STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS OF ATCO	**114 HAYES MILL ROAD , ATCO, New Jersey, 08004**

(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
F0000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/12/22 through 09/15/22 Survey Census: 53 Sample Size: 24 Supplemental Residents: 0	F0000		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/15/2022

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S0000	Initial Comments No Information	S0000		
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed	S0560	S5608:39-5.1(a) Mandatory Access To Care 1. Corrective Action: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will use staffing agencies and offer additional shifts to current staff. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected due to the nature of the deficiency 3. Measures Put Into Place: Hiring and recruitment efforts including pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace. Focus on retention efforts to include but not limited to, incentive programs, career growth and educational training opportunities and employee morale initiatives. Administrator and/or designee will continue document all recruitment and retention efforts. 4. How Will These Actions Be Measured: The Administrator or designee will review staffing schedules weekly to ensure adequate staffing for all shifts. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting 'quarterly' for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	10/17/2022

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S0560	Continued from page 1 in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 8/28/22 and 9/04/22, revealed the following: The facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows:	S0560		10/17/2022

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S0560	Continued from page 2 -08/28/22 had 5 CNAs for 52 residents on the day shift, required 6 CNAs. -09/04/22 had 5 CNAs for 48 residents on the day shift, required 6 CNAs. -09/10/22 had 6 CNAs for 53 residents on the day shift, required 7 CNAs.	S0560		10/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **09/15/2022**

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/13/22. The facility was found not to be in compliance with the requirements of 42 CFR 483.90.	K0000		
K0293 SS = F Bldg. 01	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure directional signs, which showed the direction of travel, were placed in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101 (2012 edition) section 7.10.2.1. This had the potential to affect the safety of all 53 residents. Findings include: Observation at 12:20 PM on 9/13/22 revealed directional signs were not placed to indicate the direction of travel from the Sitting Area. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed that the direction of travel was not apparent from the	K0293	K293 SS=F: Exit Signage 1. Corrective Action: Upon identification, directional signs were ordered to indicate the direction of travel from the sitting area. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: This practice had the potential to affect 53 residents. 3. Measures Put Into Place: The Directional Sign will be installed upon receipt by October 17, 2022. 4. How Will These Actions Be Measured: Monthly audit to assure signage remains in place will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting 'quarterly' for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	10/17/2022

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 reverse for further 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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K0293 SS = F Bldg. 01	Continued from page 1 Sitting Area. NJAC 8:39-31.1(c), 31.2(e)	K0293		10/17/2022
K0372 SS = F Bldg. 01	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 STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure penetrations and openings in smoke barriers were protected by a system or material capable of restricting the transfer of smoke. This deficient practice had the potential to affect the safety of all 53 residents. Findings include: Observation at 12:15 PM on 9/13/22 revealed the smoke barrier, located adjacent to Room [NJ Exec] had one white wire and one gray wire, a two-inch copper pipe, and a two-inch black pipe which penetrated both sides of the smoke barrier and were not protected by a system or material capable of restricting the transfer of smoke. Observation at 12:20 PM on 9/13/22 revealed the smoke barrier, located adjacent to Room [NJ Exec] had a one-half inch flexible conduit, one white wire and one blue wire which penetrated both sides of the smoke barrier and were not protected by a system or material capable of restricting the transfer of smoke.	K0372	K372 SS=F Subdivision of Building Spaces- Smoke Barriers 1. Corrective Action: Upon identification, the following penetrated smoke barrier areas were fixed with a material (Foam sealent) capable of restricting the transfer of smoke: Smoke barrier located across from room [NJ Exec] smoke barrier located adjacent to room [NJ Exec] smoke barrier located in the attic above the eye wash station was fixed. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: This deficient practice has the potential to affect 53 residents. 3. Measures Put Into Place: Upon completion of work by outside vendors/contractors, Maintenance director and or designee will audit areas of work to assure compliance with smoke barrier penetrations. 4. How Will These Actions Be Measured: Monthly random audits to assure compliance with penetrations and openings with smoke barriers which are protected by material capable of restricting smoke will be completed by the Maintenance Director and/or Designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting 'quarterly' for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	10/17/2022

