| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315268 | A. BUILDING **01**<br>B. WING ___ | **12/09/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BROOKHAVEN HEALTH CARE CENTER** | **120 PARK END PLACE**<br>**EAST ORANGE, NJ 07018** |

| (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 |
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| E 000 | Initial Comments<br><br>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<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/07/21 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 Occupancy<br><br>The building that was built in 80's, It is composed of Type II protected construction. The facility is divided into 9-smoke zones. The generator does approximately 50% of the building.<br><br>The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.<br><br>The facility has 122 certified beds. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/24/2021 |

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 291<br>SS=D | Emergency Lighting<br>CFR(s): NFPA 101<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.<br>18.2.9.1, 19.2.9.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 12/07/21, it was determined that the facility failed to provide a battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following:<br><br>At 11:40 AM, the Surveyor, Maintenance Director and Regional Plant Operations Director, observed in the floor 1 maintenance/boiler room, where the emergency generator transfer was located, that the room was not equipped with emergency lighting independent of the building's electrical system and emergency generator.<br><br>This finding was verified by the Maintenance Director and Regional Plant Operations Director at the time of observation.<br><br>The Administrator was notified of the above findings, at the Life Safety Code exit conference on 12/07/21.<br><br>NJAC 8:39-31.2(e)<br>NFPA 101:2012 - 19.2.9.1, 7.9 | K 291 | 1. The following corrective actions have been accomplished for the identified deficiency:<br>- There was no negative outcome noted as the main lighting for the emergency transfer switch is functioning.<br>2. All residents in the facility have the potential to be affected by the deficient practice of not having emergency lighting available in a room with an emergency generator transfer switch.<br>3. The following measures have been put into place to prevent the deficient practice from recurring:<br>- Emergency lighting fixture with battery backup installed and tested the following day on December 8 2021.<br>- Weekly audit will be completed by Director of Maintenance or designee to ensure proper functionality of emergency lighting fixture.<br>4. The Director of Maintenance or designee will audit functionality of emergency lighting weekly for 90 days, and the findings will be reported to the QAPI committee on a quarterly basis for 3 months. | 1/10/22 |
| K 363<br>SS=D | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors | K 363 | | 1/10/22 |

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| | 315268 | A. BUILDING **01**<br>B. WING ___ | **12/09/2021** |

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| K 363 | Continued From page 2<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 12/07/21, | K 363 | 1. The following corrective actions have | |

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| K 363 | Continued From page 3<br>the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close, and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place.<br><br>This deficient practice was observed in 4 of 60 resident room doors during the building tour from 10:30 AM, to 02:30 PM, and was evidenced by the following:<br><br>The following resident room door's, did not close properly and latch into its frame:<br><br># 325 a decoration hook on the door prevented the door from closing properly into its frame and latching.<br><br># 326 the door side resident room bed was in a position that blocked the door from closing properly into its frame and latching.<br><br>#201 the door side resident room bed was in a position that blocked the door from closing properly into its frame and latching.<br><br>#200 the door side resident room bed was in a position that blocked the door from closing properly into its frame and latching.<br><br>An interview was conducted with the Maintenance Director and Regional Plant Operations Director who stated and confirmed that 4 of 60 resident room doors, did not close properly and latch into its frame. | K 363 | been accomplished for the identified deficiency:<br>- Decoration hook in room 325 was immediately removed. The beds in rooms 326, 201, 200 were immediately repositioned to allow the door to close completely.<br>2. All residents in the facility have the potential to be affected by the deficient practice of not maintaining.<br>3. The following measures have been put into place to prevent the deficient practice from recurring:<br>- Nursing and housekeeping staff in-serviced on maintaining path of egress in resident rooms.<br>- Weekly audit will be completed by Director of Maintenance or designee to ensure all resident room doors have unobstructed path for egress.<br>4. The Director of Maintenance or designee will audit all resident rooms to ensure there is an unobstructed path of egress weekly for 90 days, and the findings will be reported to the QAPI committee on a quarterly basis for 3 months. | |

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| K 363 | Continued From page 4<br><br>The Administrator was informed of the finding at the Life Safety Code exit conference on 11/07/21.<br><br>NJAC 8:39-31.1(c), 31.2(e) | K 363 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 315268 | A. Building 01 - MAIN BUILDING 01<br>B. Wing | 2/24/2022 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKHAVEN HEALTH CARE CENTER | 120 PARK END PLACE<br>EAST ORANGE, NJ 07018 |

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<br>Reg. # NFPA 101<br>LSC K0291 | Correction Completed 01/10/2022 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0363 | Correction Completed 01/10/2022 | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| 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 | |
|---|---|
| 12/9/2021 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |