STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. BUILDING **01** B. WING _____	**06/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON HEALTH CARE CENTER	**535 EGG HARBOR ROAD** **SEWELL, NJ 08080**

(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 06/16/21 and 06/17/21 and 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. Jefferson Healthcare Center is a two story building that was built in the 1980s. It is composed of Type II protected construction. The facility is divided into 12 smoke zones.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of	K 222		7/9/21

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

Electronically Signed | 07/14/2021

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K 222	Continued From page 1 locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS 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	K 222		

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K 222	Continued From page 2 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 REQUIREMENT is not met as evidenced by: Based on observations and interview from 06/16/21 to 06/17/21, in the presence of the facility Maintenance Director, it was determined that the facility failed to ensure that the 15-second delayed egress feature on two exit discharge doors were provided with signs that correctly identified this feature. This deficient practice was observed for 2 of 12 15-second delayed egress doors reviewed for signage and was evidenced by the following: 1. The surveyor observed, in the presence of the Maintenance Director, on 06/17/21 at approximately 11:20 AM, that the egress door by resident rooms [redacted] and [redacted] was provided with a 15-second delayed egress feature for a non-emergency discharge. The surveyor did not observe a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15 Seconds." 2. The surveyor observed, in the presence of the Maintenance Director, on 06/17/21 at approximately 11:45 AM, that the egress door marked "C5" in the dining room was provided with a 15-second delayed egress feature for a non-emergency discharge. The surveyor did not observe a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15 Seconds". These findings were verified by the Maintenance Director during the observations and testing of	K 222	This Plan of Correction constitutes Jefferson Health Care Center's (the Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. It is the practice of the facility to ensure that the 15-second delayed egress feature on two exit discharge doors were provided with signs that correctly identified this feature. This practice was not met by failing to have the proper signage on two of the discharge doors. All residents are at risk to be affected by this practice. Signs were immediately placed on the two discharge doors explaining the 15-second delayed egress feature. The Facility Manger educated his staff on ensuring that the signs are posted on all 12 egress doors at all times. This education had a 100% completion date of July 9, 2021. The Facility Manager/designee will audit the egress doors to ensure they have the	

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K 222	Continued From page 3 the doors. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 06/17/21. NJAC 8:39-31.2(e)	K 222	proper signage. Audits will be completed once per week for one month and then monthly. The results of these audits will be presented to the QAPI committee, which meets monthly for review and revision as deemed necessary.	
K 291 SS=E	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 from 06/16/21 to 06/17/21, it was determined that the facility failed to provide emergency lighting in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was observed for 2 of 2 mechanical/electrical rooms reviewed for emergency lighting and was evidenced by the following: On 06/17/21 at 12:25 PM, the surveyor observed, in the presence of the facility's Maintenance Director, the two mechanical/electrical rooms, that contained the emergency generator's transfer switch, were not equipped with emergency lighting independent of the building's electrical system and emergency generator. These findings were verified by the facility's Maintenance Director during the observation. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 06/17/21.	K 291	This Plan of Correction constitutes Jefferson Health Care Center's (the Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. It is the practice of the facility to ensure that 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 practice was not met by failing to have emergency lighting in two mechanical/electrical rooms. All residents are at risk to be affected by this practice. Emergency lighting was installed in both mechanical/electrical rooms on June 30,	7/9/21

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K 291	Continued From page 4 NJAC 8:39-31.2(e) NFPA 101:2012 - 7.9	K 291	2021. The Facility Manager and maintenance department were educated on having emergency lighting in mechanical/electrical rooms. This education had a 100% completion date of July 9, 2021. The Facility Manager/designee will conduct monthly audits to ensure that the emergency lighting is properly functioning in the mechanical/electrical rooms. The results of these audits will be presented to the QAPI committee, which meets monthly for review and revision as deemed necessary.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, 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:	K 341		7/12/21

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K 341	Continued From page 5 Based on observation and interview from 06/16/21 to 06/17/21, it was determined that the facility failed to provide notification by audible and visible signals in one courtyard, in accordance with NFPA 101, 2012 Edition, Section 19.3.4.3.1, 9.6, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. This deficient practice was observed for 1 of 2 enclosed courtyards reviewed for notifiction by audible and visible signals and was evidenced by the following: During observation of the [redacted] Wing [redacted] on 06/17/21 at approximately 10:35 AM, in the presence of the Maintenance Director, the surveyor did not observe a notification by audible and visible signals. When interviewed, the Maintenance Director revealed that the facility was not aware of the requirements for a horn/strobe was to be tied to the fire alarm in the [redacted]-Wing [redacted]. The Administrator was notified of the findings at the Life Safety Code exit conference on 06/17/21. NJAC 8:39-31.2(e)	K 341	This Plan of Correction constitutes Jefferson Health Care Center's (the Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. It is the practice of the facility to ensure that 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. This practice was not met by failing to provide notification by audible and visible signals in one of the enclosed courtyard. All residents are at risk to be affected by this deficient practice. Horn and strobe lights were installed in the enclosed courtyard on July 12, 2021. The Facility Manager and maintenance department was educated on having audible and visible signals in all [redacted]. This education had a 100% completion date of July 9, 2021. The Facility Manager/designee will conduct monthly audits to ensure that audible and visible signals are functioning properly in the [redacted]. The results of these audits will be presented to the QAPI	

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K 341	Continued From page 6	K 341	committee, which meets monthly for review and revision as deemed necessary.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 06/16/21 to 06/17/21, in the presence of the Maintenance Director, the facility failed to maintain the sprinkler system, by ensuring that the ceiling level was smoke resistant, in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. The deficient practice was identified for 13 of 13 sprinkler systems areas reviewed for smoke resistance and was evidenced as follows:	K 353	This Plan of Correction constitutes Jefferson Health Care Center□s (the Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. It is the practice of the facility to ensure compliance with the maintenance and	7/9/21

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K 353	Continued From page 7 1. On 06/16/21 at 11:35 AM, the surveyor observed, in the conference room, that 1 of 4 fire sprinkler heads had a bad ceiling tile cut that left approximately a 1/2 inch gap; and the sprinkler head was not provided with an escutcheon plate. 2. On 06/16/21 at 12:42 PM, the surveyor observed, on the [redacted] Unit [redacted] exit stairwell, that a 4 inch pipe was going into the ceiling leaving approximately a 1/2 inch gap, allowing hot gasses and smoke past the sprinkler into the space above. 3. On 06/17/21 at 9:58 AM, the surveyor observed, on the [redacted] Unit exit corridor, that 1 of 8 fire sprinkler heads had a bad ceiling tile cut, leaving approximately a 1/4 inch gap by resident room [redacted], allowing hot gasses and smoke past the sprinkler into the space above. 4. On 06/17/21 at 10:10 AM, the surveyor observed in the [redacted] equipment room, that two approximate 1 foot x 1 foot ceiling tiles were not in place, along with vertical openings from copper pipe into the drop ceiling tiles, allowing hot gasses and smoke past the sprinkler into the space above. 5. On 06/17/21 at 10:52 AM, the surveyor observed in the kitchen dry storage room, that 1 of 5 fire sprinkler heads had a bad ceiling tile cut, leaving approximately a 1/2 inch gap, allowing hot gasses and smoke past the sprinkler into the space above. 6. On 06/17/21 at 10:58 AM, the surveyor observed in the activities/therapy/recreation room, that 5 of 12 fire sprinkler heads were not installed into the drop ceiling properly leaving an	K 353	testing automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protections. This practice was not met by failing to maintain the sprinkler system, by ensuring the ceiling level was smoke resistant for 13 sprinkler systems. All residents are at risk to be affected by this practice. The half inch gap in the ceiling tile was closed and the sprinkler head in the conference room was provided an escutcheon plate. The half inch gap was closed on the [redacted] Unit [redacted] exit stairwell. The ¼ inch gap in the ceiling tile near room [redacted] was closed. The two ceiling tiles in the [redacted] equipment room were replaced along with fixing the vertical openings from the copper pipe into the drop ceiling tiles. The ½ inch gap in the ceiling tile in the kitchen dry storage room was closed. The 5 sprinklers in the activities/therapy/recreation room were fixed to be installed properly. All three ¼ inch gaps in the ceiling tile in the soiled utility room near room [redacted] were closed. Two sprinkler heads in this room were reinstalled properly. The ½ inch in the soiled utility room near room [redacted] was closed. The ¼ inch gap was closed in the nursing supply room near room [redacted]. The concealed cover on the sprinkler head was replaced in the exit corridor, by resident rooms [redacted] and [redacted] A screw was placed in the exit sign near the [redacted] unit nurses' station to close the gap. The	

