STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315427	A. BUILDING **01** B. WING _____	**07/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	**535 N OAK AVE** **PITMAN, NJ 08071**

(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 07/12/2023 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. United Methodist at Pitman is a 5 story building that was built in 1990's. It is composed of Type 1 construction. The facility is divided into 5 smoke zones. The facility has a 125 KW generator.	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.	K 131		8/3/23

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

Electronically Signed | 08/07/2023

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 131	Continued From page 1 Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 07/12/2023, the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.3.4. between the Nursing Facility and the Assisted Living section of the facility. This deficient practice was evidenced by the following: On 07/12/2023 during the survey entrance at approximately 8:57 AM, a request was made to the Administrator and Building Services Director (BSD) 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 the facility was a three-story building with 36 Resident sleeping rooms and common areas on the 2nd. and 3rd. floors. Starting at approximately 9:25 AM on 07/12/2023 in the presence of the facility BSD a tour of the building was conducted. Along the tour of the facility the surveyor observed the following: 1.) At approximately 9:31 AM, an inspection	K 131	1. No residents were identified to be directly affected by this cited practiced. The mentioned areas of penetrations will be sealed, and missing wallboard replaced by the maintenance department prior to date of compliance. 2. All residents have the potential to affected by this cited practice. 3. Corporate Director of Building service will provide inservice education to the building service director on the importance of ensuring penetrations and missing wallboards are identified during environmental rounds within the community, and that any areas of penetration or missing wallboards identified are to be sealed and repaired timely. A repair will be made with drywall and fire rated caulk in the area identified above the ceiling tiles on the corridor door that separates the Nursing Facility and the Assisted Living by the maintenance staff and will be inspected by the building service director upon completion to ensure compliance. 4. Building Services Director will conduct environmental rounds of ceiling tiles above the corridor doors throughout the Nursing Community twice a week for four weeks then two times per month for three months to ensure no other penetrations exist. Results will be reported to the	

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	315427	A. BUILDING **01** B. WING _____	**07/14/2023**

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K 131	Continued From page 2 above the ceiling tiles of the corridor door that separates the Nursing Facility and the Assisted Living was performed. The surveyor observed one (1) approximately 1/2 inch penetration, one (1) approximately 1" by 1-1/2" penetration, one (1) 1-1/2" by 1-1/2" penetration with wires running through the penetrations. The surveyor also observed an approximately twelve (12") inch by ten (10) inch piece of wallboard missing from the fire rated wall. These penetrations would allow fire, smoke and poisonous gasses to pass from one occupancy to another in the event of a fire. The BSD confirmed the finding at the time of observations. On 07/12/2023 during the survey exit at approximately 1:35 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.1.3.4.	K 131	healthcare director and reviewed with the Nursing Home Administrator in the QAPI committee meeting. A determination for further action will be assessed at the QAPI meeting.	
K 293 SS=E	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.)	K 293		8/3/23

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K 293	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 07/12/2023 in the presence of facility management, it was determined that the facility failed to ensure that illuminated exit signs were in two (2) locations to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 07/12/2023 during the survey entrance at approximately 8:57 AM, a request was made to the Administrator and Building Services Director (BSD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a three-story building with 36 Resident sleeping rooms and common areas on the 2nd. and 3rd. floors.	K 293	1. No residents were identified to be affected by the deficient practice. 2. All residents and staff on the 2nd and 3rd floor have the potential to be affected by cited practice. An environment round inspection was completed on all exit doors and no further signage issues were identified. 3. The maintenance staff will be provided education by the building service on ensuring exits signs have proper illumination when completing environmental rounds. A work order has been generated to install an illuminated exit sign above the double doors leading out of the dining room into the corridor in both second and third floor dining rooms by the maintenance staff and one installed will be inspected the building director to ensure compliance. 4. The building service director randomly will monitor exit signs operation weekly x 1 month and then monthly x 2 months until compliance has been met. The maintenance system automatically generates a work order to inspect exit signage monthly and to ensure proper functioning and this will continue with the maintenance staff. All findings will be reported to the Nursing Home Administrator and will be reviewed in the monthly safety committee and the quarterly QAPI (Quality Assurance Performance Improvement) with immediate corrective action as warranted.	

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K 293	Continued From page 4 Starting at approximately 9:25 AM on 07/12/2023, in the presence of the facility BSD a tour of the building was conducted. During the building tour the of the facility the surveyor observed no evidence of two (2) illuminated exit signs in the following locations to clearly identify the exit access route, 1.) At approximately 10:48 AM inside the second floor Resident Dining room, the surveyor observed no evidence of one (1) illuminated exit sign above the double doors leading out of the Dining room into the corridor. 2.) At approximately 11:38 AM inside the third floor Resident Dining room, the surveyor observed no evidence of one (1) illuminated exit sign above the double doors leading out of the Dining room into the corridor. The BSD confirmed the finding at the time of observations. On 07/12/2023 during the survey exit at approximately 1:35 PM, the surveyor informed the Administrator of the deficiency.	K 293		
K 311 SS=D	Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101 Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings	K 311		8/3/23

