| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315050 | A. BUILDING **01**<br>B. WING ___ | **08/29/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BURLINGTON WOODS** | **115 SUNSET ROAD**<br>**BURLINGTON, NJ 08016** |

| (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<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>LIFE SAFETY CODE 101:2012<br><br>THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R. | K 000 | | |
| K 374 SS=D | Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>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.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 08/28/19, it was determined that the facility failed to maintain the smoke resistant integrity of 1 of 6 smoke | K 374 | Hoyer Lift device was immediately removed from the area of the smoke barrier doors. | 10/9/19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/20/2019

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315050 | A. BUILDING **01**<br>B. WING | **08/29/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BURLINGTON WOODS** | **115 SUNSET ROAD**<br>**BURLINGTON, NJ 08016** |

| (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 |
|---|---|---|---|---|
| K 374 | Continued From page 1<br>barrier door sets tested.<br><br>This deficient practice was evidenced by the following:<br><br>At 11:20 AM, the surveyor observed that 1 of 6 smoke barrier doors tested, failed to completely close when released from their automatic hold open device. The set of smoke barrier doors by resident room [redacted] did not fully close to meet the other door to form a smoke-tight barrier. This was due to a hoyer-lift that was being stored at the right door on the resident room [redacted] side. The right smoke barrier door remained almost fully open so this would now compromised two connecting smoke barriers as both were not protected from the passage of smoke from each other.<br><br>In an interview at that time, the Maintenance Director and the Plant Operations Director stated they were unaware of this issue. They also stated that the doors were tested monthly by maintenance staff and subject to quarterly inspections by the fire code officials.<br><br>The Administrator was informed of this deficiency at the Life safety code exit conference.<br><br>NJAC 8:39-31.2(e) | K 374 | Center acknowledges that all residents have the potential to be affected by this practice.<br><br>Staff were in serviced about the effects of blocking smoke barrier doors.<br><br>The Director of Maintenance or his designee will perform daily rounds to ensure compliance and audit weekly. Weekly audits will be compiled and discussed at the monthly QAPI meeting for 3 months and then quarterly thereafter. | |
| K 521<br>SS=E | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. | K 521 | | 10/9/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315050 | A. BUILDING **01**<br>B. WING ____ | **08/29/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BURLINGTON WOODS** | **115 SUNSET ROAD**<br>**BURLINGTON, NJ 08016** |

| (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 |
|---|---|---|---|---|
| K 521 | Continued From page 2<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 08/28/19, in the presence of the facility Maintenance Director and Plant Operation Director, it was determined that the facility failed to ensure that the ventilation systems were being properly maintained in accordance with the National Fire Protection Association (NFPA) 90A.<br><br>This deficient practice was evidenced by the following:<br><br>Starting at 10:50 A.M., the surveyor observed in resident room bathrooms that 21 of 23 vents did not function in the following areas of the facility: Floor # [redacted] [redacted], Floor # [redacted] : [redacted]. The surveyor had the Maintenance Director confirm if the units were functioning by placing a piece of single ply toilet tissue paper across the grills to confirm ventilation. The resident bathrooms were not provided with a window and would rely on mechanical ventilation.<br><br>An interview was conducted with the Maintenance Director and Plant Operation Director and they acknowledged that the exhaust systems in 21 of 23 resident room bathroom's tested did not function. The Plant Operations Director checked the roof-top motors and confirmed that some of the motors were not functioning when he observed | K 521 | The 21 vents have been replaced/repaired that were not functioning properly. They are Floor # [redacted] : [redacted], Floor # [redacted] : [redacted]<br><br>The center acknowledges that all residents have the potential to be affected by this practice.<br><br>Staff have been in-serviced on how to determine if ventilation fans are working properly. Staff also has been in-serviced on how to report if the ventilation is not working properly.<br><br>The Director of Maintenance or his designee will perform weekly audits to ensure compliance and audit findings will be discussed at the monthly QAPI meeting for 3 months and then quarterly thereafter. | |

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315050 | A. BUILDING 01<br>B. WING ____ | 08/29/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BURLINGTON WOODS** | **115 SUNSET ROAD**<br>**BURLINGTON, NJ 08016** |

| (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 |
|---|---|---|---|---|
| K 521 | Continued From page 3<br>them.<br><br>The Administrator was informed of this deficiency at the Life safety code exit conference.<br><br>NFPA 90A<br>NJAC 8:39-31.2(e) | K 521 | | |