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K0372 SS = F Bldg. 01	Continued from page 2 Observation at 2:00 PM on 9/13/22 revealed the smoke barrier, located in the attic above the Eye Wash Station, had a 57-inch by 20-inch opening on both sides of the smoke barrier and was not protected by a system or material capable of restricting the transfer of smoke. During an interview at the time of each observation, the U.S. FOIA (b)(6) confirmed the penetrations and openings in the smoke barriers were not protected. NJAC 8:39-31.1(c), 31.2(e)	K0372		10/17/2022
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of 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)	K0918	K918 SS=F Electrical Systems ◆ Essential Electric Systems 1. Corrective Action: Upon identification that the EPS was not equipped with a remote manual stop station, 2 quotes were obtained to purchase and install one. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect 53 residents. 3. Measures Put Into Place: Education provided to management/supervisors on the generator emergency stop procedure.Completion date: 10/7/22. Upon receipt of an install date from the manufacturer (approximately 2 weeks), EPS will be installed. 4. How will These Actions Be Measured: Continued monitoring by maintenance, testing 'monthly' during full load tests. Any concerns will be submitted to the Quality Assurance and Process Improvement Committee 'quarterly' for a period of 6 months.	10/17/2022

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K0918 SS = F Bldg. 01	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure the Emergency Power Supply (EPS) was equipped with a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the EPS in accordance with NFPA 110 Emergency and Standby Systems (2010 Edition) Section 5.6.5.6. This deficient practice had the potential to affect the safety of all 53 residents. Findings include: Observation at 11:37 AM on 9/13/22 revealed the EPS was not equipped with a remote manual stop station. At the time of the observation of the EPS, the U.S. FOIA (b)(6) confirmed the EPS did not have a remote manual stop station located outside the room housing the EPS. NJAC 8:39-31.2(e) NFPA 99, 110	K0918		10/17/2022
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K0222	K222 SS=E: Egress Doors 1. Corrective Action: Upon identification, signage stating ♦push until alarm sounds door can be opened in 15 seconds♦ was obtained and secured by room NJ Exec 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: This deficient practice had the potential to affect 21 residents 3. Measures Put Into Place: An audit to assure signage stating ♦push until alarm sounds door can be opened in 15 seconds♦ are located by the 3 exit doors was completed to assure compliance. 4. How Will These Actions Be Measured:	10/17/2022

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K0222 SS = E Bldg. 01	Continued from page 4 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure one of three exit doors equipped with a delay-egress locking system (located adjacent to Room [NJ Exec] had a readily visible, durable sign in	K0222	Continued from page 4 Monthly audit to assure signage remains in place will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting 'quarterly' for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	10/17/2022

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K0222 SS = E Bldg. 01	Continued from page 5 letters not less than 1 inch (25mm) high and not less than 1/8 inch (3.2mm) located on the door stating, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 19.2.2.2.4(2) and 7.2.1.6.1.1(4). This deficient practice had the potential to affect 21 residents. Findings include: Observation at 12:07 PM on 9/13/22 revealed the delay-egress door, located adjacent to Room [redacted] did not have the required signage stating, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". The [redacted] was present at the time of the observation and confirmed the delay-egress door lacked the required signage. NJAC 8:39-31.1(c), 31.2(e)	K0222		10/17/2022
K0363 SS = E Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled	K0363	K363 SS=E: Corridor - Doors 1. Corrective Action: Upon identification, the 1-inch gap between the door and the door frame in room [redacted] was fixed to resist the passage of smoke. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: This deficient practice had the potential to affect 21 residents in Hallway [redacted] 3. Measures Put Into Place: An audit of resident doors on Hallways, [redacted] were conducted to assure compliance 4. How Will These Actions Be Measured: PLANS TO MONITOR) Monthly audit will be completed to assure the 1-inch gap between the door and the door frames remain in compliance by Maintenance Director and/or designee. The results of these reviews will	10/17/2022

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THE FOUNTAINS OF ATCO	114 HAYES MILL ROAD , ATCO, New Jersey, 08004

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K0363 SS = E Bldg. 01	Continued from page 6 and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure doors protecting corridor openings resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) Section 19.3.6.3. This deficient practice had the potential to affect the safety of 21 residents in Hallway [redacted] Findings include: Observation at 1:38 PM on 9/13/22 revealed the corridor door to Room [redacted] had a one-inch gap between the door and the door frame when closed. During an interview at the time of the observation, The NJ Exec Order 26.4b1 confirmed the one-inch gap between the door and the door frame. NJAC 8:39-31.1(c), 31.2(e)	K0363	Continued from page 6 be submitted to the Quality Assurance and Process Improvement Committee Meeting 'quarterly' for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	10/17/2022
K0379 SS = E Bldg. 01	Smoke Barrier Door Glazing CFR(s): NFPA 101 Smoke Barrier Door Glazing 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5 This STANDARD is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure openings in	K0379	K379 SS=E Smoke Barrier Door Glazing 1. Corrective Action: Upon identification of the deficient practice, quotes were obtained to have fire-rated glazing or wire glass panels in steel frames installed. Quote approved and replacement scheduled with expected completion date 3/1/2023. Waiver requested to replace the doors. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:	10/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0379 SS = E Bldg. 01	Continued from page 7 smoke barrier doors had fire-rated glazing or wired glass panels in steel frames in accordance with NFPA 101 (2012 Edition) Section 19.3.7.6 (1)(2). This deficient practice had the potential to affect the safety of 33 residents located in Hallways NJ Exec and NJ Exec Findings include: Observation at 2:22 PM on 9/13/22 revealed the smoke barrier doors, located adjacent to Room NJ Exec had two glass inserts which measured 60 inches by 36 inches and did not have fire-rated glazing or wired glass. The etching on the glass stated, "Tempered ...16 CFR 1201-I,II ...ANSI Z97.1-2009." During a telephone conversation at 1:22 PM on 9/15/22 the U.S. FOIA (b)(6) for manufacturer confirmed the glass was not fire rated. He/she stated the glass was safety glass and would not sustain a [fire] hose stream. An email was received at 1:32 PM on 9/15/22 from the U.S. FOIA (b)(6) which stated, "Tempered glass at the time of sale by OBE, meets the quality and strength requirements of ASTM C 1036 and ASTM C 1048 for Condition A and C, Quality q3 and Kind FT (fully tempered). OBE tempered glass also meets the safety criteria of CPSC 16 CFR [Code of Federal Regulations] 1201 Categories 1 & 2 and ANSI Z97.1 and qualifies as the glazing material for use in safety glazing locations. All glass thicknesses have been certified by the SGCC Certification Program. Tempered glass will have a permanent logo affixed in a corner indicating its compliance with the safety glazing codes." Document review of The Code of Federal Regulations Safety Standard for Architectural Glazing Materials Part 1201(d)(1)(i)(ii) revealed, "The degree and nature of the risk of injury the rule is designed to eliminate or reduce. The Commission finds that the nature of the risks of injury this standard is designed to eliminate or reduce are as follows: (i) Lacerations, contusions, abrasions, and other injury or death resulting from walking or running into glazed doors or sliding glass doors believed to be open or glazed panels mistaken as a means of ingress or egress or pushing against glazing	K0379	Continued from page 7 The deficient practice has the potential to affect 33 residents. 3. Measures Put Into Place: Education to be provided to Interdisciplinary Staff on process to relocate residents in a fire emergency that are located on the NJ Exec wing. Completion date: 12/15/22. Fire-rated glazing and/or wire glass panels to be installed by manufacturer upon correspondence from them on date these panels will be ready. 4. How Will These Actions Be Measured: Monthly audit to assure fire-rated glazing and/or wire glass panel remains in place will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted nby maintenance, to the Quality Assurance and Process Improvement Committee Meeting monthly until replacement and then'quarterly' for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	10/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 09/15/2022

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K0379 SS = E Bldg. 01	Continued from page 8 material in doors or glazed panels in an attempt to open a door. (ii)Lacerations, contusions, abrasions, and other injury or death resulting from accidentally falling into or through glazed doors, sliding glass doors, glazed panels, bathtub doors and enclosures and shower doors and enclosures." The code requires openings in smoke barrier doors to be fire-rated glazing or wires glass panels in steel frames to help stop smoke from traveling through the opening. NJAC 8:39-31.1(c), 31.2(e)	K0379		10/17/2022

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/13/22. The facility was found to be in compliance with 42 CFR 483.73.	E0000		

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 reverse for further 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.

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