STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315336	A. BUILDING **01** B. WING ______	**05/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS AT MONROE HEALTHCARE AND REHABILITATION, T	**189 APPLEGARTH ROAD** **MONROE TOWNSHIP, NJ 08831**

(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 5/10/2021 Gardens at Monroe 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. Gardens at Monroe a single story Type II unprotected constructed building that was built in the 1994. The facility is divided into 7 smoke zones.	K 000		
K 222 SS=D	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 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	K 222		6/24/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/25/2021

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 222	Continued From page 1 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 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	K 222		

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K 222	Continued From page 2 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 observations and review of facility documentation, it was determined that the facility failed to provide exit access that was readily accessible by having locking arrangements (coded/ key exit door and push button lockset) in accordance with the LSC Section 19.2.2.2.4, 19.2.2.2.5, 10.2.2.2.5.2 and 7.2.1.6. This deficient practice was identified for 2 of 10 exit discharge doors and was evidenced by the following: On 5/10/2021 beginning at 9:01 AM, the surveyor, in the presence of the Director of Maintenance (DM) conducted a building tour. During the tour, the surveyor tested 10 designated exit (illuminated exit sign above door) discharge doors. These 10 designated exit discharge doors had signs posted on them that indicated: "Emergency Exit Only push until alarm sounds door can be opened in 15 seconds." The following designated exit discharge doors when tested did not open: 1. At 10:56 AM, the designated exit discharge door on the Nassau unit between Resident rooms [redacted] and #[redacted] when the surveyor pushed on the door and counted 30 seconds, the door did not open. The door was not equipped with a delayed egress locking mechanism, only a push button door lockset and electronic key pad that could	K 222	The facility immediately adjusted the door closure to enable the existing delayed egress to open after 15 seconds. This was done 5/10/2021.The facility educated the maintenance department on how to adjust the delayed egress locking mechanism. All 14 exit doors were checked to assure the delayed egress locking mechanism was functioning properly. All residents on the Nassau unit and Princeton unit had the potential to be affected by this deficient practice. Facility maintenance department was inserviced regarding exit doors having delayed egress for 15 second prior to opening and how to adjust the locking mechanism. The facility maintenance logs were updated to include checking the delayed egress locking system on all 14 exit doors. The facility maintenance department will test the delayed egress locking mechanism on all exit doors monthly and log in the maintenance log indefinitely. Administration to sample 3 random doors monthly for 3 months and quarterly thereafter to check the delayed egress locking mechanism is functional. Findings will be reported to the QA committee	

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K 222	Continued From page 3 only be accessed by staff with the combination and knowledge to open the door. 2. At 12:23 PM, the designated exit discharge door on the Princeton unit near Resident room [redacted] when the surveyor pushed on the door and counted 30 seconds, the door did not open. The door was not equipped with a delayed egress locking mechanism, only a push button door lockset and electronic key pad that could only be accessed by staff with the combination and knowledge to open the door. A review of an emergency evacuation diagram posted on the unit identified this exit discharge door as the primary or secondary exit out of the unit. On 5/10/21 at 2:34 PM, the Licensed Nursing Home Administrator was notified of these concerns. N.J.A.C. 8:39 -31.2 (e)	K 222	quarterly	
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	K 351		7/26/21

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K 351	Continued From page 4 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 and interview, 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 identified on 1 of 4 nursing units (Princeton) and was evidenced by the following: On 5/10/21 at 12:31 PM, during the building tour with the Director of Maintenance (DM), the surveyor observed that there was no fire sprinkler protection inside the 4 foot deep by 5 foot 8 inch wide employee bathroom on the [redacted] unit. At this time, the surveyor pointed inside the employee bathroom and asked the DM, "Do you see a fire sprinkler in the bathroom?" The DM examined the ceiling and stated, "No." On 5/10/21 at 2:34 PM, the Licensed Nursing Home Administrator was notified of this concern. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	The facility immediately reached out to the sprinkler company during the state survey. They will install a sprinkler head in the closet which will permanently correct this LSC violation. Maintenance department educated to report any room missing a sprinkler head to sprinkler company to correct and assure compliance. The residents on the Princeton unit have the potential to be affected by this deficient practice. The facility has retained the services of a sprinkler professional to inspect the entire facility for any missing sprinkler heads. The sprinkler company will check the entire facility quarterly for missing sprinkler heads. Reports will be in the maintenance log book.Findings will be reviewed by administration Quarterly any missing sprinkler heads will be fixed and reported quarterly to QA committee	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire	K 355		6/21/21

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K 355	Continued From page 5 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation, it was determined the facility failed to a.) perform and document on the tag attached to the fire extinguisher a monthly visual examination, b.) ensure a fire extinguisher was easily accessible, and c.) maintain a fire extinguisher in working order in accordance with the National Fire Protection Association (NFPA) requirements. This deficient practice was identified for 2 of 20 fire extinguishers and was evidenced by the following: On 5/10/21 at 9:01 AM, during a tour of the building with the facility's Director of Maintenance (DM), the surveyor observed 20 fire extinguishers that were last annually inspected in June of 2020. There was no documented evidence of a monthly visual inspection performed in the following locations: 1. At 10:09 AM, one ABC type fire extinguisher in the kitchen had no evidence of a monthly examination for April 2021 . 2. At 10:12 AM, the surveyor observed one ABC type fire extinguisher in the kitchen was blocked by a desk. Further inspection revealed that the fire extinguisher pressure indicating needle was in the RED discharge zone, which meant that this fire extinguisher would not function properly in the event of a fire. A review of the facility provided "Fire Extinguishers" Monthly Inspection sheet for April 2021 identified the three (3) portable fire	K 355	Facility immediately completed the examination of the extinguisher 5/10/2021. Facility immediately placed the fire extinguisher in a different location to have easy access and Facility immediately replaced the extinguisher without pressure with a new one.5/10/2021. Maintenance department was inserviced regarding assuring all extinguishers are examined and signed for, easily accessible and needle should show pressure. All residents have the potential to be affected by this deficient practice. The Maintenance department will conduct monthly checks of all extinguishers to assure examination, proper location and pressure and log in the maintenance log. Administration will review quarterly to assure compliance. Administrator will choose 3 random extinguishers monthly for 3 months and quarterly thereafter to assure compliance and findings will be presented to the QA committee. Pictures are attached	

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K 355	Continued From page 6 extinguishers in the kitchen had been visually inspected. One of these three fire extinguishers in the kitchen, had no documented evidence on the tag attached to the fire extinguishers, as required. On 5/10/21 at 2:34 PM, the Licensed Nursing Home Administrator was notified of these concerns. NFPA 10. N.J.A.C. 8:39 -31.1 (c).	K 355		
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 observations and interview, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 3 of 9 smoke barrier doors and was evidenced by the	K 374	The facility immediately placed permanent door sweeps on the cited doors to assure compliance. Maintenance department was inserviced regarding all fire doors not having a gap greater than 3/4 of an inch underneath.	6/24/21

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K 374	Continued From page 7 following: 1. On 5/10/21 at 10:10 AM, the surveyor, in the presence of the Assistant Administrator (AA) and the Director of Maintenance (DM), observed that the corridor double smoke barrier doors on the Nassau unit near the Director of Nursing's office when manual testing of the facility's smoke barrier door revealed it was not resistant to the transfer of smoke with an observed gap greater than 3/4 of inch from floor to bottom of the door. At this time, the surveyor used a construction tape measure and recorded 1-1/4 inch gap along the bottom edge. At this time, the AA informed the surveyor that there use to be carpet in the hallway that was recently replaced with vinyl flooring. 2. On 5/10/21 at 10:25 AM, the surveyor, AA and the DM observed that the corridor double smoke barrier doors on the Nassau unit next to Resident room [redacted] when manual testing of the facility's smoke barrier door revealed it was not resistant to the transfer of smoke with an observed gap greater than 3/4 of an inch from floor to bottom of the door. At this time, the surveyor used a construction tape measure and recorded 1-1/8 inch gap along the bottom edge. 3. On 5/10/21 at 10:53 AM, the surveyor, AA and the DM observed that the corridor double smoke barrier doors on the Nassau unit next to Resident room [redacted] when manual testing of the facility's smoke barrier door revealed it was not resident to the transfer of smoke with an observed gap greater than 3/4 of an inch from floor to bottom of the door. At this time, the surveyor used a construction tape measure and recorded 1-1/8 inch gap along the bottom edge.	K 374	Maintenance department was inserviced regarding not having a gap of 3/4" from the floor to the bottom of the door. All 9 doors were checked to assure compliance. All residents in the facility have the potential to affected by this deficiency. Monthly door check log was updated to include checking the doors for proper smoke barrier compliance. Maintenance department was inserviced regarding proper smoke barrier space under the doors, and to check and log these doors in the maintenance log book monthly. Administrator/designee will check logs quarterly and report findings to the QA committee. Administrator will choose 3 random doors and check them monthly for 3 months and then quarterly to assure compliance and report findings to the QA committee. Pictures Attached	

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K 374	Continued From page 8 On 5/10/21 at 2:34 PM, the Licensed Nursing Home Administrator was notified of these concerns. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		