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K 311	Continued From page 5 between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 07/12/2023, in the presence of facility Management it was determined that the facility failed to ensure that 1 of 6 exit access stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction. This was evidenced by the following, On 07/12/2023 during the survey entrance at approximately 8:57 AM, a request was made to the Administrator and Building Services Director (BSD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a three-story building with 36 Resident sleeping rooms, common areas with two (2) stairwells that Resident, Staff and Visitors would use in the event of an emergency to exit the building from the 2nd. and 3rd. floors. Starting at approximately 9:25 AM on 07/12/2023, in the presence of the facility BSD during a tour of the building the surveyor inspected and conducted closure test of six (6) exit access doors leading into exit stairways with the following results:	K 311	1. No residents were identified in being directly affected by the deficient practice. A work order was immediately generated and completed upon the life safety inspector□s notification of the 2nd floor stairway corridor exit access door inability to latch. Stairwell door now has a positive latch into its frame and is working properly. 2. All residents and staff on the 2nd floor have the potential of being affected by the cited practice. All exit doors were inspected to ensure proper latching and no other issues were identified. 3. The building service director will provide education to maintenance staff on importance of checking doors during environmental rounds for positive latch. Fire door inspections will be tracked by the building service director through the automated maintenance preventive measure cycles that are established for monthly routine inspection of the fire doors. Repairs will be made immediately when improper latch function of a fire door is identified as warranted. 4. The Building Services Director will audit fire doors twice a week for four weeks then twice a month for three months to	

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K 311	Continued From page 6 At approximately 11:33 AM, during a closure test of the second (2nd.) floor stairway (stairwell #1 next to resident room #201) corridor exit access door, when the door was opened to a 90 degree opening to the door frame and allowed to self-close, the door did not positive latch into its frame. This test was performed two additional times with the same results. The surveyor observed the door had no means to positive latch into its frame. A review of an emergency evacuation diagram posted in the corridor identified that stairwell as the primary exit to reach an exit discharge door. The stairwell doors would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The BSD confirmed the finding at the time of observations. On 07/12/2023 during the survey exit at approximately 1:35 PM, the surveyor informed the Administrator of the deficiency.	K 311	ensure doors close properly. Inspection findings of any improper functioning of a fire door will be reported to the Healthcare Director and reviewed with Nursing Home Administrator in the quarterly QAPI (quality assurance performance improvement) meeting with immediate corrective action as warranted. A determination for further action will be assessed at the QAPI meeting.	
K 521 SS=E	Fire Safety Hazard. NJAC 8:39- 31.2(e) 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	K 521		8/3/23

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K 521	Continued From page 7 specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 07/12/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 3 of 6 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 07/12/2023 during the survey entrance at approximately 8:57 AM, a request was made to the Administrator and Building Services Director (BSD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a three-story building with 36 Resident sleeping rooms and common areas on the 2nd. and 3rd. floors. Starting at approximately 9:25 AM on 07/12/2023, in the presence of the facility BSD a tour of the building was conducted. Along the tour the surveyor inspected and tested six (6) Resident sleeping rooms bathroom exhaust systems.	K 521	1. No residents were identified of being adversely affected by this cited practice. A work order was generated for Rooms #201, #303 and #315 and a new motor has been installed in the roof top unit #6 which controlled the exhaust fans for the rooms identified by the life safety inspector. All exhaust fans in rooms #201, #303, #315 are now in working order. 2. All residents with rooms with a bathroom exhaust system have the potential to be affected by this cited practice. A community wide environmental round inspection was completed on all bathroom exhaust systems to ensure compliance and no other bathroom exhaust system malfunctioning was identified and appeared to be in working order. 3. The Building Service Director will be in-serviced by the Nursing home administrator regarding the importance of all exhaust fans working. The Building Service Director will continue to monitor exhaust fans during routine environmental rounds and report variances from the inspection with a corrective action and work order if needed. 4. The Maintenance team will audit the bathroom exhaust fans weekly x 2 months on each floor then monthly for 1 quarter to	

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K 521	Continued From page 8 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 3 of 6 resident bathrooms in the following locations: 1.) At approximately 10:50 AM, inside Resident room #201 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the BSD that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2.) At approximately 11:39 AM, inside Resident room #303 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3.) At approximately 11:42 AM, inside Resident room #315 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The BSD confirmed the finding at the time of observations. On 07/12/2023 during the survey exit at approximately 1:35 PM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	ensure exhaust fans are in working order. Any issues identified will be immediately corrected by the Maintenance Department upon identification of problem. Findings will be reported to the healthcare director and reviewed with the nursing home administrator in the quarterly QAPI meeting with corrective action as warranted.	

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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
315427 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	535 N OAK AVE PITMAN, NJ 08071

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	K0131	08/03/2023	LSC	K0293	08/03/2023	LSC	K0311	08/03/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0521	08/03/2023	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	
7/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO