STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. BUILDING **01** B. WING _____	C **02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD** **WESTFIELD, NJ 07090**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The nursing home building construction was stated to be 70's with an addition wing constructed in 2006 ([redacted] Wing). The facility is a 1- story building Type II (000) unprotected construction and is fully sprinklered and has 14 smoke-zones. The facility is divided into 4-wings: [redacted] (2006) [redacted] (70's) [redacted] (70's) [redacted] (70's) The generator does approximately 80% of the building and the facility currently has [redacted] beds and 13- [redacted] beds and can provide dialysis for that unit located in [redacted] Hall. The [redacted] Hall wing has piped in medical gas for the above beds The building has a partial basement that includes: Laundry room, staff lounge, maintenance shop, housekeeping storage, housekeeping office, electrical room, boiler room, paint room, wheel chair room, and fire panel room. The basement has 3-exits that lead up to the public way. The basement measures approximately 80' x 60'. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/01/2023

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.

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K 000	Continued From page 1 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 227 certified beds. At the time of the survey the census was 194. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 111 SS=E	Building Rehabilitation CFR(s): NFPA 101 Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply	K 111		3/28/23

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	315122	A. BUILDING **01** B. WING _____	C **02/13/2023**

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COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD** **WESTFIELD, NJ 07090**

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K 111	Continued From page 2 with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/06/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure seperation from an edition was provided with a 90 minute fire rated door in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.1.4.3, 19.1.1.4.4, 19.1.3.10, 19.3.2, 19.3.2.1, 19.3.2.1.2 8.4, 8.5, 4.6.10, 4.6.10.1. The deficient practice was observed for 1 of 1 doors by the following: At 01:45 PM, the surveyor and MD observed that the added on Jefferson Hall wing addition seperation from old to newer wing must have communicating openings occur only in corridors and must be protected by an approved self-closing fire door with at least a 1-1/2 hour fire resistance rating. The current seperation has a 45 minute fire rated door. The findings were verified by the Maintenance Director, at the time of the observation and he confirmed the current seperation has a fire rated	K 111	Facility noted out of compliance; Jefferson Hall wing addition separation that seperates from old to newer wing must have communicating openings occur only in corridors and must be protected by an approved self-closing fire door with at least a "1-1/2" hour fire resistance rating. The current seperation has a 45 minute fire rated door. Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: - No residents were found to be affected by this deficient practice. - New self-closing fire door with a fire resistance rating of "1-1/2" hour rating, was installed in place of current door. 2) All residents have the potential to be affected by the deficient practice.	

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K 111	Continued From page 3 door labeled 45 minutes. The Administrator and Corporate staff were informed of the finding at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e)	K 111	3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: a) New self-closing fire door with a fire resistance rating of "1-1/2" hour rating, was installed in place of current door. b) All new construction and or renovations will be monitored to ensure compliance with K 111. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a. Administrator and Maintenance Director will confirm that door replacement completed and meets NFPA requirements and facility is in compliance with K 111. b. Maintenance Director or designee will audit weekly x 4 weeks then monthly x 3 months to ensure the door is in compliance with K111. b. Maintenance Director Will report compliance to Quarterly QAPI committee x 2 quarters. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance with K 111 as of 3/28/2023.	
K 222 SS=E	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	K 222		2/19/23

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K 222	Continued From page 4 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 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	K 222		

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K 222	Continued From page 5 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 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 on 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 This deficient practice was identified for 1 of 4 sets of doors and was evidenced by the following: At 11:45 AM, the Surveyor, MD observed two sets of glass sliding exit/egress doors located at the Jefferson Hall entrance. the exterior set of sliding glass doors indicated with a red strip sign approximately 2" x 20" that "IN EMERGENCY PUSH TO OPEN". The door's were observed to not have the ability to push to open in the event of an emergency due to the	K 222	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents found to be affected by the deficient practice. Thumb Turn latch was shaven down. There is no ability to lock into door frame. 2) All residents have the potential to be affected by the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Thumb Turn latch was shaven down. There is no ability to lock into door frame. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place:	

