STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315396	A. BUILDING **01** B. WING _____	**11/12/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND MANOR NURSING AND REHABILITATION CENTER	**154 SUNNY SLOPE DRIVE** **BRIDGETON, NJ 08302**

(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 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/10/21 and 11/12/21 and Cumberland Manor Nursing and Rehabilitation Center 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. Cumberland Manor Nursing and Rehabilitation Center is a three (3) story, Type II Protected building that was built in December 1997. The facility is divided into 11 smoke zones.	K 000		
K 281 SS=D	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 11/10/2021, in the presence of facility	K 281	1) On 11/11/2021 the Maintenance director installed a fixture providing	12/3/21

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

Electronically Signed | 11/26/2021

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K 281	Continued From page 1 management it was determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps. This deficient practice was evidenced by the following: During the building tour starting at 10:47 AM, in the presence of the facility's Director of Maintenance (DOM), the surveyor observed that two (2) exit discharge areas failed to be equipped with illumination or only a single bulb light fixture. There were no supplemental lights to ensure the areas were illuminated should the single bulb or single bulb light fixture failed in the following locations: 1. At 10:55 AM, the surveyor observed outside the exit discharge door on the [redacted] floor, near the back of elevators [redacted] and [redacted], had a single bulb light fixture. 2. At 11:12 AM, the surveyor observed outside the exit discharge door, next to the [redacted] floor Nursing Station, had no light fixtures to illuminate the area. These findings were acknowledged by the facility's DOM in an interview during the tour. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 11/12/2021. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281	continuous lighting with two lamps outside the exit discharge door on the [redacted] floor near the back elevators [redacted] and [redacted] The Maintenance director also installed a fixture providing continuous lighting with two lamps outside the exit discharge door next to the first floor nurses station. 2) All residents have the potential to be affected by this deficient practice. 3) The Maintenance director was in-serviced on the regulation that all means of egress are to be provided with continuous lighting with two lamps. 4) The Administrator or designee will audit all means of egress to ensure that there is continuous lighting with two lamps. Audits will take place weekly x 2 beginning 11/11/2021 and monthly x 3 months. Results of the audit will be reviewed at the quarterly QAPI meeting.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		12/3/21

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K 321	Continued From page 2 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/12/2021, in the presence of facility management, it was determined that the facility failed to provide and maintain self-closing devices and hardware on fire rated doors to hazardous areas in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5,	K 321	1) On 11/15/2021 the Maintenance director installed an automatic door closure on the door leading to the Medical Records room. 2) All residents have the potential to be affected by this deficient practice.	

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K 321	Continued From page 3 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was evidenced by the following: During a tour of the building, in the presence of the facility's Director of Maintenance (DOM) at 10:57 AM, an inspection of the Medical Records room was conducted. The surveyor observed that the room had a one (1) hour fire rated corridor door leading into the Medical Records room and that the door had no means to self-close the door into its frame. The surveyor further observed 26 banker boxes filled with combustible paper products, several filing cabinets filled with medical records and several medical record files stacked on desk and filing cabinets. The surveyor observed the room was larger than 50 square feet. These findings were acknowledge by the facility's DOM in an interview during the tour. This condition may allow a fire, smoke and poisonous gases to pass from the Medical Records records storage room into the exit corridors in the event of a fire. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 11/12/2021. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	3) The maintenance director was in-serviced on 11/15/2021 on combustible storage rooms/spaces over 50 square feet are required to self close the door to its frame. 4) The Administrator or designee will audit 5 combustible storage rooms/spaces over 50 square feet to ensure it has a self closing door weekly x 2 and monthly x 3. Results of the audit will be reviewed at the quarterly QAPI meeting.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101	K 341		12/3/21

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K 341	Continued From page 4 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 11/10/21 and 11/12/21, in the presence of facility management, it was determined that the facility failed to provide notification by audible and visible signals for 2 of 2 outside enclosed courtyards inspected in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 11/10/21 at 11:49 AM, during the building tour with the facility Director of Maintenance (DOM), the surveyor observed that the [redacted] Wing outside enclosed courtyard did not have any occupant notification devices (horn/strobe tied into the fire	K 341	1) On 11/12/2021 the fire alarm company installed a horn and strobe and tied it into the fire alarm system for the following two locations. [redacted] wing outside enclosed courtyard and resident outside enclosed area. 2) All residents have the potential to be affected by this deficient practice. 3) The Maintenance director was in-serviced on 11/15/2021 on the regulation to provide notification by audible and visible signals for enclosed courtyard. 4) The Administrator or designee will audit the enclosed courtyards to ensure the	

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K 341	Continued From page 5 alarm system). At that time, the DOM verified and confirmed there was no horn/strobe tied into the fire alarm system in the [redacted]-Wing outside enclosed courtyard. On 11/12/21 at 11:21 AM, the building tour with the facility DOM continued and an inspection of the resident outside enclosed courtyard was performed. The surveyor observed no evidence of a fire alarm occupant notification devices (horn/strobe tied into the fire alarm system). At that time, the DOM verified and confirmed there was no horn/strobe tied into the fire alarm system in the resident outside enclosed courtyard. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 11/12/2021. NJAC 8:39-31.2(a)	K 341	horn and strobes are functioning properly weekly x 2 and monthly x 3. Results of the audit will be reviewed at the quarterly QAPI meeting.	