STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING **01** B. WING _____	**01/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	**3 HAMILTON HEALTH PLACE** **HAMILTON, NJ 08690**

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 1/06/2023 and Atrium Post Acute Hamilton 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Atrium Post Acute Hamilton is a Single-story, Type II Protected building that was built in February 2015. The facility is divided into 4 smoke zones.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 1/06/2023, in the presence of facility management it was determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps for two (2) of six (6) exit discharge doors. This deficient practice was evidenced by the following:	K 281	" No residents were identified nor immediately affected by the lack of not having two sources of light by the two exits paths. There were no instances where the facility needed to be evacuated or use these exits identified in the SOD. All residents had the same potential to be affected by the same deficient practice. " The areas identified in the SOD was repaired/resolved on 1/25/2023 by the	2/1/23

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

Electronically Signed | 01/27/2023

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

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K 281	Continued From page 1 On 1/06/2023, during the survey entrance at 9:13 AM, a request was made to the Senior Maintenance Director (SMD) and Maintenance Director (MD), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are six (6) designated exit (Illuminated exit sign above door) discharge doors in the facility. Starting at approximately 9:40 AM, a tour of the building with the SMD and MD was conducted. During the tour, the surveyor inspected outside of 6 exit discharge door and observed the following, 1. At approximately 10:55 AM, the surveyor observed outside of exit discharge door D-4 one light bulb fixture. 2. At approximately 11:30 AM, the surveyor observed outside of exit discharge door D-6 a two light bulb fixture. The two light bulbs were not illuminated and had signs of being burnt out, the two bulbs were black. The SMD and MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 1/06/2023 at approximately 2:20 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281	maintenance director. Both exterior light fixtures over the emergency exit doors will be replaced by a licensed electrical contractor on 2/1. " All other exit paths were audited to ensure that that they have at least two sources of illumination. " The Maintenance Director/designee will audit all exit paths weekly to ensure that they have at least two sources of illumination. " Inservice education was provided the NHA to the maintenance team regarding ensuring that the exit lighting includes two sources of illumination. " The NHA/designee will conduct weekly audits to ensure there is two functioning sources of illumination and in working order for one year. Results of the audits will be presented during the Quarterly Quality assurance committee meetings.	
K 291 SS=E	Emergency Lighting	K 291		2/1/23

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K 291	Continued From page 2 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/06/2023, in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light above one (1) of one (1) emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 1/06/2023, during the survey entrance at 9:13 AM, a request was made to the Senior Maintenance Director (SMD) and Maintenance Director (MD), if the facility had an emergency generator. The MD told the surveyor yes we have a 500 KW generator. Starting at approximately 9:40 AM, a tour of the building with the SMD and MD was conducted. During the tour at 11:14 AM, an inspection outside of the building where the emergency generator and generator's transfer switch was located was performed. The surveyor observed that the emergency generator transfer switch was located next to the generator.	K 291	" All the residents had the potential to be affected by the deficient practice. " The maintenance director or designee will ensure that the proper emergency battery backup light will be installed above the generator transfer switch and tested on a regular basis. A licensed electrician will install this by 2/1/2023 " Inservice education was provided the NHA to the maintenance team regarding ensuring that the emergency lighting is maintained in good working order. " The NHA/designee will conduct monthly checks for 3 months to ensure that it is functioning correctly. Findings will be brought to the quarterly Quality Assurance committee.	

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K 291	Continued From page 3 The surveyor observed no evidence of a battery back up emergency light in the area for the generator transfer switch. At this time the surveyor asked the SMD and MD, "Do you have a battery back up emergency light out here for the transfer switch." The MD told the surveyor, "no we don't." The SMD and MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 1/06/2023 at approximately 2:20 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 1/06/2023, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being	K 521	" On 1/6/2023 immediately after we were made aware of the exhaust system not functioning properly for the residents in the rooms identified on the SOD. The	2/1/23

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K 521	Continued From page 4 properly maintained for three (3) of five (5) resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90 A. This deficient practice was evidenced by the following: On 1/06/2023, during the survey entrance at 9:13 AM, a request was made to the Senior Maintenance Director (SMD) and Maintenance Director (MD), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. The surveyor also requested, "How many Resident sleeping rooms are in the facility." The MD told the surveyor there are 35 Resident rooms. Starting at approximately 9:40 AM, in the presence of the facility's SMD and MD a tour of the building tour was performed. Along the tour the surveyor inspected five (5) resident sleeping rooms and one (1) unisex bathroom. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in three (3) of five (5) resident bathrooms in the following locations: 1. At approximately 10:16 AM, inside Resident room #101 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the SMD and MD that the exhaust system did not function properly. 2. At approximately 10:23 AM, inside Resident	K 521	NHA offered the residents a room change. Residents declined. The Director of Nursing/Designee checked the residents to ensure they were not effected and there were no negative outcomes due to the exhaust not working properly and continued until the vendor fixed the system. The Maintenance Director/Designee checked the rooms identified and no foul odor or air issues was identified. The NHA reviewed the grievance binder and interviewed staff: there wasn't any instances noted of resident complaints about the ventilation system. All residents had the potential to be affected if the proper ventilation system were not functioning properly. " The administration hired a contractor who will be replacing the system Completion Date 2/1/23 " Inservice education was provided the NHA to the maintenance team regarding ensuring that the ventilation system is kept in good working order. " The Maintenance Director or designee will conduct weekly checks for 3 months to ensure the system is working properly. The findings will be brought to the quarterly quality assurance committee.	

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K 521	Continued From page 5 room #109 bathroom, when tested the exhaust system did not function properly. At this time the surveyor asked the MD how many exhaust fans do you have for the bathrooms. The MD told the surveyor that there are two (2) exhaust systems on the roof of the facility. A request was made to go onto the roof of the building to inspect the exhaust systems. At 10:28 AM, an inspection on the roof of the building was performed. This inspection identified that Unit #1 Exhaust System was not running. The MD turned off the breaker and reset the unit to the on position. The system did not function. 3. At approximately 10:58 AM, inside resident room #132 bathroom, when tested the exhaust system did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The SMD and MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 1/06/2023 at approximately 2:20 PM. This was a repeat deficiency from 10/28/2020 Re-Certification survey. NFPA 90 A. NJAC 8:39- 31.2 (e).	K 521		

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K 918	Continued From page 6	K 918		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918		1/27/23

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K 918	Continued From page 7 Based on observation and interview on 1/06/2023, in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for one (1) of one (1) emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 1/06/2023 during the survey entrance at 9:13 AM, a request was made to the Senior Maintenance Director (SMD) and Maintenance Director (MD), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments and if the facility had an emergency generator. The MD told the surveyor yes we have a 500 KW generator. Starting at approximately 9:40 AM, a tour of the building with the SMD and MD was conducted. During the tour at 11:14 AM, an inspection outside of the building where the emergency generator was located was performed. The surveyor observed that the emergency shut off was located on the generator's metal housing. At this time the surveyor requested if the facility had a Remote emergency stop button that was not on the housing of the generator. The MD told the surveyor, "no." The SMD and MD confirmed the findings at the time of observations.	K 918	" No residents were identified nor immediately affected by the lack of having a remote emergency stop button. The remote button was not used or needed to be used. " All the residents had the potential to be affected by the deficient practice if the switch needed to be used. " NHA educated maintenance team regarding the placement of the emergency stop button " The stop button was moved on 1/9/2023 to a remote location not attached to the housing of the generator. " The maintenance director or designee will conduct monthly checks for 3 months to ensure that it is functioning correctly. Findings will be brought to the quarterly Quality Assurance committee.	

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K 918	Continued From page 8 The Administrator was informed of the deficiency at the Life Safety Code exit conference on 1/06/2023 at approximately 2:20 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315519 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	2/23/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 08690

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	02/01/2023	LSC K0291	02/01/2023	LSC K0521	02/01/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	01/27/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/12/2023	☐ YES ☐ NO