STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315185	A. BUILDING **01** B. WING _____	**03/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LINWOOD, LLC	**201 NEW ROAD AND CENTRAL AVE** **LINWOOD, NJ 08221**

(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 LIFE SAFETY CODE 101:2012 Existing THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R.	K 000		
K 241 SS=D	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation on 03/22/21 in the presence of the Administrator and Maintenance Director, it was determined that the facility failed to provide at least 2 acceptable exits, remote from each other, for each floor of the building. This deficient practice was found in the basement and was evidenced by the following: Throughout a tour of the facility, on 03/22/21	K 241	1. Facility contracted with an architectural engineer to conduct the necessary FSES survey and was completed on 4/11/21. The facility failed the FSES. The facility is requesting a time-limited waiver to construct a 2nd basement exit. Estimated completion 2/15/2023. 2. All residents have the potential to be affected by this deficient practice.	8/30/21

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

Electronically Signed | 04/07/2021

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K 241	Continued From page 1 beginning at 10:15 AM, the surveyor and the facility's Administrator and Maintenance Director observed that the facility's three basement areas were each provided with only one acceptable exit instead of two as required. These areas were used by staff only and no residents were able to access any of the three areas. The basements were protected by the fire alarm system and automatic fire sprinkler system. On 03/22/21, the three basement's were observed to have sprinklers and were protected by a fire alarm system. The basements were accessible only to staff and had self-closing and positive locking door knobs. The Administrator stated staff were to be in-serviced at orientation and annually thereafter on the danger of having 1 acceptable exit and would schedule a fire drill in the basements each year. All 3-basements observed had combustible storage. The Administrator was provided with the "instructions for past "waivered" citations at the Life Safety Code exit conference indicating, that the facility is required to have an onsite, physical FIRE SAFETY EVALUATION SYSTEM (FSES) survey. 19.2.4.1-19.2.4.4 NJAC 8:39 - 31.2(e)	K 241	3. No residents or visitors are allowed in the locked basements and signs are on all basement doors as a reminder. Only staff needed for operational requirements and vendors for inspections are allowed in the basement affect areas. All employees upon hire and annually are in-serviced on the lack of acceptable mode of egress in the 3 basements and that only operational staff, vendors for inspections, and employees that need to work in the basement can go into the basement. Staff in the affect area received in-service training on fire safety, prevention, and response. Facility conducts 1 fire drill a month in the basement affected area to ensure staff are familiar with proper fire safety procedures in these areas. All three basements have proper sprinkler coverage. 4. The affected basement areas have been emptied as of 8/30/2021 and in use for the mechanical equipment only. The Housekeeping and Laundry Manager or designee will monitor the affected basement area every 2 hours until the FSES survey is passed. Any out of compliance findings will be reported immediately to the administrator for appropriate correction. Monitoring will also be reported during quality assurance meetings on a quarterly basis until the FSES Survey is passed.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		5/14/21

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K 374	Continued From page 2 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 03/22/21, it was determined that the facility failed to ensure that smoke barrier doors were free of obstructions. This deficiency was evidenced by the following: At 11:30 A. M., in the presence of the Administrator and Maintenance Director, the surveyor observed one set of smoke barrier doors located by resident rooms #4 and #7 had an unattended lunch truck directly in front of one-side of the smoke doors, thus causing an obstruction on one side and a means of egress impediment from both adjacent smoke compartments. The Administrator and Maintenance Director acknowledged this finding and indicated in an interview during the observation that the staff was aware of storing items in front of these doors were not allowed.	K 374	1. The meal cart was immediately removed from the doorway. 2. All residents have the potential to be affected by this deficient practice. 3. All meal carts were checked for placement to ensure they were not blocking any smoke doors and all were in proper places. All dietary staff were inserviced on fire door safety. 4. Dietary Director will audit 2 meal carts twice a week for 4 weeks, 2 meal carts once a week for the following 8 weeks and 1 meal cart a week for the following 4 weeks to ensure they are being dropped off in proper locations. Any meal cart not dropped off in a proper location will be immediately moved and staff member addressed.	

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K 374	Continued From page 3 The surveyor informed the facility's Administrator of this finding, during the Life Safety Code survey exit conference. NJAC 8:39-31.2(e) 19.3.7.6 19.3.7.8 19.3.7.9	K 374	Dietary Director will report at the quarterly QA Meeting x3 quarters on his findings.	