STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315022	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES	**300 MEADOW LAKES** **EAST WINDSOR, NJ 08520**

(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 Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/11/23. The facility was found to be in compliance with 42 CFR 483.73. .	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 01/11/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The facility is one story first occupied in 1965. The facility has concrete flooring, multiple roofing materials including fiberglass and wood sheathing and block bearing walls. The facility is noted to be a type III (211) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has two generators. One 2250 KW (kilowatt) diesel generator generates power for the entire campus and back up 60 KW for the health center. The facility has three smoke compartments in the certified area. The facility has a census of 44. .	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101	K 222		2/3/23

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

Electronically Signed | 02/03/2023

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 222	Continued From page 1 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, 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	K 222		

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K 222	Continued From page 2 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 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 with facility staff, the facility failed to ensure that exit doors were not equipped with a latch or lock that requires the use of a tool or key or special knowledge from the egress side for one exit door in accordance with NFPA 101 Life Safety Code (2012 edition) section 7.2.1.6.1. This deficient practice had the potential to affect 10 residents. Findings include: An observation of the main dining room exit door, located between the C and B units, on 01/11/23 at 10:35 AM revealed the exit door, equipped with a wander guard, opened with a delay of 15 seconds. The door lacked a sign indicating	K 222	Observation noted the main dining room exit door was equipped with a Wanderguard system The door lacked a sign indicating, PUSH UNTIL ALARM SOUNDS. DOOR WILL OPEN IN 15 SECONDS. 1.How Corrective Action will be accomplished. Signage was purchased and immediately installed on the Healthcare Center Dining Room exit door to meet compliance. 2.All residents have the potential to be affected. 3.What measures will be put in place to	

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K 222	Continued From page 3 "PUSH UNTIL ALARM SOUNDS. DOOR WILL OPEN IN 15 SECONDS." An interview with the Maintenance Director at the time of the observation verified the door did not have a sign as indicated above. Additionally, the facility had no testing documentation. NJAC 8:39-31.1(c), 31.2(e) .	K 222	ensure the the deficient practice will not recur. Extra signs were purchased to have on hand in case of any new doors are assigned or replaced. 4.How will the facility monitor its corrective action. Security Director/Designee will document preventive maintenance weekly x4, then monthly x3 then quarterly x2 through QAPI.	
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 This REQUIREMENT is not met as evidenced by: .	K 341	Observations identified two smoke	2/14/23

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K 341	Continued From page 4 Based on observations and interviews, the facility failed to ensure that smoke detectors were greater than 36 inches from air supply diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 29.8.3.4.(6). This deficient practice had the potential to affect all 44 residents. Findings include: An observation of a corridor smoke detector near bedroom [redacted] on 01/11/23 at 9:45 AM revealed the smoke detector was eight inches from a supply air diffuser. An observation of the smoke detector in the corridor near the MDS (minimum data set) office on the [redacted]-unit on 01/11/23 at 10:35 AM revealed the smoke detector was 24 inches from a supply air diffuser. An interview with the Maintenance Director at the time of each observation verified the measurements of the smoke detectors to the supply air diffusers. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 341	detectors that were located within 36 inches of air supply diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code. 1.How Corrective Action will be accomplished. The detector near bedroom [redacted] and in the corridor near the MDS office on B-unit will be relocated in accordance with the code by an outside vendor, who is our company maintaining the fire alarm system, on February 14. Security will be responsible to make sure the work is complete. 2. All residents have the potential to be affected. 3. What measures will be put in place to ensure practice does not happen again. Any relocation of smoke detectors will be reviewed by the Director of Security. 4. How will the facility monitor its corrective action. Director of Security will provide written document of completion and report all results through QAPI. Director of Security will conduct weekly walks x4, monthly x3, and quarterly x2 to make sure all smoke heads meet the requirements.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		2/14/23

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K 345	Continued From page 5 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to complete a smoke detection sensitivity test for all 98 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 14.4.5.3.2. This deficient practice had the potential to affect all 44 residents. A review of fire safety records from the "Fire Alarm" folder revealed the most recent two fire alarm inspections on 03/30/22 and 08/22/22 did not include a smoke detection sensitivity test. An interview with the Maintenance Director on 01/11/23 at 1:00 PM revealed he did not have the test from the past two years and did not have a smoke detection sensitivity test for all 98 photo electric smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	Fire alarm inspections follow code except for a smoke alarm sensitivity test. 1. How the Corrective Action will be accomplished. Our contracted company maintaining the fire alarm system, will conduct the tests on February 13 and 14, 2023 and provide written documentation per NJDOH guidelines. Security will be responsible to make sure the work is complete. 2. All residents have the potential to be affected. 3.What measures will be put in place to make sure it will not recur. An outside vendor will conduct regular testing and document in accordance with the regulation. Any findings will be immediately corrected. 4. How will facility monitor. Security Director/Designee will keep written documentation of all testing according to regulations. Results will be	

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K 345	Continued From page 6	K 345	reported to QAPI x3 months.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to ensure the fire plan referenced moving residents beyond the smoke compartment affected by fire to an unaffected smoke compartment and preparing the unit for evacuation in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.7.2.2. This deficient practice had the potential to affect all 44 residents. Findings include: A review of the fire plan located in the "Disaster Manual" revealed the fire plan lacked reference to moving residents beyond the smoke compartment affected by fire to an unaffected	K 711	The findings indicated the fire plan in the Disaster Manual lacked a written reference to moving residents beyond the smoke compartment affected to an unaffected smoke compartment. 1. How Corrective Action will be accomplished. The Disaster manual was immediately updated by Security with the instructions indicating unaffected areas for resident evacuation. 2. All residents have the potential to be affected. 3. What measures will be put in place.	2/3/23

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K 711	Continued From page 7 smoke compartment and preparing the unit for evacuation. An interview with the Maintenance Director on 01/11/23 at 1:45 PM verified the plan did not address the above areas. NJAC 8:39-31.2(e) .	K 711	Staff will be in-serviced February 2023 to educate them on possible scenarios. A contracted licensed fire dill company who provides monthly in-service training to staff regarding fire drills and emergency response. 4. How the facility will monitor. Security Director/Designee will monitor and conduct a monthly review of disaster manual to include this information. The Administrator will review and sign off on the manual annually. All results will be reported through QAPI x3 months.	
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	K 918		2/10/23

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K 918	Continued From page 8 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on observation, document reviews and interview, the facility failed to ensure that two of two generators were maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 edition) sections 7.3.1 and 7.3.2. and 8.4.1 This deficient practice had the potential to affect all 44 residents. Findings include: An observation of the boiler room housing the two generator transfer switches on 01/11/23 at 11:00 AM revealed the area did not have battery operated emergency lighting for the two transfer switches. An interview with the Maintenance Director at the time of the observation verified the lack of battery powered emergency lighting. A review of the facility generator log for the 2250 KW (kilowatt) diesel generator revealed there	K 918	1. How the Corrective Action will be Accomplished. Maintenance Director has ordered battery operated lighting for the areas where generator transfer switches are located and will be installed by 2/1/23. All generator tests and inspections will be conducted per NJDOH guidelines. 2. All residents have the potential to be affected. 3. What changes will be put in place do deficient practice will not recur. Maintenance Director/Designee will perform weekly testing of generators and monthly load tests and document findings. Maintenance Director will conduct weekly testing of emergency lighting where generator switches are located.	

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K 918	Continued From page 9 were no weekly generator checks after June 28, 2022. In addition, there was no record of a monthly load test in October 2022 and December 2022. A review of the facility generator log for the 60 KW generator revealed there were no weekly generator inspections on 10/18/22, 10/25/22, 09/13/22, 09/06/22, 08/31/22, 08/24/22, 08/17/22, 08/03/22, 07/27/22, 07/11/22, 06/01/22, 04/14/22 and 01/28/22. An interview with the Maintenance Director on 01/11/23 at 12:45 PM indicated he would check with the previous Maintenance Director for additional documents related to weekly and monthly generator testing. At 1:45 PM on 01/11/23 he indicated there was no additional information. NJAC 8:39-31.2(e), 31.2(g) .	K 918	The Administrator will be immediately notified of any delay in testing. 4. How will the facility monitor. Maintenance Director will provide written documentation of all testing to Administrator weekly x4 monthly x3 then quarterly x2 through QAPI.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: .	K 926	1.How the Corrective Action will be	2/3/23

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K 926	Continued From page 10 Based on document review and interview, the facility failed to ensure safety training for staff who handle oxygen cylinders was provided in the past 12 months in accordance with NFPA 99 Health Care Facilities Code (2012 edition) section 11.5.2.1. This deficient practice had the potential to affect all 44 residents. Findings include: A review of the facility training information on 01/11/23 at 3:00 PM revealed training had not been provided in the past 12 months related to safety when handling oxygen cylinders for relevant staff, including nurse aides, nurses, and maintenance staff. An interview with the facility Administrator on 01/11/23 at 3:00 PM revealed there were no in-services for safety for staff handling oxygen cylinders. NJAC 8:39-31.2(e) NFPA 99 .	K 926	accomplished. The Respiratory Therapist along with the Director of Security conducted in-service training with the nursing, housekeeping and maintenance department starting on 1/31/23. Training will be conducted at various times and dates to ensure all staff are educated. 2. All residents have the potential to be affected. 3. What measures will be put in place to make sure it does not recur. Training on safe handling of oxygen cylinders will be part of our mandatory in-service training for staff. The staff will receive training upon hire and annually as part of the mandatory requirements and for NJDOH review. 4. How will the facility monitor its progress. The Director of Security will provide written in-service documentation to the Administrator weekly x4, then monthly x3 , then quarterly x2 and report all results through QAPI.	

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
315022 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES	300 MEADOW LAKES EAST WINDSOR, NJ 08520

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 K0222	02/03/2023	LSC K0341	02/14/2023	LSC K0345	02/14/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0711	02/03/2023	LSC K0918	02/10/2023	LSC K0926	02/03/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO