STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315324	A. BUILDING **01** B. WING _____	**04/14/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE HEALTHCARE & REHAB	**512 UNION STREET** **TRENTON, NJ 08611**

(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 04/12 and 13/22 and Waters Edge Healthcare and Rehabilitation 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. Waters Edge Healthcare and Rehabilitation is a five (5), Type II Protected building that was built in June 1993. The facility is divided into 15 smoke zones.	K 000		
K 281 SS=E	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, interview, and review of facility provided documentation, it was	K 281	1.The Director of Maintenance Contacted a certified Electrician to request quote to	5/16/22

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

Electronically Signed | 04/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WATERS EDGE HEALTHCARE & REHAB	**512 UNION STREET** **TRENTON, NJ 08611**

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K 281	Continued From page 1 determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps for 2 of 9 exit discharge doors. This deficient practice was evidenced by the following: On 4/13/22, the surveyor with the Director of Facility Maintenance (DFM) toured the facility and observed two areas that failed to provide proper emergency lighting in the following locations: 1. At 11:47 AM, an inspection outside of a designated exit discharge door (doors that put you outside of the building) near the Physical Therapy area was performed. The surveyor observed no evidence of an automatic egress lighting. At this time, the surveyor reviewed the facility provided lay-out which identified that there was no exit discharge door on the facility print. The surveyor asked the DFM if there had always been an exit discharge door here, and the DFM responded that he had been at the facility for a year and seven months and the exit door had been there the entire time. The DFM stated that the Licensed Nursing Home Administrator (LNHA) had been at the facility for years so he might know. 2. At 12:10 PM, an inspection outside of a designated exit discharge door near the soiled linen chute room identified that there was one light fixture. At this time, the surveyor asked the DFM if there were two light bulbs inside the fixture, and the DFM responded no. The findings were verified and confirmed by the DFM during the observations.	K 281	remediate deficiency and place facility into compliance. 2.All Residents have the ability to be affected proper lighting around facility is not maintained. 3. Quote from certified Electrician was received for remediation and remediation of egress lighting was performed. Director of Maintenance performed whole house inspection of egress doors and lighting to assure compliance. Director of Maintenance will perform weekly audit of all egress lighting to assure on going compliance. 4.The Director of Maintenance will provide Monthly reports to the Administrator regarding the status of all exterior lighting and when required servicing is performed for a six month period. If concerns continue, this audit will continue for an additional 3 months or until compliance is achieved. The Director of Maintenance will provide information from the audit inspections performed to the team at the Quarterly Quality Meetings.	

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K 281	Continued From page 2 On 4/13/22 at 1:22 PM, the surveyor asked the LNHA if the exit discharge door near the Physical Therapy area had been there since the building was built, and the LNHA responded no, it had to be put in when we leased a section of the building to a Dialysis Center. On 4/13/22 at 1:31 PM, the surveyor informed the LNHA of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to a.) provide a battery backup emergency light above the emergency generator's three transfer switches, independent of the building's electrical system and emergency generator and b.) provide a battery backup emergency light above 1 of 1 emergency generator, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following:	K 291	1. Director of Maintenance contacted certified Electrician to request quote to remediate deficiency and place facility into compliance. 2.All Residents have the ability to be affected if compliance with need for emergency lighting is not maintained. 3. Quote from the certified Electrician was received and remediation for emergency back-up lighting was performed. The Director of Maintenance will perform monthly testing of the battery backup lighting in the generator room to assure	5/16/22

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	315324	A. BUILDING **01** B. WING _____	**04/14/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE HEALTHCARE & REHAB	**512 UNION STREET** **TRENTON, NJ 08611**

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K 291	Continued From page 3 On 04/13/2022, the surveyor with the facility's Director of Facility Maintenance (DFM) conducted a tour of the facility and observed two locations that failed to provide battery backup emergency lighting as followed: 1. At 12:21 PM, an inspection inside the main electrical room where the emergency generator's three transfer switches were located was performed. The surveyor observed no evidence of a battery backup emergency light in the room for the generator's three transfer switches. At this time, the surveyor asked the DFM if there was a battery backup emergency light for the transfer switches, and the DFM responded, no. 2. At 12:25 PM, an inspection inside the emergency generator was performed. The surveyor observed no evidence of a battery backup emergency light in the room. At this time, the surveyor asked the DFM if there was a battery backup emergency light in the generator room, and the DFM responded, no. These findings were verified and confirmed by the DFM during the observations. On 4/13/22 at 1:31 PM, the surveyor informed the Licensed Nursing Home Administrator of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	ongoing compliance. 4.The Director of Maintenance will provide the Administrator a monthly report regarding the operation fo the emergency battery backup for a minimum of 6 months. If concerns continue the audit will continue for a minimum of three months or until compliance is achieved. The Director of Maintenance will provide results of the monthly testing to the team at the Quarterly Quality Meeting.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		5/16/22

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K 321	Continued From page 4 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 review of facility documentation, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 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 practiced was identified in 1 of 1	K 321	1. An automatic door closure to the Medical Records office was installed to bring the facility into compliance. 2.All residents have the ability to be affected if doors that provide a fire barrier do not operate as outlined by NFPA regulation. 3.The Director of Maintenance assessed	

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K 321	Continued From page 5 Medical Records room and was evidenced by the following: During the survey entrance on 4/12/22 at 8:40 AM, the surveyor requested the facility's Director of Facility Maintenance (DFM) to provide a copy of the facility's lay-out which identified the various rooms and smoke compartments in the facility. On 4/12/22 at 12:29 PM, during a tour of the facility, the surveyor with the DFM inspected the third floor Medical Records room. The surveyor observed that the 3/4-hour fire rated corridor door leading into the Medical Records room was in the open position and had no means to self-close the door into its frame. The surveyor observed inside the room, 29 four-drawer filing cabinets filled with combustible medical records. There were approximately 60 combustible records stored on top of the filing cabinets and desks. The surveyor in the presence of the DFM, measured and recorded the size of the room, which was 15 feet deep by 25 feet wide. The total room measurement was 375 square feet which was larger than 50 square feet. The door failed to self-close into its frame as required by code. A review of an evacuation diagram posted in the area identified that the Medical Records room was in the primary exit access path to reach an exit. This condition would allow fire, smoke and poisonous gases to pass from the Medical Records room into the exit access corridor in the event of a fire. The findings were verified and confirmed by the	K 321	all doors in the facility to assure proper function of current door closures and that no further closures were required based on regulation. The Director of Maintenance will perform monthly audits of facility door closures to assure proper function and that all doors needing closures are in place. 4. The Director of Maintenance will provide the Administrator monthly reports on the audit performed above for a minimum of 6 months. If concerns continue, the audits will continue for a minimum of 6 months or until compliance is achieved. The Director of Maintenance will provide results of the audit to the team at the Quarterly Quality meeting.	

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K 321	Continued From page 6 DFM during the observations. On 4/13/22 at 1:31 PM, the surveyor informed the Licensed Nursing Home Administrator of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 355 SS=E	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 observation, interview, and review of facility documentation, it was determined that the facility failed to a.) perform and document on the tag attached to the fire extinguisher a monthly visual examination for 4 of 26 fire extinguishers, as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers: - 7.3 Maintenance. - 7.3.1.1 All Fire Extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification.	K 355	1. The Director of Maintenance reviewed all extinguishers in house to assure all tags were up to date for current month inspection to assure compliance in cited area. 2.All Residents have the ability to be affected if the facility fire extinguishers are not inspected and maintained according to NFPA regulations. 3.The Maintenance Director and or Designee will perform monthly inspections on all fire extinguishers and date inspections on tags accordingly. The Maintenance Director and or Designee will keep a separate tracking audit tool confirming the inspection. This	5/16/22

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K 355	Continued From page 7 According to NFPA 10- 4-3.4, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. During the building tour on 4/12/22 and 4/13/22, in the presence of the facility Director of Facility Maintenance (DFM), the surveyor observed 26 fire extinguishers in various locations that were last annually inspected April 2021 with no evidence of a monthly visual inspection being documented on the tags attached to four (4) fire extinguishers in the following location: 1. On 4/13/22 at 12:14 PM, in the facility kitchen one (1) class "K-Type" wet chemical fire extinguisher was last annually inspected April 2021, had no evidence of a monthly visual examination documented on the tag for November 2021. 2. On 4/13/22 at 12:19 PM, in the main electrical room one (1) ABC type fire extinguisher was last annually inspected April 2021, had no evidence of a monthly visual examination documented on the tag for May, June, and July 2021. 3. On 4/13/22 at 12:23 PM, in the elevator mechanical room one (1) ABC type fire extinguisher was last annually inspected April 2021, had no evidence of a monthly visual examination documented on the tag for May, June, July, August, and September 2021. 4. On 4/13/22 at 12:31 PM, in the elevator pit room one ABC type fire extinguisher was last	K 355	tool will be completed simultaneously with extinguisher inspections. This tool will list all in house extinguishers to assure 100% compliance. The Director of Maintenance will provide the audit tool monthly to the Administrator for his review. 4.This audit will be performed for a minimum of six months. If concerns continue, the audit will continue until a minimum of three consecutive months of compliance is achieved. The Director of Maintenance will provide the results of the audit to the team in the Quarterly Quality Meeting.	

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K 355	Continued From page 8 annually inspected April 2021, had no evidence of a monthly visual examination documented on the tag for May 2021. The findings were verified and confirmed by the DFM during the observations. On 4/13/22 at 1:31 PM, the surveyor informed the Licensed Nursing Home Administrator of the findings at the Life Safety Code exit conference. NFPA 10 NJAC 8:39 -31.1(c), 31.2(e).	K 355		
K 541 SS=E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further	K 541		5/16/22

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K 541	Continued From page 9 use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure 2 of 5 laundry chute access doors closed and positive latched into their frames to maintain the 1-hour fire protection rating of laundry chute doors. This deficient practice was evidenced by the following findings: During the building tour on 4/12/22 and 4/13/22 in the presence of the facility's Director of Facility Maintenance (DFM), the surveyor observed the following: 1. On 4/12/22 at 10:23 AM, an inspection in the 4th floor laundry chute room was conducted. The surveyor observed that the 1-hour fire rated wash-down chute door was ajar from its frame and the door's handle and latching mechanism were missing. During a closure test of the door, the door did not close and positive latch as required to maintain the 1-fire rating. This test was repeated two additional times with the same results. 2. On 4/13/22 at 11:10 AM, an inspection inside the 2nd floor laundry chute room was conducted. During a closure test of the laundry chute door, the chute door self-closed but did not positive latch into its frame. This test was repeated two additional times with the same results. The building's laundry chute door and wash-down chute door was not protected against the passage of smoke, fire and poisonous gases to	K 541	1. The Director of Maintenance Replaced the fourth floor laundry chute latching mechanism to assure a positive latch and achieve compliance. The Director of Maintenance replaced the entire chute door and latching mechanism in the second floor laundry room to assure positive latch and achieve compliance. 2. All Residents have the ability to be affected if laundry chute doors and latches do not operate in the manner outlined in the NFPA regulations. 3.The Director of Maintenance or Designee shall perform monthly audits of all laundry chute doors and latches to assure proper latching and closure to maintain ongoing compliance with National Fire Protection Association regulation. The Director of Maintenance or Designee will provide monthly audit reports of the laundry chute doors and latches for review of status and ongoing compliance to the Nursing Home Administrator. 4.The Director of Maintenance or Designee shall perform monthly audits of all laundry chute doors and latches to assure proper latching and closure to maintain ongoing compliance with	

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K 541	Continued From page 10 pass from one floor to another floor in the event of a fire. The findings were verified and confirmed by the DFM during the observations. On 4/13/22 at 1:31 PM, the surveyor informed the Licensed Nursing Home Administrator of the findings at the Life Safety Code exit conference. NFPA 101:2012 - 19.5.4 and 9.5 NJAC 8:39-31.2(e)	K 541	National Fire Protection Association regulation. The Director of Maintenance or Designee will provide monthly audit reports of the laundry chute doors and latches to the Administrator for a minimum of six months. If concerns continue, this audit will continue for an additional 3 months or until compliance is achieved. The Director of Maintenance will provide this information from the audit to the Q.A. team a scheduled quarterly meeting.	

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
315324 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/20/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE HEALTHCARE & REHAB	512 UNION STREET TRENTON, NJ 08611

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 K0281	05/16/2022	LSC K0291	05/16/2022	LSC K0321	05/16/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0355	05/16/2022	LSC K0541	05/16/2022	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	
4/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO