STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING **02** B. WING _____	**03/31/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	**3000 HILLTOP ROAD** **WHITING, NJ 08759**

(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 An Emergency Preparedness Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on March 31, 2021 following New Jersey Department of Health, Health Facility Survey and Field Operations survey on March 19, 2021. At this Comparative Federal Monitoring Survey, Complete Care at Whiting was found to be in compliance. The requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness, is MET.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on March 31, 2021 following New Jersey Department of Health, Health Facility Survey and Field Operations survey on March 19, 2021. At this Comparative Federal Monitoring Survey, Complete Care at Whiting 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. Complete Care at Whiting is a one story building that was built in the 1990's. It is composed of Type II (000) construction and is fully sprinklered. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. There is a diesel generator that supply's backup power for the entire facility.	K 000		

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

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K 000	Continued From page 1 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 survey process was modified during this COVID-19 PHE as allowed by QSO Memo 20-31-All. The process revisions excluded approximately 50% of the rooms and portions of the barriers. The facility has 200 certified beds. At the time of the survey the census was 100. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 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,	K 222		

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K 222	Continued From page 2 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 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. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS 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. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

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K 222	Continued From page 3 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS 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. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide exit access that was readily accessible at all times by having special locking arrangements (coded key exit door and push button lockset) with staff being the only people with code access to exits regardless of resident independent cognitive ability which is not in accordance with LSC Section 19.2.2.2.4, 19.2.2.2.5, 19.2.2.2.5.2 and 7.2.1.6. The deficient practice could affect 20 of 100 residents, as well as an indeterminable number of staff and visitors. Findings include: Observation on March 31, 2021 at approximately 11:55 AM revealed exterior exit door #4 sign was composed of red lettering on a clear background, posted on clear glass door, indicating how to operate the delayed egress locking mechanism. The door was not equipped with delayed egress locking mechanism, only a push button door lockset and electronic key pad that could only be accessed by staff with the combination and knowledge to open the door. The facility failed to provide exit access that was readily accessible at all times by having special locking arrangements	K 222		

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K 222	Continued From page 4 in accordance with LSC Section 19.2.2.2.4, 19.2.2.2.5, 19.2.2.2.5.2 and 7.2.1.6. The finding was verified by the Regional Administrator, Administrator A and Maintenance Director at the times of the observation.	K 222		
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 and interview, the facility failed to provide automatic emergency illumination that would operate automatically along the means of egress and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.8, 7.8.1.1, 7.8.1.2, 7.8.1.4. The deficient practice could affect 30 of 100 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on March 31, 2021 at approximately 12:02 PM during the facility tour revealed courtyard #2 had a gate with a keypad and keyed-lockset there was no emergency lighting at the lock or beyond the gate.	K 281		

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K 281	Continued From page 5 Observation on March 31, 2021 at approximately 12:56 PM during the facility tour revealed exterior exit door #18 had only a single bulb emergency lighting fixture. The findings were verified by the Regional Administrator and Administrator A at the times of the observation.	K 281		
K 291 SS=F	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, the facility failed to provide battery backup emergency light above the generator transfer switch and provide the required illumination automatically in the event of any interruption of normal lighting in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.9.1, 7.9, 7.9.2.1, NFPA 99, 2012 Edition, Section 6.4.2.2.3.2 and NFPA 70, 2011 Edition, Section 517.32 (D). The deficient practice could affect 100 of 100 residents, as well as an indeterminable number of staff and visitors. Findings Include: On March 31, 2021 at approximately 1:13 PM during the facility tour of the electrical room and generator transfer switch revealed all lighting in the room could be powered off. The switch in the room supplied normal and emergency lighting and had no lighting in the room when the switch	K 291		

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K 291	Continued From page 6 was in the off position. There was no battery backup emergency light above the generator transfer switch. Interview on March 31, 2021 at 1:15 PM with the Regional Administrator revealed the facility was not aware of the requirements for battery powered emergency light at essential transfer switch locations for a minimum of 1 1/2 hours in the event of failure of normal lighting. The findings were verified by the Regional Administrator, Administrator A and Maintenance Director at the times of the observation.	K 291		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly identify doors, with a sign on a door, which is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall have a "No Exit" sign in accordance with NFPA 101, 2012 LSC Edition, Section 7.10 and 7.10.8.3. The deficient practice could affect 30 of 100 residents, as well as an indeterminable number of staff and visitors.	K 293		

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K 293	Continued From page 7 Findings Include: On March 31, 2021 at approximately 11:10 AM observation revealed the exterior door from room [redacted] was not an exit and displayed the incorrect sign "NOT AN EXIT". On March 31, 2021 at approximately 12:05 PM observation revealed the exterior doors into the enclosed courtyard was not an exit and did not have a "No Exit" sign. The findings were verified by the Regional Administrator, Administrator A and Maintenance Director at the times of the observation.	K 293		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 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	K 321		

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K 321	Continued From page 8 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, the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous areas in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 8.3, 8.5.6.2 and 8.7. This deficient practice of not ensuring that room doors will close, and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. The deficient practice could affect 60 of 100 residents, as well as an indeterminable number of staff and visitors. Findings Include: On March 31, 2021 at approximately 11:21 AM observation revealed the door to the Mechanical in the east wing had an approximate gap of one-half inch where the door had warped and no longer fit into the doorframe and was not self-closing. On March 31, 2021 at approximately 11:22 AM observation revealed the door to the soiled utility room in the [redacted] door lock hardware was	K 321		

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K 321	Continued From page 9 removed and was not self-closing and latching. On March 31, 2021 at approximately 11:23 AM observation revealed the door to the [redacted] bathing room in the east wing contained equipment and boxes, the door lock hardware was removed and was not self-closing and latching. On March 31, 2021 at approximately 11:39 AM observation revealed the door to the soiled utility room in the [redacted] wing, the door was not self-closing and latching. The findings were verified by the Regional Administrator, Administrator A and Maintenance Director at the times of the observation.	K 321		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 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	K 341		

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K 341	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide notification by audible and visible signals 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 could affect 80 of 100 residents, as well as an indeterminable number of staff and visitors. Findings Include: On March 31, 2021 at approximately 12:05 PM observation revealed was no horn/strobe tied to the fire alarm in the two enclosed courtyards. The findings were verified by the Regional Administrator, Administrator A and Maintenance Director at the time of the observation.	K 341		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		

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K 353	Continued From page 11 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system, by ensuring the ceiling level was smoke resisting in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. The deficient practice of failing to provide a complete smoke resisting ceiling at the level of the installed sprinklers would not ensure prompt and proper operation of the sprinklers. The deficient practice could affect 20 of 100 residents, as well as an indeterminable number of staff and visitors. Findings Include: On March 31, 2021 at approximately 11:20 AM observation revealed a three feet by three feet section of ceiling in the Mechanical room was removed to facilitate repair work on the sprinkler riser, there was a sprinkler located two inches from the opening allowing hot gasses and smoke past the sprinkler into the space above. The finding was verified by the Regional Administrator, Administrator A and Maintenance Director at the time of the observation.	K 353		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		

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K 374	Continued From page 12 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, the facility failed to provide doors in smoke barrier walls that did not have gaps between the doors to resist the passage of smoke, flame, or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. The deficient practice could affect 80 of 100 residents, as well as an indeterminable number of staff and visitors. Findings Include: On March 31, 2021 at approximately 11:32 AM observation revealed that the [redacted] smoke barrier door there was approximately one-quarter inch gap between the meeting edges of the door and the astragal preventing it from being smoke resistive. On March 31, 2021 at approximately 11:42 AM observation revealed that the [redacted] wing smoke barrier door there was approximately	K 374		

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K 374	Continued From page 13 one-quarter inch gap between the meeting edges of the door and the astragal preventing it from being smoke resistive. On March 31, 2021 at approximately 11:58 AM observation revealed that the [redacted] smoke barrier door there was approximately one-quarter inch gap between the meeting edges of the door and the astragal preventing it from being smoke resistive. On March 31, 2021 at approximately 12:54 PM observation revealed that the PUI smoke barrier door there was approximately one-half inch gap between the meeting edges of the door and the astragal was damaged preventing it from being smoke resistive. The findings were verified by the Regional Administrator, Administrator A and Maintenance Director at the times of the observation.	K 374		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not maintain the required clearance around electrical panels, electrical equipment and	K 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING **02** B. WING _____	**03/31/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	**3000 HILLTOP ROAD** **WHITING, NJ 08759**

(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 911	Continued From page 14 controls in accordance with NFPA 101, 2012 LSC Edition, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26. This deficient practice of not ensuring thirty-six inches in front to the electrical panels will prevent hospital staff and emergency personnel from disconnecting the electrical power quickly. In addition, cardboard storage boxes stored in front of electrical equipment may provide an ignition source and pose a fire risk. The deficient practice could affect 20 of 100 residents, as well as an indeterminable number of staff and visitors. Findings Include: On March 31, 2021 at approximately 1:17 PM observation revealed in the Mechanical room cardboard boxes stored within twelve inches of the front of electrical disconnect #1 and #2 and extending out approximately five feet in front of the panels. The finding was verified by the Maintenance Director at the times of the observation	K 911		
K 927 SS=E	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with	K 927		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING **02** B. WING _____	**03/31/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	**3000 HILLTOP ROAD** **WHITING, NJ 08759**

(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 927	Continued From page 15 conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not store and trans fill liquid oxygen in accordance with NFPA 99, 2012 Edition, Section 11.3.3.2 and 11.3.2.7 by ensuring that the room is properly designed and protected. The deficient practice could affect 20 of 100 residents, as well as an indeterminable number of staff and visitors. Findings Include: On March 31, 2021 at approximately 12:36 PM observation revealed the liquid oxygen storage and trans filling room had source of ignition (light switch) within the room. The finding was verified by the Regional Administrator and Administrator A at the times of the observation.	K 927		