| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315047 | A. BUILDING **01**<br>B. WING _____ | **09/22/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WYNWOOD REHABILITATION AND HEALTHCARE CENTER** | **1700 WYNWOOD DRIVE**<br>**CINNAMINSON, NJ 08077** |

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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>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 222 SS=D | Egress Doors<br>CFR(s): NFPA 101<br><br>Egress Doors<br>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:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>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.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are | K 222 | | 10/20/20 |

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

Electronically Signed | 10/06/2020

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| K 222 | Continued From page 1<br>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.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by: | K 222 | | |

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| K 222 | Continued From page 2<br>Based on observation and interview on 09/21/2020, in the presence of facility management, it was determined that the facility failed to ensure that staff and residents were provided with a means to unlock exit access doors at all times.<br><br>This deficient practice was evidenced by the following:<br><br>During a tour of the facility starting at 9:30 AM, in the presence of the facility's Administrator, the surveyor observed, in the corridor between resident rooms #21 and #22, a heavy gauge plastic curtain hanging from the ceiling. The plastic curtain was secured to the ceiling and opposite walls and prevented access to the corridor. Before the plastic curtain, the surveyor observed a plastic exit sign attached to a surface mounted ceiling light. This plastic exit sign had a right directional arrow, which directed traffic to the right side of the corridor to the Physical Therapy (PT)area. The PT area was equipped with a combination lock door knob that required a code to be entered to allow the user to pass through the door, to get to the exit door. The PT door was not magnetized and does not release to the fire alarm and no access code was available.<br><br>At that time, the surveyor conducted an interview with the Administrator who stated the COVID unit was on the other side of the plastic curtain and that traffic should exit to the right. The Administrator confirmed that the PT door access code was not available and that traffic could not exit the door without it.<br><br>NJAC 8:39-31.2(e) | K 222 | Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.<br><br>Corrective action taken:<br><br>The PT door knob was immediately unlocked and will be kept unlocked throughout working hours. For after hours a key to unlock the door will be kept on the nurses key ring. The supervisor will also have a key to unlock it. Staff was in-serviced on the new plans. Facility wide audit was done to ensure no other exits had similar issues.<br><br>No residents were affected by this practice. No other exits are in an office or have a similar issue.<br><br>Maintenance Director/Designee will do weekly rounds and audits to ensure that doors leading to exits are accessible. These audits will be reviewed together with the Administrator/Designee weekly X3 then monthly X4 and presented to quarterly QAPI to ensure compliance. | |
| K 293 | Exit Signage | K 293 | | 10/20/20 |

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| K 293<br>SS=D | Continued From page 3<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview conducted on 09/21/2020, in the presence of facility management, it was determined that the facility failed to ensure the exit directional signs were illuminated at all times.<br><br>This deficient practice was evidenced by the following:<br><br>At 1:50 PM, the surveyor, in the presence of the Corporate Maintenance Director (CMD), observed that the exit directional sign, in the exit corridor above the smoke barrier doors between resident rooms #49 and #50, was not illuminated.<br><br>In an interview at the time of observation, the CMD confirmed the exit sign was not illuminated.<br><br>NJAC 8:39-31.2(e) | K 293 | Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.<br><br>Corrective Action Taken:<br><br>The exit sign bulb was replaced. Facility wide audit was conducted to ensure no other exit signs were not illuminated.<br><br>No residents were affected by this.<br><br>Maintenance Director/Designee to do daily rounds to ensure all exit signs are illuminated.<br><br>Weekly rounds and audits to be done by the Administrator/Designee and Maintenance Director/Designee weekly | |

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| K 293 | Continued From page 4 | K 293 | X3 thereafter monthly X4 and reviewed quarterly at QAPI meetings to ensure compliance. | |
| K 521 SS=D | 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.<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 09/21/2020, in the presence of facility Management, 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>During a tour of the facility, in the presence of the facility's Corporate Maintenance Director (CMD) and facility Director of Maintenance (DOM), the surveyor performed an inspection of four (4) Resident bathrooms and found that the exhaust system in 1 of 4 resident bathrooms was not functioning properly as follows:<br><br>At 1:48 PM, in resident room #50 bathroom, the surveyor observed a ventilation grill that was approximately 8" x 8" in size. The ventilation was | K 521 | Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.<br><br>The exhaust fan was immediately replaced. Facility wide audit to ensure all other exhaust fans were working.<br><br>No residents were affected by this.<br><br>Maintenance Director/Designee to do daily rounds to ensure exhaust fans are working adequately.<br><br>Weekly rounds and audits to be done by | 10/20/20 |

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| K 521 | Continued From page 5<br>tested by placing a single-ply of tissue across the grill. The tissue did not hold in place, indicating the ventilation was not functioning properly. All bathrooms had no window with an area that would open and relied on mechanical ventilation.<br><br>During the time of the observation, the surveyor interviewed the CMD who confirmed that the bathroom exhaust system did not function properly.<br><br>NFPA 90A<br>NJAC 8:39-31.2 (e) | K 521 | Administrator/Designee and Maintenance Director/Designee X3, thereafter monthly X4 which will be presented to Quarterly QAPI to ensure compliance. | |
| K 914 SS=D | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced | K 914 | | 10/20/20 |

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| K 914 | Continued From page 6<br>by:<br>Based on observation and review of facility provided documentation on 09/21/2020 in the presence of facility management, it was determined that the facility failed to test electrical receptacles in resident rooms every 12 months in accordance with NFPA 99.<br><br>This deficient practice was evidenced by the following:<br><br>During a tour of the facility, starting at 10:00 AM in the presence of the Director of Maintenance (DOM), the surveyor observed that the resident rooms were provided with electrical receptricals that were less than hospital grade, which required testing for grounding, polarity, and blade retention.<br><br>A review of the facility's electrical inspection documentation for the previous 19 months identified that the last licensed electrical inspection was performed on 03/19/2020 with the previous inspection conducted on 12/05/2020, which was more than 15 months between inspections.<br><br>NJAC 8:39-31.2(e)<br>NFPA 99 | K 914 | Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.<br><br>Electrical Inspection was performed on 03/19/2020 upon Maintenance Director becoming aware of its delinquency.<br><br>No residents were affected by this practice.<br><br>Maintenance Director/Designee will do weekly audits of the life safety paperwork to ensure that no inspections are outstanding. These audits will be reviewed together with the Administrator/Designee weekly X3 then monthly X4 and presented to quarterly QAPI to ensure compliance. | |