STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	**794 N FORKLANDING ROAD** **MAPLE SHADE, NJ 08052**

(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 02/16/22 and 02/17/22 and Sterling Manor 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. Sterling Manor is a single (1) story, Type V Protected building that was built in January 1977. The facility is divided into 7 smoke zones.	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation on 02/16/2022, in the presence of facility management, it was determined that the facility failed to ensure that exit discharge doors were provided with	K 281	1. A battery operated emergency light was immediately installed in the exit discharge door of the main dining room to ensure a safe and direct passage from	3/7/22

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

Electronically Signed | 03/14/2022

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 281	Continued From page 1 continuous lighting with two lamps for 1 of 9 exit discharge doors. This deficient practice was evidenced by the following: On 02/16/2022 at 11:47 AM, during tour with the facility's Regional Administrator (RA) and Director of Maintenance (DOM), the surveyor observed outside the designated exit discharge of the main dining room no evidence of lighting outside the door. The findings were verified and confirmed by the RA and DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 02/17/2022. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281	inside the main dining room to the exterior of the building. 2. All residents have the potential to be affected by the deficient of failing to ensure that exit discharge doors are provided with continuous lighting with two lamps for exit discharge doors. 3. The Administrator conducted walking rounds to audit all exit discharge doors to ensure interior and exterior light fixtures were properly illuminated. The Administrator in-serviced the maintenance department regarding the necessity of ensuring that exit discharge door light fixtures illuminate the appropriate lighting as designed. 4. The Administrator will conduct walking rounds daily for 1 quarter to ensure that all light fixtures are continuously illuminated at the exit discharge doors. 5. All findings will be reported at the Quarterly Quality Assurance Meeting.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation on 2/16/2022, in the presence of facility management, it was determined that the facility failed to provide a	K 291	1. A new battery operated backup emergency light was immediately installed above the emergency generator's transfer	3/7/22

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K 291	Continued From page 2 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 identified in 1 of 1 main electrical rooms and was evidenced by the following: On 02/16/2022 at 9:51 AM, during tour with the facility's Director of Maintenance (DOM), an inspection inside the main electrical room, where the emergency generator's transfer switch was located, was performed. The surveyor observed no evidence of a battery back up emergency light. The surveyor asked the DOM if there was a battery back up emergency light for the transfer switch. The DOM showed the surveyor a new battery back up emergency light that was not installed and said, "No I did not get a chance to install the light yet." The findings were verified and confirmed by the DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 02/17/2022. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	switch to provide rapid lighting in the event of a facility power outage. 2. All residents have the potential to be affected by the deficient practice of failing to provide a battery backup emergency light above the emergency generator's transfer switch independent of the building's electrical system and emergency generator. 3. The Administrator conducted walking rounds of the main electrical room and in-serviced the maintenance department regarding the importance of ensuring the the light above the emergency generator's transfer switch is always in working order. 4. The Administrator will monitor for the presence and operation of the battery back up emergency light in the main electrical room above the emergency generator's transfer switch daily for one quarter. All findings will be reported at the Quarterly Quality Assurance meeting.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in	K 341		4/29/22

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K 341	Continued From page 3 accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/16/2022, in the presence of facility management, it was determined that the facility failed to provide notification by audible and visible signals for 2 of 2 outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 02/16/2022 starting at 9:37 AM with the facility's Regional Administrator (RA) and Director of Maintenance (DOM), a tour of the facility was conducted. During the tour, the surveyor observed no evidence of an audio and visual (horn and strobe) alarm connected the the building's fire alarm and detection system to notify residents in the event of a fire alarm sounding in the following locations,	K 341	1. Twenty four hour fire watch monitoring was conducted by hospitality aids and smoking monitors until the fire alarm security company installed horn and strobe alarms on the [redacted] resident smoking patio and [redacted] smoking patio which will connect to the existing fire alarm system. 2. All residents have the potential to be affected by the deficient practice of failing to provide notification by audible and visible signals for enclosed courtyards. 3. The Administrator in-serviced all staff regarding the implementation of 24-hour fire watch until the installation of the horn and strobe alarms on the smoking patios, the necessary communication required during fire watch, and how to address events related to fire watch. The maintenance department will be	

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K 341	Continued From page 4 1. At 10:40 AM, the surveyor observed no evidence of a horn and strobe in the enclosed outside [redacted] resident smoking area. At this time the surveyor asked the DOM, do you have a audio and visual alarm for the fire alarm system out here. The DOM looked around and said, "I don't see one." There were two residents smoking at the time of observations. 2. At 12:07 PM, the surveyor observed no evidence of a horn and strobe in the enclosed outside the [redacted] patio area next to resident room [redacted]. The findings were verified and confirmed by the RA and DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 02/17/2022.	K 341	in-serviced by the Administrator regarding the importance of daily monitoring of audible and visible alarms. 4. The Administrator upon completion of installing the horn and strobe lights will review service invoice provided by installation company to ensure accurate fire alarm system completion. The Administrator will review fire watch rounds daily for completeness until the installation of horn and strobe alarms are installed. The Administrator or designee will monitor daily for one month after the installation of the horn and strobe alarms for audible function and operation. Finding will be reported at the Quarterly Quality Assurance meeting.	
K 353 SS=E	NJAC 8:39-31.2(a) Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		3/11/22

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K 353	Continued From page 5 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: On 2/16/2022 during the survey entrance at 9:15 AM, a request was made to the Administrator and Regional Administrator (RA) if the facility had any waivers.The RA told the surveyor, yes for the sprinkler system repairs. The facility was cited K-353 sprinkler Maintenance and Testing during the 11/02/2020 Recertification Survey. The Facility had a Time Limited Waiver granted by CMS until December 30, 2023. Deficiency from 11/2/2020 Recretification Survey: Based on observation, interview, and record review on 10/29/20 in the presence of the facility Regional Maintenance Director, Administrator and Facility Owner, it was determined that the facility failed to maintain the sprinkler system in operating condition according to NFPA 25/13 regulations. This deficient practice was evidenced by the following: 1. At 10:45 AM, the surveyor reviewed the provided fire sprinkler quarterly documentation from the facility vendor. The documents reviewed were dated: 10/22/20, (07/07/2020 Annual Inspection), and 4/6/2020 in which all the inspection reports from 04/29/2016 to the current report dated 10/22/2020 indicated that: *Copper Pipe throughout attics shows signs of	K 353	1.The facility has a time-limited waiver which has been approved by CMS, expiring on 12/30/2023. 2. All residents have the potential to be affected by the deficient practice of failing to maintain the escutcheon plates in proper position. 3. The Administrator conducted walking rounds throughout the facility to ensure that all escutcheon plates are properly affixed to the ceiling tiles. The maintenance was in-serviced regarding the importance of ensuring proper positioning of escutcheon plates and ceiling tiles. 4. The Administrator will monitor for the appropriate placement of escutcheon plates throughout the facility weekly for one quarter. 5. All findings will be reported at the Quarterly Quality Assurance meeting.	

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K 353	Continued From page 6 corrosion/mechanical patches (found during the Annual Inspection). A document from the facility vendor dated 02/13/2020 indicated that The [redacted] Fire Department (authority having jurisdiction) is requiring that the leaks in the system be fixed permanently (no repair clamps) and a 200 psi for 2-hour hydrostatic test be performed with no leaks. The most current fire sprinkler vendor document dated 10/22/2020 indicated on page 2. under: Pipes and Fittings (visible): NO: 1. in good condition and no external corrosion NO: 2. no leaks or mechanical damage NO: 3. correct alignment- no external loads Building: NO: 4. wet piping not exposed to freezing temperatures During an interview with the facility owner on 10/29/20 at 11:13 AM, he stated that currently there is no documentation indicating that the pipe was fixed permanently and a 200 psi for 2-hour hydrostatic test was performed. 2. While touring the building on 10/29/20 from 9:10 AM to 11:15 AM, the surveyor, Regional Maintenance Director, Administrator, and Facility Owner observed fire sprinkler heads with escutcheon plates that were not in the proper position along with ceiling tiles with bad cuts around the fire sprinkler heads in the following areas of the facility:	K 353		

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K 353	Continued From page 7 Resident Rooms: 27, 37, 38, and 39-2 (interior closets) An interview was conducted with the Regional Maintenance Director during the observations and he agreed and stated that the ceiling tiles and escutcheon plates must be in the proper position and the ceiling tiles must have better cuts around the fire sprinkler heads in the facility. The ceiling tile is an integral part of the sprinkler system. When fire occurs the smoke and heat rises until it meets the ceiling, then the smoke and heat travels horizontally until it encounters a smoke detector or a sprinkler head. If there is a gap greater than 1/8 inch from a missing and/or an escutcheon plate not in proper position and/or a broken ceiling tile, the sprinkler head function is now impaired. The smoke and heat will rise up through the hole where the tile was located and fill up the space above the ceiling before it attempts to activate the sprinkler head and fire alarm detection system. NJAC 8:39-31.2(c) NJAC 8:39-31.2(e) NFPA 13, 25	K 353		
K 355 SS=E	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 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced	K 355		3/11/22

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K 355	Continued From page 8 by: Based on observation on 02/16/2022 and 02/17/2022, in the presence of facility management, it was determined that the facility failed to a.) install portable fire extinguishers within the required height for 7 of 20 fire extinguishers, and b.) perform and document, on the tag attached to the fire extinguisher, a monthly visual examination for 2 of 20 fire extinguishers, as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. During the building tour on 02/16/2022 and 02/17/2022, in the presence of the facility Regional Administrator (RA) and Director of Maintenance (DOM), the surveyor observed 7 of 20 portable fire extinguishers that were installed too high (5'-2" to 5'-9" high) in the following locations: The surveyor recorded measurements from the floor to the extinguishers pressure indicating needle, 1) One ABC type extinguisher, facility identification [redacted], by the residents' scale was installed 5'- 6" to the center of the pressure indicating needle. 2) One ABC type extinguisher, between resident rooms [redacted] and [redacted] was installed 5'- 5" to the center of the pressure indicating needle. 3) One ABC type fire extinguisher, across from resident room #[redacted] was installed 5'-4" to the center of the pressure indicating needle.	K 355	1. ABC type portable fire extinguishers #[redacted] and class "-Wet" chemical extinguisher were removed and rehung to meet the required height. ABC type portable fire extinguisher #11 and ABC type portable fire extinguisher in the dietary storage room were immediately visually examined and reviewed with updated date noted on the tag. 2. All residents have the potential to be affected by the deficient practice of failing to install portable fire extinguishers within the required height and perform and document monthly on the tag attached to the fire extinguishers. 3. The Administrator conducted walking rounds throughout the facility to ensure that all portable fire extinguishers were installed at the appropriate height and dates of monthly review were indicated on the tag. The Administrator in-serviced the maintenance department regarding the importance of ensuring the appropriate height and monthly date review of all fire extinguishers. 4. The Administrator will monitor the height of all portable fire extinguishers and documentation of date review of all portable fire extinguishers monthly for one quarter. 5. All findings will be reported at the Quarterly Quality Assurance meeting.	

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K 355	Continued From page 9 4) One ABC type extinguisher, facility identification [redacted], was installed 5'-5" to the center of the pressure indicating needle. 5) One ABC type extinguisher, facility identification [redacted], was installed 5'-4" to the center of the pressure indicating needle. 6) One ABC type extinguisher, facility identification [redacted], was installed 5'-2" to the center of the pressure indicating needle. 7) One class "K-Wet" chemical extinguisher in the kitchen was installed 5'-9" to the center of the pressure indicating needle. During the tour, the surveyor observed 18 of 20 fire extinguishers were last annually inspected July 2021, with no evidence of a monthly visual inspection being documented on the tags attached to 2 of 20 fire extinguishers in the following locations: 1) At 9:40 AM, one ABC type extinguisher, in the Dietary storage room, had no evidence of a monthly visual examination documented on the tag attached to the extinguisher for November and December of 2021 and January 2022. 2) At 10:18 AM, one ABC type extinguisher, facility identification #11 by the Resident scale, had no evidence of a monthly visual examination documented on the tag for January 2022. The findings were verified and confirmed by the RA and DOM during the observations. The surveyor informed the Administrator of the	K 355		

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K 355	Continued From page 10 finding at the Life Safety Code exit conference on 02/17/2022. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors 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	K 363		3/11/22

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K 363	Continued From page 11 frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/16/22, 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 room doors with gaps larger than 1/8 of an inch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 1 of 61 resident room/office corridor doors and was evidenced by the following: During the building tour, with the facility's Regional Administrator (RA) and Director of Maintenance (DOM), at 11:17 AM, the surveyor observed the corridor door leading into the West Wing residents' lounge had a 1/2 inch gap along the top of the door. This would allow fire, smoke and poisonous gasses to pass into the exit access corridor in the event of a fire. The findings were verified and confirmed by the RA and DOM during the observation. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 02/17/2022.	K 363	1. Installation of door jamb/weather strip was applied to the top of the corridor door leading into the [redacted] residents' lounge. 2. All residents have the potential to be affected by the deficient practice of properly confine fire and smoke products and to properly defend occupants in place. 3. The Administrator completed walking rounds throughout the facility to ensure that all corridor doors did not have any gaps greater than 1/8 of an inch to prevent the passage of smoke. The Administrator in-serviced the maintenance department regarding the importance of ensuring all corridor doors meet the required standards of the National Fire Protection Association. 4. The Administrator will conduct walking rounds weekly for one quarter to ensure that all corridor doors do not exceed the 1/8 of an inch gap. 5. All findings will be reported at the Quarterly Quality Assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	**794 N FORKLANDING ROAD** **MAPLE SHADE, NJ 08052**

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K 363	Continued From page 12 NJAC 8:39-31.1(c), 31.2(e)	K 363		