

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

PRINTED: 10/13/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004
--	--

(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	E 000		
K 000	<p>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.</p> <p>INITIAL COMMENTS</p> <p>LIFE SAFETY CODE 101: 2012.</p> <p>THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE 101: 2012.</p>	K 000		
K 222 SS=D	<p>Egress Doors CFR(s): NFPA 101</p> <p>Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release</p>	K 222		5/21/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/20/2021
--	-------	-----------------------------

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: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/03/2021
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004		
(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 222	<p>Continued From page 1</p> <p>upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</p> <p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation, it was determined that the facility failed to provide exit access that was readily accessible by having locking arrangements</p>	K 222	<p>1. The company that maintains automated controls within the facility was contacted to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2021
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004	
(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 222	Continued From page 2 (coded/key exit door and push button lockset) for 1 of 4 exit discharge doors. Facility staff being the only people with code access to an exit, which is not in accordance with LSC Section 19.2.2.2.4, 19.2.2.2.5, 10.2.2.2.5.2, and 7.2.1.6. This deficient practice was evidenced by: During a tour of the building at 10:22 AM, in the presence of the facility Director of Maintenance (DOM), an inspection of the resident's Activity Room was performed. During a test of a designated exit discharge door, when the surveyor turned the doorknob and pushed on the exit door to open and counted for 30 seconds, the door was not equipped with a delayed egress locking mechanism, only a push-button door lockset and electronic keypad that could only be accessed by staff with the combination and knowledge to open the door. A review of an emergency evacuation diagram posted on the unit identified this exit discharge door as the primary or secondary exit out of the unit. The facility failed to provide exit access that was readily accessible at all times by having special locking arrangements.	K 222	resolve the issue. Adjustments to the latch and magnet were completed, which resolved the issue (invoice attached). Prior to their arrival, staff was notified of the delayed egress issue and were provided with access codes and key fobs to ensure all residents could be safely evacuated if necessary. 2. Due to the nature of this deficiency, all residents have the potential to be affected by this issue. 3. As part of monthly environmental safety rounds, the Director of Maintenance will test all exit doors in the facility to ensure proper operation and compliance with Life Safety Code standards. 4. The Director of Maintenance will report findings of the rounds to the QAPI committee on no less than a quarterly basis for the remainder of 2021. Based on the results of these reports, a decision will be made regarding the need for continued submission and reporting.	
K 351 SS=D	NJAC 8:39 -31.2 (e) 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	K 351		5/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2021
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004	
(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 351	<p>Continued From page 3</p> <p>accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>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.</p> <p>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 sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.</p> <p>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)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations on 4/30/2021, in the presence of Facility Management, it was determined that the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy.</p> <p>This deficient practice was evidence by the following:</p> <p>Reference #1: National Fire Protection Association (NFPA) 13 Standard for the Installation of Sprinkler Systems.</p> <p>Installation Requirements:</p> <p>-8.8.4.1.1 Unobstructed Construction.</p> <p>-8.8.4.1.1.1 Under unobstructed construction, the distance between the sprinkler deflector and the ceiling shall be a minimum of 1 inch (25.4 mm) and a maximum of 12 inches (305 mm) throughout the area of coverage of the sprinkler.</p>	K 351	<ol style="list-style-type: none"> The company that provides fire sprinkler service within the facility was dispatched to resolve the issue. In the housekeeping closet, the pendant was replaced to make it compliant with code. In the shower room, an additional sprinkler head was added to ensure full and proper coverage (vendor invoice attached). Due to the nature of this deficiency, all residents have the potential to be affected by this issue. As part of monthly environmental safety rounds, the Director of Maintenance will evaluate a representative sample of sprinkler heads to ensure that they are compliant with codes and provide full coverage in the event of a fire. The Director of Maintenance will report 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/03/2021
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004		
(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 351	<p>Continued From page 4</p> <p>Reference #2: Uniform Construction Code, Special detailed requirements based on use and occupancy section 407 group I-2, [F] 407.5 Automatic sprinkler system. Smoke compartments containing patient sleeping units shall be equipped throughout with an automatic fire sprinkler system in accordance with Section 903.3.1.1. The smoke compartment shall be equipped with approved quick-response or residential sprinklers in accordance with section 903.3.2.</p> <p>This deficient practice was evidenced by the following:</p> <p>During the survey entrance at 8:41 AM, the surveyor requested the facility's Licensed Nursing Home Administrator (LNHA) and Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms in the facility.</p> <p>During a tour of the building starting at 8:55 AM, in the presence of the facility DOM, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location:</p> <ol style="list-style-type: none"> At 10:16 AM, the surveyor observed inside a housekeeping closet near the activities office a downward type pendant fire sprinkler head. The surveyor measured from the fire sprinkler deflector plate to the wallboard ceiling above was thirteen (13) inches. At 10:42 AM, the surveyor observed inside the residents shower room, a 3 feet wide by 3 feet 4-inch deep shower stall had no evidence of fire sprinkler coverage. The location of the sprinkler head in the shower room would not reach into the 3' by 3'-4" shower stall. At this time, the surveyor pointed to the sprinkler in the room 	K 351	<p>findings of the rounds to the QAPI committee on no less than a quarterly basis</p> <p>for the remainder of 2021. Based on the results of these reports, a decision will be made regarding the need for continued submission and reporting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2021
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004	
(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 351	Continued From page 5 and asked the DOM, "Would this sprinkler reach into the shower stall?" The DOM said, "No." Code requires fire sprinkler heads to be within twelve (12) inches of the ceiling of a room. A review of the facility-provided layout identified that there are 32 Residential sleeping rooms on the unit. The Administrator was notified of the deficiency at the Life Safety Code exit conference at 1:35 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility-provided documentation on 4/30/2021, it was determined the facility failed to perform and document on the tag attached to the fire extinguisher a monthly visual examination for 4 of 11 fire extinguishers, as required by code and National Fire Protection Association (NFPA) requirements. This deficient practice was evidenced by the following: During a tour of the building starting at 8:55 AM,	K 355	1. Although documentation existed that confirmed that all fire extinguishers had been visually inspected, this documentation was not in compliance with the requirements of this section. The 4 fire extinguishers were again visually inspected by the Director of Maintenance and found to be safe for continued use. 2. Due to the nature of this deficiency, all residents have the potential to be affected	5/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/03/2021
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004		
(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 355	<p>Continued From page 6</p> <p>in the presence of the facility Director of Maintenance (DOM), the surveyor observed 11 fire extinguishers were last annually inspected June 2020 with no documented evidence of a monthly visual inspection performed for the month of February 2021 in the following locations:</p> <ol style="list-style-type: none"> 1. At 9:00 AM, one ABC-type fire extinguisher in the Kitchen revealed no evidence of a monthly examination for December 2020, January, and February 2021. 2. At 9:03 AM, one ABC-type fire extinguisher in the Kitchen revealed no evidence of a monthly examination for February 2021. 3. At 9:10 AM, one "Class K" Wet Chemical type fire extinguisher in the Kitchen revealed no evidence of a monthly examination for February 2021. 4. At 9:11 AM, one ABC-type fire extinguisher in the Kitchen had no evidence of a monthly examination for February 2021. <p>A review of the facility-provided "Fire Extinguishers" Monthly Inspection sheet February 2021 identified the four (4) portable fire extinguishers in the Kitchen had been visually inspected. The four (4) fire extinguishers had no documented evidence on the tag attached to the fire extinguishers, as required.</p> <p>The Administrator was notified of the deficiency at the Life Safety Code exit conference at 1:35 PM.</p> <p>According to NFPA 10- 4-3.4, at least monthly, the date the inspection shall be performed and the initials of the person performing the inspection</p>	K 355	<p>by this issue.</p> <ol style="list-style-type: none"> 3. As part of monthly environmental safety rounds, the Director of Maintenance will review tags on a representative sample of fire extinguishers to ensure monthly visual inspections are performed and documented properly. 4. The Director of Maintenance will report findings of the rounds to the QAPI committee on no less than a quarterly basis for the remainder of 2021. Based on the results of these reports, a decision will be made regarding the need for continued submission and reporting. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2021
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004	
(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 355	Continued From page 7 shall be recorded at least monthly, and that records shall be kept on a tag or label attached to the fire extinguisher.	K 355		
K 521 SS=D	NFPA 10. NJAC 8:39 -31.1 (c). 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 observation, interview, and record review conducted on 04/30/21, in the presence of facility management, it was determined that the facility failed to maintain their Packaged Terminal Air Conditioner (PTAC) units in a safe and optimal condition. This deficient practice was evidenced by the following: Starting at 8:55 AM while touring the facility, in the presence of the facility's Director of Maintenance (DOM), the surveyor observed that PTAC units had clogged and dirty filters in the following resident rooms: 1. At 10:47 AM, Sampled Resident [REDACTED]. 2. At 10:51 AM, Sampled Resident [REDACTED].	K 521	1. The filters for the PTAC units in the affected rooms were immediately cleaned. 2. Due to the nature of the deficiency, all residents had the potential to be affected by this issue. As such, all PTAC unit filters in the facility were inspected and cleaned if necessary. 3. As part of monthly environmental safety rounds, the Director of Maintenance will inspect the filters of no less than four PTAC units to ensure they are clean, that cleaning logs are in place and regular cleaning is properly documented.	5/21/21

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

PRINTED: 10/13/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/03/2021
NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004		
(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 521	<p>Continued From page 8</p> <p>When interviewed at the time of the observations, the DOM agreed that the PTAC filters should not be like that in the facility. The DOM told the surveyor that there is a cleaning log attached to the PTAC units in each Resident room.</p> <p>For both Sampled Resident's rooms (█ and █), the cleaning log sheets for PTAC filters were missing.</p> <p>The Administrator was notified of the deficiency at the Life Safety Code exit conference at 1:35 PM.</p> <p>NJAC 8:39 - 31.2(e)</p>	K 521	<p>4. The Director of Maintenance will report findings of the rounds to the QAPI committee on no less than a quarterly basis for the remainder of 2021. Based on the results of these reports, a decision will be made regarding the need for continued submission and reporting.</p>		