STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING **01** B. WING _____	**02/21/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

(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
E 000	Initial Comments This facility is not 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		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of	E 037		4/15/20

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

Electronically Signed | 03/12/2020

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E 037	Continued From page 1 emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		

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E 037	Continued From page 2 staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,	E 037		

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E 037	Continued From page 3 personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and a review of emergency preparedness training documentation on 2/12/20, in the presence of facility management, it was determined that the facility failed to train staff on the Emergency Preparedness Plan (EPP) annually. This deficient practice was identified for all but 3 active staff and was evidenced by the following:	E 037	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. No residents were found to be affected by the deficient practice. Training scheduled for all current employees on 3/17/20 and 3/18/20 and all new hires will be trained during orientation process.	

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E 037	Continued From page 4 A review of the facility's emergency preparedness documentation revealed there were no records of training for the previous 12 months. In an interview at 9:30 AM, the facility's Director of Maintenance stated there was no training when he was hired [redacted], and that he had only provided emergency preparedness training to 3 staff members. NJAC 8:39-31.2(e), 31.6(a)	E 037	HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. All residents had the potential to be affected by the deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. The Director of Maintenance and Educator will educate current facility staff and ensure new hires are educated during orientation on Emergency Preparedness Plan. Director of Maintenance will maintain a list of all staff educated annually on the Emergency Preparedness Plan. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. The Director of Maintenance will submit the percentage of employees educated results to monthly safety committee meeting and results will be submitted to monthly QAPI meeting for review monthly x 3 to ensure compliance and	

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E 037	Continued From page 5	E 037	reassessed for further action.	
K 000	INITIAL COMMENTS	K 000		
	LIFE SAFETY CODE 101:2012 The facility is not in substantial compliance with the minimum Life Safety Code requirements as surveyed under CMS-2786R.			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/11/20 and 2/12/20, in the presence of facility management, it was determined that the facility failed to ensure that the exit discharge gate from the courtyard serving 2 of 11 resident sleeping wings was accessible to access the common way. This deficient practice was evidenced by the following: On 2/11/20 at 11:45 AM, the surveyor and the facility's Director of Maintenance (DM) observed that the exit gate from the [redacted] Unit courtyard to the fire road (common way) was damaged and could not be opened. Further observations revealed the left gate was braced by lumber,	K 211	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. No residents were found to be affected by the deficient practice. The exit gate from [redacted] Unit courtyard was removed and will not be replaced. All exits have been checked to ensure all is in working order. No further deficient practice noted. HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. All residents have the potential to be	4/15/20

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K 211	Continued From page 6 preventing it from opening. Both gate doors were also strapped together in the closed position with heavy-duty plastic zip-ties. In an interview at that time, the newly hired DM stated a wind storm damaged the gate a few weeks earlier and was scheduled to be repaired. The DM further stated he would remove the gate doors to allow for evacuation in the event of an emergency. On 2/12/20, at 9:30 AM, the surveyor observed that the doors of the gates were still strapped together. NJAC 8:39-31.2(e)	K 211	affected by the deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. The exit gate from [redacted] Unit courtyard has been removed and will not be replaced. All exits have been checked to ensure all is in working order. No further deficient practice noted. During weekly rounds maintenance will audit all exit doors to ensure they are working properly and there is clear pathway to safety. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. Results of audits will be submitted to monthly QAPI meeting for review monthly x 3 to ensure compliance and reassessed for further action.	
K 345 SS=E	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	K 345		4/15/20

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K 345	Continued From page 7 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 interview and record review on 2/11/20, in the presence of facility management, it was determined that the facility failed to conduct load voltage tests on the 2 batteries in the fire alarm system in accordance with NFPA 72 throughout the previous 2 Semi-annual system inspections. This deficient practice was evidenced by the following: A review of the facility's fire alarm inspections for the previous 12 months revealed that the facility's licensed vendor's inspections did not include a load voltage test of the 2 sealed lead-acid batteries. These inspections were dated 3/19/19 and 9/9/19. In an interview at 10:15 AM, the facility's newly hired Director of Maintenance stated he would contact the inspector to schedule these tests. NJAC 8:39-31.2(e) NFPA 72	K 345	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. No residents were found to be affected by the deficient practice. The battery load voltage test was completed. No other deficient practice noted. HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. Inspection vendor conducted load voltage test on both batteries. The inspection vendor updated their inspection form to include checking voltage, under load for 2 batteries All residents had the potential to be affected by the deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. Maintenance Director will ensure during	

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K 345	Continued From page 8	K 345	semi-annual inspections both batteries load voltage is tested. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. Findings from semi-annual inspections will be presented in semi-annual QAPI meeting for review to ensure compliance and reassessed for further action.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/11/20, in the presence of facility management, it was determined that the facility failed to maintain 1 of	K 374	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED	4/15/20

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K 374	Continued From page 9 14 smoke barrier doors to automatically close with the activation of the fire alarm system to provide at least 20 minutes of fire protection. This deficient practice was evidenced by the following: At 12:00 PM, the surveyor and the facility's Director of Maintenance (DM) observed that the smoke barrier door near exit #8 outside the main dining room did not close when released from the magnetic hold-open device. When released, one of the double doors rubbed the floor and stopped 2-feet open. The door wedged into the floor and could not be manually closed at the time. In an interview at that time, the DM confirmed the door would not close and contacted maintenance staff to repair the door. NJAC 8:39-31.1(c), 31.2(e)	K 374	BY THE DEFICIENT PRACTICE. No residents were found to be affected by the deficient practice. The smoke barrier door near exit #8 was immediately fixed. All other smoke doors were checked. No further deficient practice noted. HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. The smoke barrier door near exit #8 was immediately fixed. All other smoke doors were checked. No further deficient practice noted. All residents had the potential to be affected by the deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. Maintenance Director will conduct weekly rounds to check that smoke doors to ensure they automatically close and enter results in the electronic maintenance system (TELS) HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS	

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K 374	Continued From page 10	K 374	BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. Maintenance Director will present results of weekly rounds to monthly safety and monthly QAPI meeting for review monthly x 3 to ensure compliance and reassessed for further action.	
K 918 SS=D	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		4/15/20

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K 918	Continued From page 11 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 interview and record review on 2/11/20 in the presence of facility management, it was determined that the facility failed to conduct 12 load tests Annually on a 20 to 40-day interval for 2 of 12 required tests in accordance with NFPA 99. This deficient practice was evidenced by the following: A review of the facility's generator log for the previous 12 months revealed that the facility conducted 12 load tests on the generator. Still, these tests were not conducted on a 20 to the 40-day interval as follows: -10/3/19 to 11/27/19 = 55 days -11/27/19 to 1/2/20 = 15 days In an interview at 10:15 AM, the facility's newly hired Director of Maintenance confirmed these dates and stated he would enter the data into their electronic scheduling system to prevent the error in the future. NJAC 8:39-31.2(e) NFPA 99	K 918	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. No residents were found to be affected by the deficient practice. A generator load test was completed and voltage notated on updated report dated 3/11/20. No other deficient practice was noted. HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. All resident had the potential to be affected by the deficient practice. The Electronic Maintenance System (TELS) has been updated so weekly test will be based on the 20 to the 40-day interval. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR.	

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CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

(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 918	Continued From page 12	K 918	The Director of Maintenance will in-service the maintenance department on the 20-40-day interval for generator load test. Maintenance Director will audit the Electronic Maintenance System monthly to ensure generators are inspected according to the 20-40-day interval. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. Results will be submitted to monthly safety committee meeting and monthly QAPI meeting for review monthly x 3 to ensure compliance and reassessed for further action.	