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K 222	Continued From page 6 door having a thumb turn latch that locked into the door frame. If that thumb latch was in the locked position the door could not be pushed open as stated "IN EMERGENCY PUSH TO OPEN" The current evacuation plan indicated that the front doors were designated an exit/egress route. The MD and MDSF both confirmed the findings during the observations. The Administrator and Corporate staff were informed of the findings at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	a. Administrator, Maintenance Director or designee will audit weekly X 4 weeks then monthly x 3 months to ensure that door latch has no ability to lock into door frame and is in compliance with K 222. b. Maintenance Director will report compliance to QAPI committee. 5) Date of Compliance: Administrator will ensure compliance and Facility is in compliance with K 222 as of 2/19/2023.	
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 on 02/06/23, in the presence of facility Maintenance Director (MD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice	K 281	Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: Electrical work was completed to ensure	3/9/23

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K 281	Continued From page 7 affected 4 of 12 occupied access areas observed and was evidenced by the following: 1). At 09:11 AM, the surveyor in the presence of the MD, observed outside the conference room in the exit/egress corridor, wall switches (2) when turned off the corridor was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention in that area. 2). At 10:38 AM, the surveyor in the presence of the MD and MD from a sister facility, observved that the basement exit/egress corridor wall switches (2) when turned off the room was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention in that area. 3). At 11:32 AM, the surveyor in the presence of the MD and MD from a sister facility, observved the [redacted] Hall corridor exit/egress corridor outside resident room 104 leading to the courtyard that wall switches (2) when shutoff did not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention in that area. 4). At 11:40 AM, the surveyor in the presence of the MD and MD from a sister facility, observved in the [redacted] Hall dayroom that wall switches (2) shutoff all the illumination along the means of egress in that room. The room was was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. the room was occupied and observed to have 14	K 281	all deficient areas have illumination of the means of egress via continuous operation without manual intervention. 2) All residents have the potential to be affected by the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Electrical work was completed to ensure all deficient areas have illumination of the means of egress via continuous operation and without manual intervention. - Any new construction will be monitored for compliance with K 281. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a. Administrator and Maintenance Director will confirm that all electrical work in deficient areas has been completed. b. Administrator, Maintenance Director or designee will audit weekly x 4 weeks then monthly x 3 months to ensure that the means of egress in corridors/Day room is illuminated without manual intervention in the 4 areas identified. c. Results of Audits to be reported to QAPI committee. 5) Date of Compliance: Administrator will ensure compliance and Facility is in compliance with K281 as of 3/09/2023.	

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K 281	Continued From page 8 ceiling light fixtures. The Maintenance Director confirmed the finding at the time of observation. The Administrator and Corporate staff were informed of these findings at the Life Safety Code survey exit conference on 02/07/23. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281		
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 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)	K 321		3/24/23

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K 321	Continued From page 9 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 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled 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 9 of 25 hazardous storage room doors and was evidenced by the following: 1). Basement fire door no label indicating fire rating. 2). Laundry room door has a label that cannot be identified and the door will not latch. 3). Personal laundry/PPE storage room door will not latch into frame. 4). Activities room filled with combustible storage bins, the door has an auto closer installed, but the door gets stuck on the floor and will not close into its frame. 5). Environmental services room has an auto closing device installed but the arm is not attached. 6). Wheel chair storage room needs an auto closing device installed. 7). Fire alarm panel and fire sprinkler room door	K 321	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by this deficient practice. 2) All residents have the potential to be affected by the deficient practice 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: a) Basement door brought into compliance and new door installed with fire rated door; b) Laundry room door scheduled to be replaced with fire rated door; c) Personal Laundry/PPE storage room, hardware replaced/Fixed and door latches correctly; d) Activities room, Door and hardware fixed and door does not get stuck on floor; e)Environmental services room, Arm reattached and door closes automatically; f) Wheelchair storage room, Auto closing device installed; g) Fire alarm panel room, Hardware replaced/Fixed and door latches correctly; h) Maintenance door, door replaced to a fire rated door;	

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K 321	Continued From page 10 will not latch into its frame due to broken hardware. 8). Maintenance room door not fire rated. 9). Therapeutic recreation room auto closing device on door, but the door sticks to the floor. The Maintenance Director confirmed the finding's during the observations. The Administrator and Corporate staff were informed of the finding's at the Life Safety exit conference on 02/02/23. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321	i) Therapeutic recreation room, door and hardware fixed and door does not get stuck on floor. Maintenance Director and or designee will monitor all new construction and or renovations in facility for facility compliance with K 321. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a. Administrator and Maintenance Director will confirm that all work in deficient areas has been completed. b. Maintenance Director or designee will audit weekly x 4 weeks Then monthly x 3 months to ensure compliance in 9 areas noted to be deficient for K 321. b. Will report compliance to Quarterly QAPI committee X 2 Quarters. 5) Date of Compliance: Administrator will ensure compliance and Facility is in compliance with K321 as of 3/24/2023.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		3/13/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. BUILDING **01** B. WING _____	C **02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD** **WESTFIELD, NJ 07090**

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K 345	Continued From page 11 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review on 02/07/23, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents in the facility and was evidenced by the findings below: 1). On 02/06/23 and 02/07/23 the surveyor observed that the fire alarm panel was in trouble mode. On 02/06/23 the main fire panel was observed and the annunciator screen indicated: yellow indicator light: activated 0001 common trouble ACT Duct detector: Hamiliton wing by central supply An interview was conducted with the Maintenance Director during the fire panel observations where he stated the fire alarm vendor was notified and the part was ordered to repair the system. No further documentation was provided from the fire alarm vendor. The MD stated the facility was changing fire alarm vendors, but provided no documentation indicating so. On 02/07/23 at 11:27 AM, the surveyor had the Maintenance Director activate the fire alarm system, after putting it on test mode and calling the proper authorities. The MD tested the system to make sure the system activated in all wings of	K 345	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by this deficient practice a) Part was replaced for the duct detector and system was reprogrammed and fire panel is in working order. Annunciator panel screen showing system Normal. b) Battery replaced on Control Unit 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: a) Facility has corrected the issue noted and panel and system in in regular working mode. b) Facility has corrected the issue with duct detector and batteries were replaced on the panel as per the recommendation of the report of alarm vendor. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance. - Maintenance director will audit annunciator panel and fire panel weekly x	

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K 345	Continued From page 12 the building and fire doors closed as intended. The fire alarm system activated in : [redacted] Hall [redacted] Hall [redacted] Hall [redacted] Hall All smoke barrier doors closed properly 2). At 10:45 AM, the MD provided documentation from the fire alarm vendor dated: 09/29/22 the report indicated: Control Unit Batteries: Charger test and Discharge test both "failed" The Maintenance Director was unaware the report indicated this and would reach out to the vendor for clarification. No updated information was provided at the Life Safety Code exit conference. The Administrator and Corporate staff were informed of the findings at the Life Safety Code Exit Conference on 02/07/23. NFPA 70 NFPA 72 NJAC 8:39-31.2(e) NFPA 101- 2012 edition 9.6.1.3- 9.6.1.5	K 345	4 weeks then monthly X 3 months to ensure compliance with K345. - Findings will be reported to the QAPI committee. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 3/13/2023.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.	K 347		2/28/23

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K 347	Continued From page 13 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), it was determined that the facility failed to ensure that there was a testing, maintenance, and battery replacement program to ensure proper operation of the battery operated smoke detectors as per NFPA 72. This deficient practice was evidenced for 100 of 108 observed battery operated smoke detectors and evidenced by the following: A tour of the facility from 09:30 AM, to approximately 02:00 PM, revealed that the facility resident rooms were provided with battery operated smoke detectors, except for the Jefferson Hall wing. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance and testing documentation, for the testing of the detectors for battery replacement (including the make, model, installation date, type of battery and replacement date. The Maintenance Director provided a "smoke detector check list" indicating room numbers only, with a sheet for notes that was left blank. In an interview during the observation's, the facility's Maintenance Director, stated that there was no documentation other than a "smoke detector check list " indicating room numbers only and a blank notes form. The administrator and Corporate Staff were	K 347	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: Testing was completed of the detectors for battery replacement (including the make, model, installation date [when known], type of battery and replacement date [if applicable]. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Facility will add to routine maintenance audits, monthly and not less than quarterly; to include testing and preventative maintenance of smoke detectors (including make, model, installation date [when known] type of battery and replacement date (when applicable). 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance. - Maintenance Director or designee will complete Audits monthly and not less than quarterly to ensure facility compliance with K 347. - Audit check off will be added to TELS	

