STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315461	A. BUILDING **01** B. WING _____	**12/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	**100 LONG-A-COMING LANE** **BERLIN, NJ 08009**

(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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/11/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/11/23 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 Occupancy Berlin Rehabilitation and Healthcare Center is a two-story building that was built in 1999, It is composed of Type I protected construction. The facility is divided into ten - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 118 of 126.	K 000		
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 347	1. No residents were cited as being	1/30/24

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

Electronically Signed | 01/12/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315461	A. BUILDING **01** B. WING _____	**12/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	**100 LONG-A-COMING LANE** **BERLIN, NJ 08009**

(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 347	Continued From page 1 failed to ensure smoke detection was installed in rooms open to the corridor in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.1. This deficient practice had the potential to affect 28 residents who resided at the facility. Findings include: An observation on 12/11/23 at 2:20 PM revealed no smoke detectors were located in the lounge T2039 next to the nurse's station that was open to the corridor. During an interview at the time of the observation, the Maintenance Director confirmed the smoke detectors were not installed in the resident lounge. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 347	directly affected by not having a smoke detector in lounge T2039. 2. All residents on that unit (28) have the potential to be affected by this practice. 3. A smoke detector was placed in the lounge T2039 next to the nurses station that was open to the corridor and was verified as functioning by contracting installation sprinkler company. (PO uploaded as well a photograph of installed sprinkler head) 4. Maintenance Director will submit quarterly monitoring of fire alarm system and will report any changes to smoke detector compliance to QAPI quarterly.	
K 379 SS=F	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 REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure smoke barrier doors were equipped with fire rated glazing or wired glass in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.7.6. This deficient practice had the potential to affect all 118 residents who resided on the second floor at the	K 379	1. No residents were affected by this practice. 2. All residents have the potential to be affected by this practice. 3. All smoke barrier doors were audited by testing laboratory and confirmed that all doors met the required door rating of	1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315461	A. BUILDING **01** B. WING _____	**12/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	**100 LONG-A-COMING LANE** **BERLIN, NJ 08009**

(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 379	Continued From page 2 facility. Findings include: Observations on 12/11/23 at 12:00 PM to 3:00 PM revealed that four of 18-smoke barrier doors were equipped with regular glass and not fire rated glazing which shall be marked with D-20 or D-W 20 or be equipped with wired glass. During an interview at the time of the observation, the Maintenance Director confirmed the smoke barrier doors were not equipped with fire rated glass or wired glass. NJAC 8:39-31.2(e)	K 379	20 or more. No areas were identified as being non-compliant upon completion of audit. 4. Maintenance Director will audit monthly to ensure smoke barrier doors have rating noted on glass and will report monthly to QAPI for three months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315461	A. Building 01 - MAIN BUILDING 01 B. Wing	2/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	100 LONG-A-COMING LANE BERLIN, NJ 08009

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 Reg. # NFPA 101 LSC K0347	Correction Completed 01/30/2024	ID Prefix Reg. # NFPA 101 LSC K0379	Correction Completed 01/30/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
12/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO