STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. BUILDING **01** B. WING _____	**05/06/2021**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 5/6/2021 Standard Recertification Survey. Westfield Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Westfield Center is a single story Type II unprotected constructed building that was built in the 1970's. The facility is divided into 10 smoke zones.	K 000		
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 review of facility	K 293	I.	5/10/21

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

Electronically Signed | 05/25/2021

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K 293	Continued From page 1 documentation, it was determined that the facility failed to ensure that six (6) illuminated exit signs were posted, to clearly identify the exit access path. This deficient practice was evidenced by the following: During a facility tour on 5/5/2021 and 5/6/2021, in the presence of the Maintenance Director (MD), the surveyor observed the following: On 5/5/2021 at 9:40 AM, there was no illuminated exit sign above the corridor double smoke doors next to the Physical Therapy area. At 10:00 AM, there was no illuminated exit sign above the corridor double smoke doors near visitation room [redacted]. A review of an emergency evacuation diagram posted in the area, identified that was the primary and/or secondary exit access route to reach an exit discharge door. At 11:06 AM, there was no illuminated exit signs (one on each side) of the [redacted] Unit corridor doors. On 5/6/2021 at 9:20 AM, there was no illuminated exit sign above the corridor double smoke doors next to Resident room [redacted]. At 9:38 AM, there was no illuminated exit sign above the corridor double smoke doors next to Resident room [redacted] When the fire alarms are activated, the smoke doors automatically close and exit access route with illuminated exit signs would need to be identified.	K 293	- Illuminated exit sign above the corridor double smoke doors next to the Physical Therapy area was replaced immediately. - illuminated exit sign above the corridor double smoke doors near visitation room [redacted] was replaced immediately. - Illuminated exit signs (one on each side) of the [redacted] Unit corridor doors was replaced immediately. - Illuminated exit sign above the corridor double smoke doors next to Resident room [redacted] was replaced. - Illuminated exit sign above the corridor double smoke doors next to Resident room #[redacted] was replaced. All access to exits were checked for functional illuminated exit signs. Unilluminated exit signs, if any, were replaced. Immediately, Maintenance Director in-serviced maintenance staff on making sure that all exit signs are checked, functional and replaced if needed. Maintenance Director started in-servicing facility staff on identifying/reporting/recording of all maintenance issues into the electronic work order system (TELS). II. All residents have the potential to be affected by the same deficient practice. III. Maintenance Director/Maintenance Staff/Environmental Services Director will complete daily rounds of the units to identify/report/record findings related to maintenance issues, including unilluminated exit signs as part of the facility preventative maintenance program. All staff will be in-serviced on	

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K 293	Continued From page 2 NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 NJAC 8:39 -31.1 (c)	K 293	identifying/reporting/recording of all maintenance issues into TELS. IV. Maintenance Director/Administrator will conduct random audits of the exit signs through daily rounds. Audits will be conducted weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	
K 321 SS=D	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	K 321		6/18/21

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K 321	Continued From page 3 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/5/2021, it was determined that the facility failed to a.)ensure that doors to hazardous areas were self-closing and positive latch into their frames and b.) ensure a fire door maintained its fire rated assembly. This deficient practiced was evidenced by the following: At 9:14 AM, during a tour of the building basement in the presence of the facility Maintenance Director (MD), the surveyor identified that the corridor door leading into the main electrical room did not self-close when opened to a 90 degree opening with a positive latch into its frame as required to maintain the rooms one hour fire rated construction. This test was repeated two additional times with the same results. During the above observation, the surveyor also noted that there were two pieces of plywood, each measuring 19 inches by 13 inches, that were screwed onto the inside of the door. Further inspection identified that the door had two openings through the door which had been filled in with wood and painted over. The two penetrations to the door that had been filled in had compromised the doors fire rating. At that time, the surveyor asked the MD how long had	K 321	I. - Corridor door leading into the main electrical room was quoted and ordered through [redacted] door company immediately. Door was delivered on 6/14/21 and installed on 6/15/21; invoice with $1028.00 amount provided upon delivery/installment: invoice# - INV.-2011b. - Medical records room door was repaired immediately. - All facility doors were checked for proper closure, no additional findings identified. II. All residents have the potential to be affected by the same deficient practice. III. - Maintenance staff will complete daily maintenance rounds of the facility as a part of the preventative maintenance program. - All staff will be re-inserviced on identifying/reporting/recording maintenance issues into TELS electronic work order system. IV. - Maintenance Director/Environmental Services Director will conduct random audits of the facility doors for proper	

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K 321	Continued From page 4 that door been like that. The MD stated, "it was like that when I started." At 10:40 AM, an inspection of the facility's medical records storage room was performed. A closure test of the 3/4 hour fire rated corridor door was conducted. When the door was opened to a 90 degree opening and allowed to self-close, the door did not close with positive latch into its frame as required to maintain the room's one hour fire rated construction. This test was repeated two additional times with the same results. The room was larger than 50 square feet. This would allow fire, smoke and poisonous gases to pass from the main electrical room and medical records storage room into the exit corridors in the event of a fire. NJAC 8:39-31.2 (e).	K 321	closure as a part of the preventative maintenance program. - Audits will be conducted weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. - Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	
K 351 SS=D	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,	K 351		5/31/21

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K 351	Continued From page 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 and interview on 5/5/2021, it was determined that the facility failed to provide automatic fire sprinkler protection to all areas in accordance with NFPA 13. This deficient practice was evidenced by the following: During the building tour in the presence of the facility Maintenance Director (MD) at 11:34 AM, an inspection inside the [redacted] Unit Resident shower room was conducted. The surveyor observed that there was no fire sprinkler coverage within the 6 feet, 3 inch long by 3 feet, 5 inch wide corridor leading into the shower area of the room. The one fire sprinkler inside the shower room would not reach around the corner into the corridor. At that time, the surveyor pointed to the only fire sprinkler in the shower room and asked the MD if that sprinkler would go around the corner into the corridor. The MD stated, "no it would not." NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	I. - Work order for the identified sprinkler head was placed with [redacted] Fire & Safety company immediately. [redacted] Fire and Safety technician was scheduled to move the sprinkler head inside the [redacted] Unit Resident shower room on 5/28/21; job was completed, invoice # 137062. - All sprinkler heads were checked for deficient practice; rest of the sprinkler heads were in compliance with the life safety code. II. All residents of the Memory Unit have the potential to be affected by the same deficient practice. III. Maintenance staff/Maintenance Director will continue to monitor the sprinkler heads through daily rounds as a part of the facility preventative maintenance program. IV. Maintenance Director/Environmental Services Director will conduct random audits of all facility sprinkler heads for deficient practice as a part of preventative maintenance program. Audits will be conducted weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. Results of the audits will be presented to the monthly QAPI meeting for review and revision as deemed appropriate.	