STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315094	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD** **MERCERVILLE, NJ 08619**

(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 5/10/22, 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 2-story building that was built in 70's, It is composed of Type III unprotected. The facility is divided into 6- smoke zones. The generator does 100% of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 114 certified beds. At the time of the survey the census was 74.	K 000		

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

Electronically Signed | 06/01/2022

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K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on documentation review on 5/10/22, in the presence of the Maintenance Director and Regional Operations Director, it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was evidenced for 10 of 10 fire doors observed, by the following: At 9:30 AM, the surveyor reviewed all documentation provided by the Maintenance Director. The annual fire door inspection documentation was not provided for the facility's fire door assemblies. An interview was conducted with the Maintenance Director during the document review, and he stated that he currently could not find any fire door annual inspection logs for the last 12 months. The Administrator was informed of this finding at the Life Safety Code exit conference on 5/10/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15	K 211	1. The Facility failed to ensure there was proper documentation for the Annual fire door inspection. 10 of the 10 Fire Door assembly were immediately inspected to ensure all NFPA standards were being met. 2. As noted in the 2567, this alleged deficient practice has the potential to affect all occupants in the facility. 3. Maintenance Director completed the annual fire door inspection log for the facility documentation requirement. Any alteration to the doors will require an inspection. 4. Maintenance Director or Designee is responsible for the completion of the annual fire door inspection log. Results of the annual fire door inspection log will be presented by the Administrator to monthly QAPI committee for review and recommendation	6/1/22

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K 211	Continued From page 2 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8	K 211		
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/10/22 in the presence of the Maintenance Director and Regional Operations Director, it was determined that the facility failed to ensure that exit corridors in non-resident areas measured at least 44 inches wide in accordance with 19.2.3.4. exception #1. This deficient practice was evidenced by the following: At 10:00 AM, the surveyor and the Administrator observed that the 2nd floor office area was provided with three corridor areas that measured less than the required 44 inches in width. The Maintenance Director measured the width of the three corridors. Two of the corridor areas measured 36 inches wide and one measured 41 inches wide. Regulations for an acceptable means of egress require a minimum corridor width of 44 inches in	K 232	K232 Aisle, Corridor or Ramp Width The Facility submitted an updated FSES to show we are complying with our past waivered citation. We had a passing score. All facility person has the ability of being affected by this deficient practice. No residents were affected by this practice. The second floor of Mercerville Center is not accessible to residents. A coded lock has been in operation at the first-floor door that only the staff of Mercerville have access to the code. New FSES was requested to put us in compliance with standards. Staff who need access to the second floor are trained in the coded lock. The door is always to be closed and the lock automatically engages to prevent any unauthorized person or resident from entering the area. The Maintenance Director and/or	6/2/22

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K 232	Continued From page 3 areas not used for residents. A coded lock was installed to prevent accidental access to the second floor by residents. This area was used for staff offices and morning meeting by department heads. The second floor area was protected by an automatic fire sprinkler system and a fire alarm system. The Administrator was informed of the on going deficiency and was informed that the facility now was required to have a new Fire Safety Evaluation System (FSES) for the 5/10/22 facility recertification for past "waivered" citations. NJAC 8:39-31.1(c)	K 232	designee will check the coded lock to the second floor to ensure proper operation, during monthly quality rounds ongoing. And will review the FSES at the quarterly QA meeting to ensure we are still in compliance. Substantial compliance will be achieved by 6/2/22.	
K 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 5/10/22, in the presence of the Maintenance Director and Regional Operations Director, it was determined that the facility failed to maintain the fire sprinkler system in accordance with NFPA 13 and 72, by failing to ensure that the water supply valves were provided with tamper alarms.	K 352	K352 Sprinkler System- Supervisory Signals 1. The Maintenance Director immediately ordered the tamper switch and it has now been installed. He confirmed that the monitoring system will connect the switch to the enunciator panel. All Residents have the potential to	7/21/22

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K 352	Continued From page 4 This deficient practice was identified for 1 of 1 post indicator valve and was evidenced by the following: At 12:30 PM, the surveyor observed on the outside of the facility that the red locked post indicator valve was not monitored. Although the valve was chained with a pad lock, the valve was not provided with an alarm to notify the facility, if the water was turned off and that the fire sprinkler system was inactive. During an interview at the time of the observations, the Maintenance Director and Regional Operations Director stated that they were unaware of the requirement. The Administrator was notified of the finding at the Life Safety Code exit conference on 5/10/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25, 72 NFPA 101 2012 edition Life Safety Code 9.7.2.1* (Supervisory Signals)	K 352	be affected. 2. No other areas within the center were found with these concerns. 3. The Maintenance Director and/or designee will complete audits to ensure the tamper switch is being monitored. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Administrator to monthly QAPI committee for review and recommendation. 4. Substantial compliance was achieved 7/21/22	
K 521 SS=F	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	K 521		6/1/22

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K 521	Continued From page 5 by: Based on observation and interviews on 5/10/22, in the presence of the Maintenance Director and Regional Operations Director, it was determined that the facility failed to provide smoke dampers for 1 of 1 vents observed. This deficient practice was evidenced by the following: In the presence of the Maintenance Director and Regional Operations Director the surveyor observed an open transfer grill in the Physical Therapy (PT) room closet. The closet was observed to have had a hot water heater and an open vent approximately 2' x 1' from the closet to the PT room. The PT room was occupied by residents at the time of the observation. The Maintenance Director and Regional Operations Director confirmed the finding during the observation, that the open vent was not provided with any smoke-actuated dampers or other approved means to resist the transfer of smoke into areas of refuge in that area. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/10/22. NFPA 90 A NFPA 101-2012 edition Life Safety Code NFPA 101-19.5.2.1 section 9.2.2 NFPA 101 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NFPA 101 19.3.6.4.1 Transfer grills, regardless of whether they are protected by fusible link dampers, shall not be used in corridor walls or doors. NJAC 8:39-31.2(e)	K 521	1. The Facility failed to provide smoke dampers for 1 of 1 vent observed. The Maintenance Director properly sealed off the open transfer grill in the Physical Therapy closet to prevent transfer of smoke in any area of refuge. 2. This alleged deficient practice has the potential to affect all occupants in the facility. 3. Maintenance Director conducted a full facility inspection to all open vents and did not find any further need to install dampers or noncompliance. Maintenance Director was educated on properly updating his damper log ensuring all open vents had proper seal to prevent transfer of smoke. 4. Maintenance Director or designee will complete monthly facility audits for 3 months, then every 6 months for a year to ensure seal and dampers are properly in place. Results of these audits will be presented by the Administrator to monthly QAPI committee for review and recommendation	

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K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing 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 5/10/22,	K 918	K918 Electrical Systems- Essential	7/14/22

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K 918	Continued From page 7 the facility did not ensure a remote manual stop station for 1 of 1 generator, was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice had the potential to affect all residents. On 5/10/22, the Surveyor in the presence of the Maintenance Director and Regional Operations Director, observed that the exterior diesel generator did not have a remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator. The surveyor conducted an interview at that time with the Maintenance Director and Regional Operations Director, who confirmed that the exterior generator did not have a remote manual stop station. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/10/22. 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	Electric System 1. The Maintenance Director immediately ordered the remote manual stop button and confirmed with a company to install the switch. All Residents have the potential to be affected. 2. No other areas within the center were found with these concerns. 3. The Maintenance Director and/or designee will complete audits to ensure the stop button is in working order. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Administrator to monthly QAPI committee for review and recommendation. 4. Substantial compliance will be achieved by 7/14//22	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or	K 923		6/1/22

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K 923	Continued From page 8 gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 5/10/22, in the presence of the Maintenance Director and Regional Operations Director, it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 7 of 46 portable oxygen cylinders and was evidenced by	K 923	1. The Maintenance Director immediately individually secured the 3 portable oxygen tanks and 4 H tanks to prevent from tipping , rupture and damage. All residents have the potential to be affected 2. The Maintenance Director audited all oxygen storage areas throughout the facility. No other oxygen storage areas within the center were found with these concerns.	

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K 923	Continued From page 9 the following: At 10:55 AM, the surveyor observed in the exterior oxygen cylinder storage shed that three portable oxygen cylinders and four large filled H-tanks (larger than a standard portable oxygen tank) were free standing and not secured. An interview was conducted with the Maintenance Director and Regional Operations Director, who both stated that the cylinders must be individually secured from tipping, rupture and damage at all times. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/10/22. NJAC 8:39-31.2(e) NFPA 99	K 923	3. The Maintenance Director or designee will perform audits to ensure all oxygen tanks are secured properly. Audits will be completed weekly for 4 weeks and then monthly for 3 months. Results of these audits will be presented by the administrator to the to monthly QAPI committee for review and recommendation. 4. Substantial compliance achieved 6/1/22	