPPLIER	·			TREET ADDRESS, CITY, STATE, ZIP CODE		
REGO P/	ARK NURSING HOME	1			11 26 CORONA AVENUE LUSHING, NY 11368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 324	Continued From pa of staff and visitors	-	K 3:	24	Plan of Correction for monitoring corre actions	ective	05/11/21
	<ul> <li>Findings include:</li> <li>Observation on May 4, 2021 at approximately 10:11 AM in kitchen revealed that the ANSUL manual release was obstructed by a garbage cart on the floor and a telephone charger connected to an electrical socket three inches below the release mechanism, it was not readily accessible and immediately available.</li> <li>Observation on May 4, 2021 at approximately 10:15 AM in kitchen revealed deep-fat fryer was not located sixteen inches form surface flames of adjacent cooking equipment and there was no steel or tempered glass baffle plate eight inches high installed.</li> <li>The findings were verified by the Maintenance Director and Housekeeping Supervisor at the</li> </ul>				The Engineer or Designee will review environment of care rounds for any case non-compliance. The Facilities Manager Designee will report the result of these at to the Safety committee on a quarterly ba as well as correction plan if warranted. <b>Responsibility:</b> Administrator	or udits	
K 351 SS=D	CFR(s): NFPA 101 Spinkler System - I 2012 EXISTING Nursing homes, an construction type, a approved automatic accordance with NI Installation of Sprin In Type I and II com protection measure substituted for sprin areas where state of sprinklers.	nstallation d hospitals where required by are protected throughout by an c sprinkler system in FPA 13, Standard for the	К 3	51	<ul> <li>Plan of Correction for affected areas</li> <li>1) The Maintenance staff permaner relocated the light fixture.</li> <li>2) 2) The facility will permanently in a sprinkler pendant in the identian area behind the dryer.</li> </ul>	ently Install	08/24/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	PLE CONSTRUCTION G <b>01 - MAIN BUILDING 01</b>		TE SURVEY IPLETED
		335379	B. WING		05	/04/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 0 111 26 CORONA AVENUE FLUSHING, NY 11368	ODE	I
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIOI DATE
K 351	of the closet does r sprinkler coverage required by NFPA 1 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9 This REQUIREMEN by: Based on observat did not provide com required by CMS re environment. The fa sprinkler system in requirements of NF 19.3.5 and 9.7, NFF 8.1, 8.1.1, 8.5.2.1, 8 Table 8.6.5.1.2. The and obstructed spri the extinguishment deficient practice co residents, as well a of staff and visitors. Findings Include: Observation on Ma 9:50 AM in first floo sprinkler was obstru three inches deep a sprinkler head. Observation on Ma 1:32 PM in laundry	eeping rooms where the area not exceed 6 square feet and covers the closet footprint as 3, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5, 0.7, 9.7.1.1(1) NT is not met as evidenced tion and interview, this facility plete sprinkler coverage as egulation § 483.90(a) Physical acility failed to install the accordance with the PA 101, 2012 Edition, Section PA 13, 2012 Edition, Section 8.5.5, 8.5.5.2, 8.6.3.3 and e lack of sprinkler coverage nkler could delay or prevent of a fire in this area. The build affect 20 of 200 s an indeterminable number	K 35	<ul> <li>Plan of Correction to identify potentially affected</li> <li>The maintenance staff checked for obstructions and/or lack of None were found.</li> <li>Plan of Correction for system prevent reoccurrence</li> <li>The Engineer or Designee will environment of care rounds an findings to the Safety Committe of six (6) months.</li> <li>Plan of Correction for monitor actions</li> <li>The Engineer or Designee will environment of care rounds for non-compliance. The Facilities Designee will report the result to the Safety committee on a q as well as correction plan if wat</li> <li>Responsibility: Administrator</li> </ul>	all sprinklers coverage. <b>measures to</b> conduct d report the ee for a period <b>pring corrective</b> review any cases of Manager or of these audits uarterly basis,	08/24/21

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	Γ		OM	FORM IB NO.	05/18/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COM	E SURVEY PLETED
		335379	B. WING	i		05/0	04/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REGO PA	ARK NURSING HOME	E			11 26 CORONA AVENUE LUSHING, NY 11368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 351		verified by the Maintenance ekeeping Supervisor at the		351			
K 353 SS=E	Sprinkler System - CFR(s): NFPA 101 Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMAR for any non-require system. 9.7.5, 9.7.7, 9.7.8, This REQUIREMED by: Based on observa failed to maintain th the ceiling level wa free from loading (on not having the corre- sprinklers in accord Edition, Section 19 NFPA 13, 2010 Edi NFPA 25, 2011 Edi 5.2.1.1.2, 5.4.1.4. T	Maintenance and Testing Maintenance and Testing r and standpipe systems are and maintained in accordance hdard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked system test supply source KS information on coverage ed or partial automatic sprinkler	K	353	<ul> <li>Plan of Correction for affected areas <ol> <li>The facility permanently completed the ceiling assembly and sealed the plumbin pipe to prevent hot gases and smoke pasprinkler into the space above in the The Storage Closet.</li> <li>The facility permanently completed the ceiling assembly to prevent hot gases at smoke past the sprinkler into the space in the Kitchen.</li> <li>The Maintenance staff removed the yer foam and obstruction on the identified sprinkler head in the Freezer.</li> <li>The Facility ordered the required spasprinklers for each type of sprinkler pen used in the facility and will store them in approved cabinet.</li> <li>The facility permanently completed the ceiling assembly to prevent hot gases at smoke past the sprinkler into the space in the identified Storage Room.</li> </ol> </li> </ul>	ng ast the erapy nd above ellow re idant n the idant n the	05/11/21

If continuation sheet Page 10 of 16

STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
				NG <b>0</b>	11 - MAIN BUILDING 01	CON	
		335379	B. WING			05/	04/2021
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
REGO P	ARK NURSING HOME				1 26 CORONA AVENUE LUSHING, NY 11368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
	the level of the insta	ge 10 alled sprinklers, sprinklers free not ensure prompt and proper	K 35		Plan of Correction to identify other are potentially affected		05/11/21
	operation of the sprinklers. The deficient practice could affect 50 of 200 residents, as well as an indeterminable number of staff and visitors.				The maintenance staff checked all sprink for foreign material All sprinkler heads w free of foreign material. The maintenance staff checked all ceiling	nkler heads were	
	Findings Include:			,	integrity throughout the facility. No openi were found that would allow hot gases of smoke past the sprinkler into the space	ngs r	
	9:52 AM in therapy foot by two foot sec	y 4, 2021 at approximately storage closet revealed one tion of ceiling tile missing and			Plan of Correction for system measure prevent reoccurrence	es to	
	stopped allowing he sprinkler into the sp	mbing piping not properly fire of gasses and smoke past the pace above. y 4, 2021 at approximately			The Engineer or Designee will conduct environment of care rounds and report th findings to the Safety Committee for a pe of six (6) months.		
	10:09 AM in kitcher foot section of ceilir gases and smoke p	n revealed one foot by one ng tile missing allowing hot past the sprinkler into the			Plan of Correction for monitoring corrections	ective	
	10:10 AM in walk ir	y 4, 2021 at approximately rfreezer revealed sprinkler foam and obstructed.			The Engineer or Designee will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted.		
	10:26 AM in the spi sprinkler box did no	n on May 4, 2021 at approximately n the sprinkler room the facility ox did not have the correct number of prinklers for each type used in the			<b>Responsibility:</b> Administrator		
	Observation on May 4, 2021 at approximately 10:39 AM in storage room revealed six sections of four foot by two foot of ceiling tile missing allowing hot gases and smoke past the sprinklers into the space above.						

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		AND HUMAN SERVICES			FC	ORM A	05/18/202 PPROVE 938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	) DATE S COMPL	SURVEY ETED
		335379	B. WING	i		05/04	1/2021
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 11 26 CORONA AVENUE LUSHING, NY 11368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETIO DATE
K 353	1:32 PM in laundry one foot of ceiling t and smoke past the above. The findings were v	y 4, 2021 at approximately room revealed one foot by ile missing allowing hot gases e sprinkler into the space verified by the Maintenance ekeeping Supervisor at the	K	353			
K 355 SS=F	inspected, and mai NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.1 This REQUIREMED by: Based on observat failed to visually inst monthly, not obstruet accordance with th 2012 Edition, Section NFPA 10, 2010 Edit 6.1.3.3.1, 7.2, 7.2.1 The deficient praction residents, as well at of staff and visitors Findings include:	guishers uishers are selected, installed, ntained in accordance with l for Portable Fire 2, NFPA 10 NT is not met as evidenced tion and interview, the facility spect fire extinguishers inced and ready for use in e requirements of NFPA 101, on 19.3.5.12, 9.7.4.1 and tion, Sections 5.5.5.3, 6.1.3.1 1.2, 7.2.2, 7.2.4.3 and 7.2.4.4. ce could affect 160 of 200 is an indeterminable number	K	355	<ul> <li>Plan of Correction for affected areas</li> <li>The Maintenance staff immediately reinspected all fire extinguishers in the facility and marked each tag as inspected</li> <li>The Maintenance staff immediately remove the garbage cart that obstructed the "K" firextinguisher.</li> <li>The Maintenance staff immediately remove the medication cart that obstructed the fire extinguisher in the basement corridor outside the sprinkler room.</li> <li>Plan of Correction to identify other areas potentially affected</li> <li>Maintenance staff were in-serviced that all fire extinguishers inspection tags will be signed for each monthly inspection along with the Records &amp; Logs inspection sheets</li> <li>Plan of Correction for system measures prevent reoccurrence</li> <li>The established Preventive Maintenance &amp; Scheduling will be followed reflecting the</li> </ul>	l. ed ed e ss. sto	08/12/21
	9:55 AM in therapy	y 4, 2021 at approximately room revealed that the fire ot inspected monthly. The			Scheduling will be followed reflecting the monthly and annual testing of the fire extinguishers.		

Facility ID: 1693

		AND HUMAN SERVICES					APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         335379			(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>			(X3) DATE SURVEY COMPLETED		
		B. WING			05/04/2021			
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
REGO PA	ARK NURSING HOME	1			1 26 CORONA AVENUE LUSHING, NY 11368			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 355	Continued From page 12 inspection tag was blank and did not indicate that monthly inspection (date and initials) was completed.		K 3	55	All staff will be in-serviced to keep all fire extinguishers free of obstructions for immediate use. The Engineer of Designe be responsible for the in-service training staff.	e will	08/12/21	
	Interview on May 4 AM Maintenance D extinguisher was in inspections was av tag on all fire exting indicate the month			The Engineer or Designee will monitor all testing and report the findings to the Safety Committee for a period of six (6) months. <b>Plan of Correction for monitoring corrective</b> <b>actions</b> The Engineer or Designee will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted.				
	Observation on Ma 10:11 AM in kitcher extinguisher was o was not readily ide immediately availal							
	10:24 AM in the ba sprinkler room reve was obstructed by	y 4, 2021 at approximately sement corridor outside ealed that the fire extinguisher a medication cart it was not accessible and immediately			<b>Responsibility:</b> Administrator			
K 700 SS=F	Director and House time of the observa		K 70	00	Plan of Correction for affected are The Director of Housekeeping	eas	05/11/21	
	18.7 and 19.7 Oper that are not addres but are deficient. T applicable Life Safe	s - Other KS section any LSC Section rating Features requirements sed by the provided K-tags, his information, along with the ety Code or NFPA standard included in Form CMS-2567.			immediately stopped the practice of drying rags and mop heads in a dryer in the facility.			

Facility ID: 1693

If continuation sheet Page 13 of 16

CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         335379		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		DENTIFICATION NUMBER.	A. BUILDING	G 01 - MAIN BUILDING 01		COMPLETED	
		B. WING	STREET ADDRESS, CITY, STATE, ZIP		05/04/2021		
NAME OF PROVIDER OR SUPPLIER							
REGO PARK NURSING HOME							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
K 700	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		K 70	<ul> <li>Plan of Correction to idea areas potentially affected. The practice of using the d material used with chemica cause a fire or explosion a spontaneously combust was stopped. The facility hired a vendor dry all rags and mop heads facility.</li> <li>Plan of Correction for systemeasures to prevent record. The Director of Housekeep monitor all materials throug facility are being sent out of environment of care round the findings to the Safety Operiod of six (6) months.</li> <li>Plan of Correction for motion for size are round the findings to the Safety Operiod of six (6) months.</li> <li>Plan of Correction for motion for non-compliance. The Fa Manager or Designee will result of these audits to the committee on a quarterly b correction plan if warrantee.</li> <li>Responsibility: Administrator</li> </ul>	ryer for all als that could nd/or as permanently to clean and s outside the <b>stem</b> <b>ccurrence</b> ing will shout the luring s and report committee for a <b>nitoring</b> ing will review s for any cases cilities eport the a Safety asis, as well as	05/11/21	
K 918 SS=F	that are not air drie up heat and sponta the chemical reacti	se laden rags. Some of those d, have been known to build aneously combust as a result of on. - Essential Electric Syste	K 91	8 Plan of Correction for affect The facility has contracted wi Emergency Generator contra permanently install a remote off outside the generator enc	th our ctor to Emergency shut	8/18/21	

Facility ID: 1693

If continuation sheet Page 14 of 16

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTI	IPLE	0MB NO. 0938-039 (X3) DATE SURVEY			
ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01 - MAIN BUILDING 01			COMPLETED 05/04/2021			
		B. WING						
NAME OF PROVIDER OR SUPPLIER				ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
REGO P/	ARK NURSING HOME	:			1 26 CORONA AVENUE LUSHING, NY 11368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE	
K 918	Continued From page 14 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source		K 91	potentially affected The facility will have permanently i			08/18/21	
	and associated equ supplying service w 10-second criterion			remote Emergency shut off outside the generator encasement.				
	test, a process sha confirm this capabi			Plan of Correction for system measur prevent reoccurrence				
	critical branches. M generator and trans accordance with N			The Engineer or Designee will report when he emergency generator remote shutoff was nstalled to the Safety Committee.				
	Generator sets are under load 30 minu day intervals, and e			Plan of Correction for monitoring corrective actions				
	months for 4 contin under load conditio simulated cold star transfer of all EES competent personr stored energy powe accordance with NI			The Engineer or Designee will review environmental rounds for any case of n compliance. The Facilities Manager or Designee will report to the Safety comm on a quarterly basis, as well as correcting plan if warranted.	nittee			
	circuit breakers are program for periodi components is esta manufacturer requi maintenance and to readily available. E	e inspected annually, and a cally exercising the ablished according to rements. Written records of esting are maintained and ES electrical panels and , readily identifiable, and			Responsibility: Administrator			
	separate from norm the possibility of da power source is a c installations. 6.4.4, 6.5.4, 6.6.4 (	nal power circuits. Minimizing mage of the emergency design consideration for new NFPA 99), NFPA 110, NFPA						
	by:	NT is not met as evidenced tion and interview the facility						
	did not ensure a re	tion and interview the facility						

DEPAR <sup>®</sup> CENTE	PRINTED: 05/18/2021 FORM APPROVED MB NO. 0938-0391									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED				
335379			B. WING	;		05/04/2021				
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE					
REGO PARK NURSING HOME			111 26 CORONA AVENUE FLUSHING, NY 11368							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
К 918	was provided in acc requirements of NF 9.1.3.1, NFPA 110, 5.6.5.6. This deficie prevent inadvertent The deficient practi residents, as well a of staff and visitors. Findings Include: Observation on Ma 2:20 PM during the facility generator wi Inside the generator emergency shut off revealed that there shut off outside the The findings were v	y 4, 2021 at approximately facility tour identified the as outside and encased. Further observation was no remote emergency generator encasement.	K	918						