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K 353	Continued From page 8 approximate 1/2 inch gap, allowing hot gasses and smoke past the sprinkler into the space above. 7. On 06/17/21 at 11:10 AM, the surveyor observed in the soiled linen room, by resident room 107, that 3 of 3 fire sprinkler heads had an approximately 1/4 inch gap at the ceiling tile, with 2 of 3 sprinkler heads not in the intended installed position, allowing hot gasses and smoke past the sprinkler into the space above. 8. On 06/17/21 at 11:15 AM, the surveyor observed in the soiled utility room, by resident room [redacted] that 1 of 1 fire sprinkler heads had an approximately 1/2 inch gap, allowing hot gasses and smoke past the sprinkler into the space above. 9. On 06/17/21 at 11:18 AM, the surveyor observed in the nursing supply room, by resident room [redacted] that 1 of 1 fire sprinkler heads had an approximately 1/4 inch gap, allowing hot gasses and smoke past the sprinkler into the space above. 10. On 06/17/21 at 11:25 AM, the surveyor observed in the exit corridor, by resident rooms [redacted] and [redacted], that the concealed cover was missing on 1 of 5 fire sprinkler heads leaving an approximately 1 inch gap, allowing hot gasses and smoke past the sprinkler into the space above. 11. On 06/17/21 at 11:29 AM, the surveyor observed by the [redacted] Unit nurses' station, that the exit sign was missing a screw and dropped on one side exposing an approximately 1/2 inch gap, allowing hot gasses and smoke past the sprinkler into the space above.	K 353	sprinkler head outside resident room [redacted] was fixed to. The sprinkler head no long drops ½ inch allowing hot gasses and smoke past the sprinkler into the space above. The sheetrock was replaced in the boiler room/maintenance office. The Facilities Manager completed all these tasks except The Fire Sprinkle Service, Inc. fixed the sprinkler in the activities room. All of these were completed by July 7, 2021. The Facility Manager and maintenance department were educated on maintaining the sprinkler system. This education had a 100% completion date of July 9, 2021. The Facility Manager/designee will conduct weekly audits for 4 weeks then monthly to ensure that the sprinkler system is maintained properly. The results of these audits will be presented to the QAPI committee, which meets monthly for review and revision as deemed necessary.	

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K 353	Continued From page 9 12. On 06/17/21 at 12:28 PM, the surveyor observed, outside resident room [redacted] that the concealed fire sprinkler head dropped approximately 1/2 inch, allowing hot gasses and smoke past the sprinkler into the space above. 13. On 06/17/21 at 12: 38 PM, the surveyor observed in the boiler room/ maintenance office, that an approximately 6 inch x 4 inch piece of sheetrock was removed from the ceiling, allowing hot gasses and smoke past the sprinkler into the space above. The findings were observed and verified by the Maintenance Director at the time of the observations. The administrator was notified of the findings at the Life Safety Code exit conference on 06/17/21.	K 353		
K 374 SS=D	NJAC 8:39-31.2(e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	K 374		7/9/21

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JEFFERSON HEALTH CARE CENTER	**535 EGG HARBOR ROAD** **SEWELL, NJ 08080**

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K 374	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 06/16/21 to 06/17/21, it was determined that the facility failed to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. This deficient practice was observed for 2 of 6 sets of smoke doors reviewed for closure and was evidenced by the following: 1. At approximately 10:21 AM, the surveyor observed on floor [redacted], the set of smoke-doors by resident rooms [redacted] and [redacted], an approximately 1/4 inch gap between the top meeting edges (approximately 4 inches) of the door, preventing it from being smoke resistive. 2. At approximately 10:28 AM, the surveyor observed on floor [redacted], the set of smoke-doors by the activities office, an approximately 1/4 inch gap between the meeting edges of the door, preventing it from being smoke resistive. The findings were verified by the Maintenance Director at the time of the observations. The Administrator was notified of the findings at the life safety code exit conference on 06/17/21. NJAC 8:39-31.2(e)	K 374	This Plan of Correction constitutes Jefferson Health Care Center□s (the Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. It is the practice of the facility to ensure compliance with the Subdivision of building spaces for smoke barrier doors. This practice was not met by failing to provide smoke barrier wall doors that completely close to resist the passage of smoke, flame or gases during a fire. All residents are at risk to be affected by this practice. The ¼ inch gap was immediately closed on the set of smoke barrier doors by resident rooms [redacted] and [redacted] and by the activities office. The Facility Manager and maintenance department were educated on ensuring that smoke barrier wall doors are completely closed to resist the passage of smoke, flame, or gases during a fire. This education had a 100% completion date of July 9, 2021. The Facility Manager/designee will conduct weekly audits for 4 weeks then monthly to ensure all smoke barrier wall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. BUILDING **01** B. WING _____	**06/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 374	Continued From page 11	K 374	doors are completely resistant to the passage of smoke. The results of these audits will be presented to the QAPI committee, which meets monthly for review and revision as deemed necessary.	