STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315510	A. BUILDING **01** B. WING _____	**11/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH	**395 AMWELL ROAD** **HILLSBOROUGH, NJ 08844**

(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 11/3/22 and 11/7/22, 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 The facility is a 3-story building with a basement, that was built in 2012, It is composed of Type I fire resistant construction. The facility is divided into 12- smoke zones. The generator does 100% of the facility.	K 000		
K 281 SS=F	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 interview on 11/3/22, in the presence of facility management, it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 1 of 6 exit access areas observed and was evidenced by the following:	K 281	The corrective action put into place to rectify the deficient practice identified during the facilities annual life safety survey was to: 1. Purchased a light switch cover (date 11/16/22) to go over the light switch so that emergency illumination is operating automatically along the means of egress. Delivered and installed on 11/19/22.	11/23/22

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

Electronically Signed | 11/23/2022

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K 281	Continued From page 1 At 10:37 AM, the surveyor in the presence of the Maintenance Director (MD) and Director of Facilities (DOF) observed the exit/egress main foyer had five light switches by the receptionist desk that shutoff all the lighting when in the off position. In an emergency, the lights would not automatically turn-on to illuminate the exit. The foyer measured approximately thirty feet by thirty feet (30' X 30') in size. The facility's MD and DOF, both confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was informed of these findings at the Life Safety Code survey exit conference on 11/7/22. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	2. Director of Maintenance/designee will audit the grounds monthly to monitor additional areas that can be affected by this deficient practice. 3. Director of Maintenance/designee will check that the switch covers are in place once a week for 4 weeks initially. Thereafter, it will be added to the monthly Emergency lighting check list and audited monthly by the Director of Maintenance/designee. 4. The Director of Maintenance/designee will report the results of the audit and the corrective actions during the quarterly QAPI meetings.	
K 291 SS=F	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 on 11/3/22, in the presence of facility management, it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator (2) transfer switches independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient	K 291	The corrective action put into place to rectify the deficient practice identified during the facilities annual life safety survey was to: 1. Purchased EX. Order 26.(4) B1 Emergency Lights for Power Failure with a 90-minute run time (date 11/17/22). Installed on 11/20/22.	11/23/22

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K 291	Continued From page 2 practice was identified for 2 of 2 transfer switches and was evidenced by the following: At 01:07 PM, the surveyor in the presence of the Maintenance Director (MD) and Director of Facilities (DOF) observed in the basement boiler room where the (2) generator transfer switches were located, that the ATS-1 and ATS-2 transfer switches, was not equipped with battery back-up emergency lighting. The MD and DOF both confirmed the findings at the time of the observations. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit on 11/7/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	2. Director of Maintenance/designee will do monthly building walk through to identify other potential areas that may be affected by this deficient practice. 3. Director of Maintenance/designee will run a test on the emergency lights once weekly for 4 weeks and then monthly thereafter. This check will be added to the Emergency lighting check list and audited monthly by the Director of Maintenance/designee. 4. The Director of Maintenance/designee will report the results of the audit and the corrective actions during the quarterly QAPI meetings.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		11/23/22

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K 324	Continued From page 3 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review, on 11/7/22, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 1 kitchen [redacted] system inspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10. The deficient practice was evidenced by the following: At 12:50 PM, the surveyor and the federal surveyor in the presence of the Maintenance Director (MD) and Director of Facilities (DOF) observed in the facility kitchen, that the monthly inspection tag was blank and no required monthly inspection of the ansul system was logged. At this time, the surveyor interviewed the MD and DOF who both confirmed that the ansul monthly inspection tag was not completed and left blank. The Licensed Nursing Home Administrator was informed of the deficiency at the Life Safety Code exit conference on 11/7/22. NJAC 8:39-31.2(e)	K 324	The corrective action put into place to rectify the deficient practice identified during the facilities annual life safety survey was to: 1. Inspect the [redacted] system and update the inspection tag on 11/7/22 by the Director of Facilities. 2. Director of Maintenance/designee will make monthly rounds to identify other potential deficient practices. 3. Director of Maintenance/designee will audit the [redacted] system monthly on the same schedule as the fire extinguishers. The [redacted] system will continue to be audited by contracted company on a semiannual basis. 4. The Director of Maintenance/designee will report the results of the audit and the corrective actions during the quarterly QAPI meetings.	

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K 324	Continued From page 4 NFPA 96 and NFPA 10.	K 324		
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: Based on observation and interview on 11/3/22, in the presence of facility management, it was determined that the facility failed to install supervised smoke/heat detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. This deficient practice was observed in 1 of 1 areas and was evidenced by the following: During the tour of the building, in the presence of the Maintenance Director (MD) and Director of Facilities DOF), the surveyor and the federal surveyor, observed that the facility failed to	K 341	1. The facility will correct the action found in the 2567 of the missing smoke/heat detectors by installing new smoke/heat detectors. Smoke detector company was out on 12/30/22 to evaluate the area. We are pending the drawings and quote for the installation of the smoke/heat detectors. Anticipated completion date of 2/28/23. Facility has applied for waiver. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by having the Director of Maintenance/designee doing	2/13/23

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K 341	Continued From page 5 provide supervised smoke/heat detection in the following location: At 12:15 PM, an inspection inside the main kitchen was performed. The surveyor observed no evidence of a smoke/heat detector within 20 feet of the stove as required by code. The MD and DOF confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the deficiency at the Life Safety Code exit conference on 11/7/22. NJAC 8:39 -31.2 (a).	K 341	monthly building rounds to identify other missing areas. 3. The Director of Maintenance/designee will monitor the smoke/heat detectors once installed in the kitchen twice a year by the alarm company. We also have a monitoring company that has 24/7 monitoring for any troubles. 4. The facility will monitor the corrective actions to ensure that the deficient practice is being corrected and will not recur by reporting any abnormal findings in QAPI Quarterly. 5. Administrator has submitted a time-limited waiver for this deficient practice. We are anticipating a completion date of 3/31/23 at the latest. The fire alarm company is waiting for approval from the township of Hillsborough to begin the work.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and	K 351		11/30/22

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K 351	Continued From page 6 sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/7/22 in the presence of facility management, it was determined that the facility failed to a.) provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment and b.) to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in these areas. This deficient practice was identified for 4 of 4 exterior attached overhangs and was evidenced by the following: At 1:25 PM, the surveyor, federal surveyor, Maintenance Director (MD), and Director of Facilities (DOF), observed that 4 of 4 exterior attached overhangs, were not provided with any fire sprinkler protection. The overhangs were finished in a plastic wood composite type material. At the time of the observation, an interview was conducted with the MD and DOF who both confirmed the facility's four exterior attached overhangs, did not have any fire sprinkler coverage. The Licensed Nursing Home Administrator was	K 351	1. The facility is working to correct the deficient practice by having a sprinkler company provide a quote to install sprinkler protection to the 4 attached overhangs. The facility had a company come out on January 6th to provide a quote for the sprinklers. The sprinkler company has installed the sprinklers in the 4 attached overhangs. 2. The facility will identify other areas having the potential to be affected by the same deficient practice by having the Director of Maintenance/Designee doing monthly building rounds to identify other areas missing sprinklers. 3. The Director of Maintenance/designee will monitor the sprinkler system once installed in the 4 overhangs on monthly basis for 3 months. After that period of time, it will be monitored by the sprinkler company yearly. 4. The facility will monitor the corrective actions to ensure that the deficient practice is being corrected and will not recur by reporting any abnormal findings in QAPI Quartely.	

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K 351	Continued From page 7 informed of the findings at the Life Safety Code exit conference on 11/7/22. NJAC 8:39-31.2(e)	K 351		
K 353 SS=F	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 interviews on 11/3/22, in the presence of facility management, it was determined that the facility failed to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated 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. This deficient practice was identified for 9 of 30 areas observed	K 353	The corrective action put into place to rectify the deficient practice identified during the facilities annual life safety survey was to: 1. Filled the gaps with fire rated caulk and install fire rated insulation ordered on 11/7/22. Insulation and caulk completed on 11/9/22. Manufacturer Data sheet 2. Director of Maintenance/designee will make monthly rounds to monitor other	11/23/22

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K 353	Continued From page 8 and was evidenced by the following: During a tour of the building with the Maintenance Director (MD) and Director of Facilities (DOF), the surveyor observed the following: 1. Floor 1 open ceiling approximately nine feet by four inches (9' x 4") across from Resident Room # 106. 2. Electrical panels marked "EP", "PPN", and "RPN" approximately 6' x 6" opening above panels around BX cables entering above the drop ceiling. 3. Electrical closet Floor 3, by Resident Room #308, approximately 4' x 6" opening in the drop ceiling. 4. Electrical closet Floor 2, marked "EP3N", "PP3N", and "RP3N" approximately 6' x 7" opening above the electrical panels around BX cables entering above the drop ceiling. The MD and DOF confirmed the above findings during the observations. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 11/7/22. NJAC 8:39-31.2(e) 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.	K 353	areas that can be potentially affected. 3. Director of Maintenance/designee will review the electrical panels monthly throughout the building to ensure proper fire insulation is in place. 4. Director of Maintenance/designee will monitor for any changes and report during our quarterly QAPI meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		11/23/22

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K 918	Continued From page 9 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: Based on observation and interview on 11/3/22, in the presence of facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 generator's and installed in accordance with the requirements	K 918	The corrective action put into place to rectify the deficient practice identified during the facilities annual life safety survey was to: 1. Electrician come out and install a	

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K 918	Continued From page 10 of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 1:05 PM, the surveyor, federal surveyor, Maintenance Director (MD), and Director of Facilities (DOF) observed the exterior generator. There was a remote manual stop station to prevent inadvertent or unintentional operation on the yellow cabinet, but there was no manual stop station observed remotely outside the area of the generator location. An interview was conducted during the time of the observation with the MD and DOF, who both confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation, located remotely outside the area of the enclosure housing the prime mover. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference held on 11/7/22. 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	manual stop station outside of the generator location (the fence). This was completed on 11/22/22 by the electrician. The manual stop is connected directly to the emergency shut off on the generator. 2. Director of Maintenance/designee will monitor monthly other areas of the building that have the potential to be affected by this deficient practice. 3. Director of Maintenance/designee will monitor the manual stop station that was installed by the electrician on a monthly basis. 4. Director of Maintenance/designee will monitor for any changes and report during our quarterly QAPI meeting.	
K 927 SS=F	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or	K 927		11/23/22

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	315510	A. BUILDING **01** B. WING _____	**11/07/2022**

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BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH	**395 AMWELL ROAD** **HILLSBOROUGH, NJ 08844**

(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 927	Continued From page 11 to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/7/22, in the presence of facility management, it was determined that the facility failed to maintain the trans filling liquid oxygen room to prevent accidental ignition in accordance with NFPA 99, 2012 Edition, Section 11.3.3.2 and 11.3.2.7 by ensuring that the room is properly designed and protected. This deficient practice was evidenced for 1 of 1 wall light switches and 1 of 1 light fixtures and was evidenced by the following: 1. At approximately 10:38 AM, the surveyor, federal surveyor, Maintenance Director (MD), and Director of Facilities (DOF) observed in the liquid oxygen trans filling room, that a source of ignition (light switch) within the room was observed. 2. At approximately 10:40 AM, the surveyor, federal surveyor, MD, and DOF, observed in the liquid oxygen trans filling room, that a non-explosion proof light fixture was installed. An interview was conducted during the observation with the MD and DOF who both stated and confirmed that the trans filling room had a source of ignition; (1) light switch and (1) non-explosion proof light fixture. The Licensed Nursing Home Administrator was informed of the finding at the Life Safety Code exit conference on 11/7/22.	K 927	The corrective action put into place to rectify the deficient practice identified during the facilities annual life safety survey was to: 1. Removed the light switch in the oxygen room on 11/8/22 so that the light remains on at all times. The lights are LED lights. 2. Director of Maintenance/designee will make monthly rounds to other areas that could store liquid oxygen and monitor that there is no light switch.. 3. Director of Maintenance/designee will monitor monthly to monitor proper that light switch remains out of oxygen room. 4. Director of Maintenance/designee will monitor for any changes and report during our quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 927	Continued From page 12 NJAC 8:39-31.2(e)	K 927		