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K 347	Continued From page 14 informed of the findings at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347	maintenance monitoring system for reporting of the completion of audits. - Maintenance Director will report audit findings to the QAPI committee X 3 months. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 2/28/2023.	
K 351 SS=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 accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. 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. 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. 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) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 02/06/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to a.) provide complete sprinkler coverage as required by Centers for	K 351	Facility noted out of compliance; observed the exterior overhang approximately 15' x 6' leading into the [redacted] Hall wing was observed to have no fire sprinkler coverage. The overhang	3/21/23

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K 351	Continued From page 15 Medicare/Medicaid Services regulation § 483.90(a) physical environment and b.) to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in this area. This deficient practice was identified for 1 of 1 exterior combustible overhangs leading to the [redacted] Hall wing and was evidenced by the following: On 02/06/23 at 12:50 PM, the surveyor and MD observed the exterior overhang approximately 15' x 6' leading into the [redacted] Hall wing was observed to have no fire sprinkler coverage. The overhang was finished in a combustible white vinyl type board material. The MD confirmed the finding during the exterior overhang observation, and he stated the area was not provided with any fire sprinkler protection. The Administrator and Corporate staff were informed of the finding at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e)	K 351	was finished in a combustible white vinyl type board material. Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: Sprinkler system was installed in overhang outside Jefferson Hall wing. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Sprinkler system was installed in overhang outside Jefferson Hall wing. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance with K 351 and that installation was completed for sprinkler system on overhang outside [redacted] Hall. - Maintenance Director or designee will audit New sprinkler heads outside [redacted] Hall wing weekly X 4 weeks then monthly X 3 months to ensure sustained compliance with K 351. - Maintenance Director will report findings of audits to QAP Committee. - All new construction will be monitored	

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K 351	Continued From page 16	K 351	for compliance with K 351. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 3/21/2023.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview and document review on 02/06/23, in the presence of the Mainntenance Director (MD) and Maintenance Director from a sister facility (MDSF), the facility failed to provide documentation that the facility Essential Electrical System (EES) for critical care residents on [redacted] was a Type I system divided into Critical branch, life safety branch, and equipment branch as required. The deficient practice affected one of twelve smoke compartments with the capability of affecting [redacted] residents. At the time of the survey the facility had 12 residents on [redacted]. This deficient practice was evidenced by the following: It was observed on 05/31/07 at 4:00 p.m., that the facility had one main generator located outside,	K 901	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents found to be affected by the deficient practice. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents using a [redacted] are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Time Limited Waiver request has been submitted on 3/16/2023. During the upgrades; a) the facility will be inspected daily to	3/19/23

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K 901	Continued From page 17 with one control/transfer switch panel inside the facility in the main electrical room. The facility's documentation for testing of the emergency power supply (EPS) did not indicate what type of system the facility had. Observation of the electrical panels did not show a critical power circuit, life safety circuit, and emergency systems circuit. Interview with the facility Maintenance Director on 02/06/23, revealed that the facility did not know what was on the generator load bank completely. No documentation could be provided that indicated what type of Emergency Power System (EPS) was in place and what type of Essential Electrical System (EES) was wired in the building and by what circuits. The facility could not provide documentation of a Type I Essential Electrical System (EES) with critical branch/ life safety branch, and emergency system branch for a facility with life support equipment [redacted] residents) as required in a Type I (EES) system. Actual NFPA requirement: Type I essential electrical systems are comprised of two separate systems capable of supplying a limited amount of lighting and power service, which is considered essential for life safety and effective facility operation during the time the normal electrical service is interrupted for any reason. These two systems are the emergency system and the equipment system. The emergency system shall be limited to circuits essential to life safety and critical patient care. These are designated the life safety branch and the critical branch. The equipment system shall supply major electrical equipment necessary for patient care and basic Type I operation. Both systems shall be arranged for connection,	K 901	ensure all exits are free from obstruction and the job site is free from any hazardous and unsafe material. All systems will be checked monthly. b) All staff working in the affected area will receive additional in-service training on fire safety, prevention, and response. c) Fire drills will be performed monthly in the affected area. Facility will be upgrading its electrical systems for compliance with a [redacted] unit and with K 901. Work required for facility compliance with K 901 will be evaluated with the initial engineering plans and will be completed as per requirements of K 901. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: During the upgrades; Maintenance Director or designee will conduct daily audits to ensure all exits are free from obstruction and the job site is free from any hazardous and unsafe material. Maintenance Director or designee will conduct monthly audits to ensure systems are working correctly. Maintenance Director or designee will audit monthly x 3 months to ensure all staff working in the affected area have received training. Maintenance Director or designee will audit fire drills monthly x 3 months. Maintenance director will report results of audits to QAPI committee. Maintenance Director will audit quarterly to ensure work is being completed at pace set out in Limited Time Waiver.	

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K 901	Continued From page 18 within time limits specified in this chapter, to an alternate source of power following a loss of the normal source. The number of transfer switches to be used shall be based upon reliability, design, and load considerations. Each branch of the emergency system and each equipment system shall have one or more transfer switches. One transfer switch shall be permitted to serve one or more branches or systems in a facility with a maximum demand on the essential electrical system of 150 kVA (120 kW). NFPA 99 section 3.4.2.2.1. The Administrator and Corporate staff were informed of the finding's at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 99, 2010 edition section 6.4 Category 1 spaces. 6.7.5.1.1	K 901	Maintenance director will report audit findings QAPI committee and to the administrator. 5) Date of Compliance: Administrator will ensure compliance and facility has submitted a limited time waiver to New Jersey Department of Health on 3/16/2023 for an extension for work to be completed by 5/15/2024. Facility is in compliance with requirements as of 3/19/2023.	
K 911 SS=F	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 on 02/06/23, in the presence of the Maintenance Director (MD), the facility did not ensure guarding of live parts of electrical equipment and controls with	K 911	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: All Electrical Panels identified as not	2/24/23

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K 911	Continued From page 19 unlocked panels in resident accessible areas in accordance with NFPA 101, 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas for 11 of 11 open electrical panels observed. While touring the building from 09:30 AM, to 02:30 PM, the surveyor and Maintenance Director (MD), observed open electrical wall panels throughout the facility, that were not locked. The open panels were located in the following exit/egress corridor's of the facility: [redacted] Hall [redacted] Hall [redacted] Hall [redacted] Hall The observations were confirmed by the MD during the tour of the facility. The Administrator and Corporate staff were informed of the above observations at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	locked were locked and those needing a new lock, a new lock was installed. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: All Electrical Panels identified as not locked were locked. Locks added to Those that were missing lock hardware. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance with K 911 and that locks are on each electrical panel . - Maintenance Director will audit biweekly the electrical panels to ensure they are locked. - All new construction will be monitored for compliance with K 911. - Compliance will be reported the QAPI committee X 3 months. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 2/24/2023.	
K 915 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories	K 915		3/19/23

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K 915	Continued From page 20 *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), it was determined that, the facility failed to provide a Type 1 Essential Electrical System in accordance with NFPA 99. This deficient practice was evidenced by the following: At approximately 11:00 AM, the surveyor observed all documents provided by the facility for record review. The provided electrical annual inspection (visual electrical survey) dated: 12/09/22 did not provide any information on "Essential Electrical System Design Standards". The facility currently has a Ventilator (vent) unit that requires a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. The surveyor observed only one generator transfer switch in the basement and could not	K 915	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by the deficient practice. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents using a ventilator are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Time Limited Waiver request has been submitted on 3/16/2023. During the upgrades; a) the facility will be inspected daily to ensure all exits are free from obstruction and the job site is free from any	

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K 915	Continued From page 21 identify any electrical panels indicating: Life Safety, Critical and Equipment branches. At 01:25 PM, the surveyor observed the electrical panels in the [redacted] Hall wing where the Vent unit was located. The panels were not identified as required for a Type 1 Essential Electrical System in accordance with NFPA 99. At approximately 12:15 PM, the surveyor interviewed the Maintenance Director where he indicated that he was not sure if the current electrical system for the vent unit was a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. At approximately 01:15 PM, while touring the facility, the surveyor, Maintenance Director could not locate the required three branch panels that are divided as follows: 1) Life Safety 2) Critical 3) Equipment (Each branch is required to have at least 1-transfer switch) The Administrator and Corporate staff were informed of the finding at the Life Safety Code exit conference on 02/07/23. *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. NJAC 8:39-31.2(e)	K 915	hazardous and unsafe material. All systems will be checked monthly. b) All staff working in the affected area will receive additional in-service training on fire safety, prevention, and response. c) Fire drills will be performed monthly in the affected area. Facility will be upgrading its electrical systems for compliance with a [redacted] unit and with K 915. Work required for facility compliance with K 915 will be evaluated with the initial engineering plans and will be completed as per requirements of K 915. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: During the upgrades; Maintenance Director or designee will conduct daily audits to ensure all exits are free from obstruction and the job site is free from any hazardous and unsafe material. Maintenance Director or designee will conduct monthly audits to ensure systems are working correctly. Maintenance Director or designee will audit monthly x 3 months to ensure all staff working in the affected area have received training. Maintenance Director or designee will audit fire drills monthly x 3 months. Maintenance director will report results of audits to QAPI committee. Maintenance Director will audit quarterly to ensure work is being completed at pace set out in Limited Time Waiver. Maintenance director will report audit	

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	315122	A. BUILDING **01** B. WING _____	C **02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD** **WESTFIELD, NJ 07090**

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K 915	Continued From page 22 NFPA 99- 6.7.5.1.1 6.7.5.1.3* Critical Branch 6.7.5.1.4 Equipment Branch 6.7.5.1.2 Life Safety Branch	K 915	findings QAPI committee and to the administrator. 5) Date of Compliance: Administrator will ensure compliance and facility has submitted a limited time waiver to New Jersey Department of Health on 3/16/2023 for an extension for work to be completed by 5/15/2024. Facility is in compliance with requirements as of 3/19/2023.	
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	K 918		3/8/23

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K 918	Continued From page 23 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 02/06/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure a remote manual stop station for one of one generators and installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 1:05 PM, the surveyor and MD observed the exterior generator. There was no remote manual stop station observed remotely outside the area of the generator location. An interview was conducted during the time of the observation with the MD, who confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation, located remotely outside the area of the enclosure housing the prime mover. The Administrator was informed of the findings at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and	K 918	Facility noted out of compliance; It was determined that the facility failed to ensure a remote manual stop station for one of one generators. Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by the deficient practice. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Manual Stop station was installed to prevent inadvertent or unintentional operation, located remotely outside the area of the enclosure housing the prime mover. 4) How the facility will monitor its	

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K 918	Continued From page 24 5.6.5.6.1.	K 918	corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: - Maintenance Director will ensure that facility is in compliance with K 918 and that manual station is installed - Maintenance Director or Designee will audit weekly X 4 weeks then monthly x 3 months to ensure that facility is in compliance with K 918. - Maintenance Director will report results of the audits to the QAPI committee. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 3/08/2023.	
K 921 SS=E	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily	K 921		2/24/23

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K 921	Continued From page 25 available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and documentation review on 02/06/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that PCREE (patient care-related electrical equipment) were maintained in accordance with NFPA 99-testing and maintenance requirements PCREE as per NFPA 99-99:10.5.3 The deficient practice was evidenced for three of three PCREE area observations and was evidenced by the following: 1). At 11:46 AM, the surveyor observed in resident room [redacted] that a resident [redacted] was on and the [redacted] was against the nightstand and privacy curtain blocking the intake and exhaust of the unit, not allowing the [redacted] to have clear access. 2). At 01:08 PM, the surveyor observed in resident room [redacted] at bed [redacted], that a resident [redacted] was on and the filter was against the rear wall, blocking the intake and exhaust of the unit, not allowing the [redacted]r to have clear access.	K 921	Facility noted out of compliance; In resident room [redacted] Room [redacted] Bed #1; Room [redacted] that a [redacted] was on and in use and the [redacted] was against something blocking the intake and exhaust of the unit, not allowing the concentrator to have clear access Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: On 2/06/23; In Room [redacted] was moved away from nightstand and privacy curtain allowing for clear access. On 2/06/2023; In Room [redacted] Bed [redacted] was moved away from rear wall allowing for clear access. On 02/06/2023; In room [redacted] was moved away from the nightstand and privacy curtain allowing for clear access. 2) How the facility will identify other	

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K 921	Continued From page 26 3). At 01:31 PM, the surveyor observed in resident room 325, that a resident [redacted] was against the nightstand and privacy curtain, blocking the intake and exhaust of the unit, not allowing the [redacted] to have clear access. An interview was conducted during the observations with the Maintenance Director where he stated that the [redacted] were put into use by the nurses and he would inform them of the observation's of being to close, blocking the intake and exhaust of the unit, not allowing the [redacted] to have clear access. The Administrator and Corporate staff were informed of the finding's at the Life Safety Code exit conference on 02/07/23. NJAC 8:39-31.2(e) NFPA 99-99:10.5.3 NFPA 99- 5.1.3.3.3.3 ventilation for motor-driven equipment	K 921	residents having the potential to be affected by the same deficient practice: All residents using a [redacted] are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: - Education will be provided to Licensed nurses, Certified Nurse aides on proper usage of [redacted]. - Audits will be completed to ensure compliance. 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a) Maintenance director or designee will Audit [redacted] weekly x 4 weeks; then monthly X 2 months of 5 residents who use a [redacted] to ensure that intake and exhaust of unit are not obstructed. b) Maintenance Director will present audit findings to the facility QAPI Committee X 3 months. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 2/24/2023.	
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	K 923		2/24/23

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K 923	Continued From page 27 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or 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 observation and interview on 02/06/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a sister facility (MDSF), the facility failed to provide storage of cylinders, so empty cylinders are segregated from full cylinders, or appropriately labeled full and empty in accordance with NPFA 99, 2012 Edition	K 923	Facility noted out of compliance; facility failed to provide storage of cylinders, so empty cylinders are segregated from full cylinders, or appropriately labeled full and empty in accordance with NPFA 99, 2012 Edition	

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K 923	Continued From page 28 Sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. The deficient practice was evidenced for 1 of 1 O2 storage rooms observed by the following: At 01:02 PM, The Surveyor, Maintenance Director and Maintenance Director from a sister facility, observed that the Washington Hall oxygen storage room contained 15 portable oxygen cylinders on one cart. The facility uses a red zip tie system to determine empty cylinders and currently the oxygen storage cart contained both empty and full cylinders and the empty cylinders could not be determined as the zip ties were not being used at the time of the observation's. An interview was conducted with the Maintenance Director at the time of the observations, where he stated and confirmed that the oxygen cylinders revealed full and empty cylinders and were not segregated and not marked to identify which were full or empty. The Administrator and Corporate Staff were informed of the observations at the life safety code exit conference on 02/07/23. NJAC 8:39-31.2(e)	K 923	Plan of Correction has been implemented to address Root cause of the deficient process. 1) How the corrective actions will be accomplished for those residents found to be affected by the practice: No residents were found to be affected by the deficient practice. Facility immediately acquired and installed additional Oxygen cylinder holding racks and clearly labeled 1 rack Empty and 1 rack Full for the Oxygen holding areas in facility. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk of the deficient practice. 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: - New racks installed to ensure Full cylinders are segregated from empty cylinders as the primary method of compliance - Education was provided to managers and maintenance team to ensure managers and maintenance team are aware of facility policy relating to Oxygen storage and the new racks 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a) Maintenance director or designee will conduct Audits of Oxygen room to ensure compliance; Weekly X 4 weeks; then monthly X 3 months.	

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K 923	Continued From page 29	K 923	b) Findings will be presented to the facility QAPI committee X 4 months. 5) Date of Compliance: Administrator will ensure compliance and facility is in compliance as of 2/24/2023.	

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
315122 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

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 K0111	03/28/2023	LSC K0222	02/19/2023	LSC K0281	03/09/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	03/24/2023	LSC K0345	03/13/2023	LSC K0347	02/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	03/21/2023	LSC K0901	03/19/2023	LSC K0911	02/24/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0915	03/19/2023	LSC K0918	03/08/2023	LSC K0921	02/24/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	02/24/2023	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	
2/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO