PRINTED: 08/24/2021 FORM APPROVED OMB NO. 0938-0391

) DATE SURVEY COMPLETED			
		315231	B. WING _			0	6/25/2021
	ROVIDER OR SUPPLIER ON HEALTH CARE CENT	TER	•	535	EET ADDRESS, CITY, STATE, ZIP CODE EGG HARBOR ROAD VELL, NJ 08080	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
K 000	Appendix Z-Emergen Provider and Supplie Guidance 483.73, Re Care (LTC) Facilities. INITIAL COMMENTS	equirements for Long Term	K	000			
	New Jersey Departm Survey and Field Ope 06/17/21 and was for with the requirements Medicare/Medicaid at Safety from Fire and National Fire Protecti	t 42 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING					
K 222 SS=E	building that was buil composed of Type II facility is divided into Egress Doors	protected construction. The	K2	222			7/9/21
	equipped with a latch use of a tool or key frusing one of the followarrangements: CLINICAL NEEDS OLOCKING Where special locking clinical security need only one locking devieach door and provis rapid removal of occurrence.	neans of egress shall not be or a lock that requires the som the egress side unless wing special locking R SECURITY THREAT g arrangements for the sof the patient are used, ce shall be permitted on ions shall be made for the upants by: remote control of			TITLE		(X6) DATE

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.

Electronically Signed

07/14/2021

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 01		ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		315231	B. WING			06	5/25/2021
NAME OF PROVIDER OR SUPPLIER JEFFERSON HEALTH CARE CENTER		•	535	EET ADDRESS, CITY, STATE, ZIP CODE EGG HARBOR ROAD VELL, NJ 08080	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 222	locks; keying of all lo all times; or other sucto the staff at all time 18.2.2.2.5.1, 18.2.2.2 SPECIAL NEEDS LOWhere special lockinsafety needs of the p Clinical or Security Lebeing met. In addition electrical locks that faupon loss of power to protected by a supersystem and the locke complete smoke deteconstantly monitored within the locked spa and detection system doors upon activation 18.2.2.2.5.2, 19.2.2.2 DELAYED-EGRESS ARRANGEMENTS Approved, listed delainstalled in accordance permitted on door as ordinary hazard contentroughout by an applicate detection system automatic sprinkler sinstalled in accordance permitted. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROL ARRANGEMENTS Access-Controlled Equipment of the permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY I ARRANGEMENTS Elevator lobby exit accordance with 7.2.	cks or keys carried by staff at ch reliable means available s. 2.6, 19.2.2.2.5.1, 19.2.2.2.6 DCKING ARRANGEMENTS of arrangements for the atient are used, all of the ocking requirements are in, the locks must be all safely so as to release to the device; the building is vised automatic sprinkler of space is protected by a action system (or is at an attended location ce); and both the sprinkler is are arranged to unlock the sare arranged to unlock the semblies serving low and tents in buildings protected proved, supervised automatic or an approved, supervised automatic or an approved, supervised system. LED EGRESS LOCKING Gress Door assemblies the semblies of with 7.2.1.6.2 shall be seemblies of with 7.2.	K	222			

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 0	1	COMPLETED
		315231	B. WING		06/25/2021
	ROVIDER OR SUPPLIER ON HEALTH CARE CEN	NTER	5	TREET ADDRESS, CITY, STATE, ZIP CODE 35 EGG HARBOR ROAD EWELL, NJ 08080	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
K 222	by an approved, supdetection system an automatic sprinkler services 18.2.2.2.4, 19.2.2.2. This REQUIREMENT by: Based on observation of 16/21 to 06/17/2 facility Maintenance that the facility failed delayed egress feat doors were provided identified this feature. This deficient practical 15-second delayed signage and was evon 1. The surveyor obsection maintenance Director approximately 11:20 resident rooms 15-second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "C5" in the case 15-second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed non-emergency discobserve a readily visindicating "Push Unibe Opened in 15 Second delayed no	dervised automatic fire and an approved, supervised system. 4 IT is not met as evidenced ons and interview from 1, in the presence of the Director, it was determined at to ensure that the 15-second aure on two exit discharge at with signs that correctly e. ce was observed for 2 of 12 egress doors reviewed for idenced by the following: erved, in the presence of the or, on 06/17/21 at a charge. The surveyor did not sible sign with 1-inch letters til Alarm Sounds, Door Can degress feature for a charge. The surveyor did not sible sign with 1-inch letters til Alarm Sounds, Door Can degress feature for a charge. The surveyor did not sible sign with 1-inch letters til Alarm Sounds, Door Can degress feature for a charge. The surveyor did not sible sign with 1-inch letters til Alarm Sounds, Door Can charge. The surveyor did not sible sign with 1-inch letters til Alarm Sounds, Door Can	K 222	This Plan of Correction constitutes Jefferson Health Care Center's (the Center) written allegation of complia for the deficiencies cited. However, submission of this Plan of Correction not an admission that a deficiency e or that one was cited correctly. This of Correction is submitted to meet requirements established by federal state law. It is the practice of the facility to ensi that the 15-second delayed egress f on two exit discharge doors were pre with signs that correctly identified thi feature. This practice was not met if failing to have the proper signage or of the discharge doors. All residents are at risk to be affected this practice. Signs were immediately placed on the discharge doors explaining the 15-se delayed egress feature. The Facility Manger educated his state ensuring that the signs are posted o 12 egress doors at all times. This education had a 100% completion de July 9, 2021. The Facility Manager/designee will a	n is xists Plan and ure eature eovided s by n two d by ne two econd aff on n all ate of
		e verified by the Maintenance observations and testing of		the egress doors to ensure they hav	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 315231 B. WING 06/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD **JEFFERSON HEALTH CARE CENTER SEWELL, NJ 08080** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 222 Continued From page 3 K 222 the doors. proper signage. Audits will be completed once per week for one month and then monthly. The results of these audits will The facility's Administrator was informed of these findings during the Life Safety Code survey exit be presented to the QAPI committee, conference on 06/17/21. which meets monthly for review and revision as deemed necessary. NJAC 8:39-31.2(e) K 291 **Emergency Lighting** K 291 7/9/21 SS=E 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: This Plan of Correction constitutes Based on observation and interview from 06/16/21 to 06/17/21, it was determined that the Jefferson Health Care Center's (the Center) written allegation of compliance facility failed to provide emergency lighting in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. for the deficiencies cited. However. submission of this Plan of Correction is This deficient practice was observed for 2 of 2 not an admission that a deficiency exists mechanical/electrical rooms reviewed for or that one was cited correctly. This Plan emergency lighting and was evidenced by the of Correction is submitted to meet requirements established by federal and following: state law. On 06/17/21 at 12:25 PM, the surveyor observed, in the presence of the facility's Maintenance It is the practice of the facility to ensure Director, the two mechanical/electrical rooms, that emergency lighting of at least 1-1/2that contained the emergency generator's hour duration is provided automatically in transfer switch, were not equipped with accordance with 7.9. 18.2.9.1, 19.2.9.1. emergency lighting independent of the building's This practice was not met by failing to electrical system and emergency generator. have emergency lighting in two These findings were verified by the facility's mechanical/electrical rooms. Maintenance Director during the observation. All residents are at risk to be affected by The facility's Administrator was informed of these this practice. findings during the Life Safety Code survey exit conference on 06/17/21. Emergency lighting was installed in both mechanical/electrical rooms on June 30.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 315231 B. WING 06/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD **JEFFERSON HEALTH CARE CENTER SEWELL, NJ 08080** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 291 Continued From page 4 K 291 NJAC 8:39-31.2(e) 2021. NFPA 101:2012 - 7.9 The Facility Manager and maintenance department were educated on having emergency lighting in mechanical/electrical rooms. This education had a 100% completion date of July 9, 2021. The Facility Manager/designee will conduct monthly audits to ensure that the emergency lighting is properly functioning in the mechanical/electrical rooms. The results of these audits will be presented to the QAPI committee, which meets monthly for review and revision as deemed necessary. K 341 Fire Alarm System - Installation K 341 7/12/21 CFR(s): NFPA 101 SS=E Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in 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:

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		315231	B. WING _			06/25/2021	
	ROVIDER OR SUPPLIER ON HEALTH CARE CEN	ΓER		STREET ADDRESS, CITY, STATE, Z 535 EGG HARBOR ROAD SEWELL, NJ 08080	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
K 341	facility failed to provide visible signals in one with NFPA 101, 2012 9.6, 9.6.3, 9.6.3.2, 9.6 Edition, Section 18.5 This deficient practice enclosed courtyards audible and visible sittle following: During observation of on 06/17/2 AM, in the presence of the surveyor did not caudible and visible sittle Maintenance Direwas not aware of the horn/strobe was to be was to be was to be a the Administrator was a divisible and visible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle Maintenance Direwas not aware of the horn/strobe was to be a the Administrator was a divisible sittle was not aware of the horn/strobe was to be a the Maintenance Direwas not aware of the horn/strobe was not aware of the horn/s	it was determined that the de notification by audible and courtyard, in accordance Edition, Section 19.3.4.3.1, 6.3.6 and NFPA 72, 2010, 18.5.2.4, 24.4.2.20.9. Was observed for 1 of 2 reviewed for notifiction by gnals and was evidenced by If the Wing 1 at approximately 10:35 of the Maintenance Director, observe a notification by gnals. When interviewed, ector revealed that the facility	К3	This Plan of Correction Jefferson Health Care C Center) written allegatic for the deficiencies cited submission of this Plan not an admission that a or that one was cited co of Correction is submitte requirements establishe state law. It is the practice of the fi that a fire alarm system systems and componenthe purpose in accordan National Electric Code, National Fire Alarm Coc effective warning of fire building. This practice of failing to provide notificat and visible signals in or courtyard. All residents are at risk this deficient practice. Horn and strobe lights of the enclosed courtyard The Facility Manager and department was educat audible and visible sign	Center's (the on of compliance d. However, of Correction is deficiency exists orrectly. This Plan ed to meet ed by federal and facility to ensure its installed with his approved for nice with NFPA 70, and NFPA 72, de to provide in any part of the was not met by atton by audible ne of the enclosed to be affected by were installed in on July 12, 2021. Individuals in all fine in		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE NG 0 1	CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315231	B. WING _			06	6/25/2021
	ROVIDER OR SUPPLIER ON HEALTH CARE CEN	TER		53	TREET ADDRESS, CITY, STATE, ZIP CODE B5 EGG HARBOR ROAD EWELL, NJ 08080		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE .	(X5) COMPLETION DATE			
K 341	1 Continued From page 6		K	341	committee, which meets monthly for review and revision as deemed necessary.		
	Sprinkler System - M CFR(s): NFPA 101	aintenance and Testing	K	353			7/9/21
	Automatic sprinkler a inspected, tested, an with NFPA 25, Stand Testing, and Maintair Protection Systems. maintenance, inspec	re location and readily stem last checked					
	any non-required or p system. 9.7.5, 9.7.7, 9.7.8, ar This REQUIREMENT	S information on coverage for partial automatic sprinkler					
	06/16/21 to 06/17/21 Maintenance Directo maintain the sprinkle the ceiling level was accordance with NFF Section 19.3.5.1, Sec NFPA 13, 2010 Editio 25, 2011 Edition, Sec	r system, by ensuring that smoke resistant, in PA 101, 2012 LSC Edition, ction 4.6.12, Section 9.7, on, Section 6.2.7.1 and NFPA			This Plan of Correction constitutes Jefferson Health Care Center □s (the Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exis or that one was cited correctly. This Pl of Correction is submitted to meet requirements established by federal ar state law.	s sts an	
	1	eas reviewed for smoke			It is the practice of the facility to ensure compliance with the maintenance and	€	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315231	B. WING _	B. WING		06/	25/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	,	
IEEEED8/	ON HEALTH CARE CENT	TED.		5	535 EGG HARBOR ROAD		
JEFFERS	ON HEALTH CARE CENT	EK		5	SEWELL, NJ 08080		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 353	sprinkler heads had a approximately a 1/2 in head was not provide 2. On 06/16/21 at 12: observed, on the a 4 inch pipe was goin approximately a 1/2 in and smoke past the sabove. 3. On 06/17/21 at 9:5 observed, on the fire sprinkler heads haleaving approximately room, allowing how the sprinkler into the sabove. 4. On 06/17/21 at 10: observed in the approximate 1 foot x in place, along with very pipe into the drop ceil gasses and smoke paspace above. 5. On 06/17/21 at 10: observed in the kitche of 5 fire sprinkler head leaving approximately gasses and smoke paspace above. 6. On 06/17/21 at 10: observed in the activity room, that 5 of 12 fire	as AM, the surveyor erence room, that 1 of 4 fire a bad ceiling tile cut that left ench gap; and the sprinkler d with an escutcheon plate. 42 PM, the surveyor Unit exit stairwell, that ing into the ceiling leaving ench gap, allowing hot gasses prinkler into the space 8 AM, the surveyor Unit exit corridor, that 1 of 8 and a bad ceiling tile cut, or a 1/4 inch gap by resident of gasses and smoke past espace above. 10 AM, the surveyor equipment room, that two 1 foot ceiling tiles were not ertical openings from coppering tiles, allowing hot east the sprinkler into the 52 AM, the surveyor endry storage room, that 1 ds had a bad ceiling tile cut, or a 1/2 inch gap, allowing hot east the sprinkler into the 58 AM, the surveyor endry storage room, that 1 ds had a bad ceiling tile cut, or a 1/2 inch gap, allowing hot east the sprinkler into the	K	353	testing automatic sprinkler and standpi systems are inspected, tested, and maintained in accordance with NFPA 2 Standard for the Inspection, Testing, at Maintaining of Water-based Fire Protections. This practice was not met failing to maintain the sprinkler system, ensuring the ceiling level was smoke resistant for 13 sprinkler systems. All residents are at risk to be affected be this practice. The half inch gap in the ceiling tile was closed and the sprinkler head in the conference room was provided an escutcheon plate. The half inch gap we closed on the the conference room was closed. The two ceiling tiles in the the equipment room we replaced along with fixing the vertical openings from the copper pipe into the drop ceiling tiles. The ½ inch gap in the ceiling tile in the kitchen dry storage rowas closed. The 5 sprinklers in the activities/therapy/recreation room were fixed to be installed properly. All three inch gaps in the ceiling tile in the soiled utility room near room were reinstalled properly. The ½ inch in the soiled utility room near room were reinstalled properly. The ½ inch in the soiled utility room near room was closed in nursing supply room near room was closed in nursing supply room near room was closed in the exit corridor, by resident rooms and A screw placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the unit was placed in the exit sign near the uni	5, and by by as ell. re e om 1/4 I the the was	
	room, that 5 of 12 fire						

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	DE CONSTRUCTION 01	COMPLETED
		315231	B. WING		06/25/2021
	ROVIDER OR SUPPLIER ON HEALTH CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD SEWELL, NJ 08080	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
K 353	approximate 1/2 inch and smoke past the above. 7. On 06/17/21 at 11 observed in the soile room 107, that 3 of 3 approximately 1/4 inc 2 of 3 sprinkler head position, allowing hos sprinkler into the spate 8. On 06/17/21 at 11 observed in the soile room that 1 of 1 approximately 1/2 incand smoke past the above. 9. On 06/17/21 at 11 observed in the nurs room that 1 of 1 approximately 1/4 incand smoke past the above. 10. On 06/17/21 at 1 observed in the exit of and that 1 of 5 firms and the side above. 11. On 06/17/21 at 1 observed in the exit of approximately 1 inch and smoke past the sabove. 11. On 06/17/21 at 1 observed by the exit sign was missing one side exposing and side exposing	a gap, allowing hot gasses sprinkler into the space 10 AM, the surveyor d linen room, by resident if ire sprinkler heads had an ch gap at the ceiling tile, with so not in the intended installed to gasses and smoke past the ince above. 15 AM, the surveyor d utility room, by resident fire sprinkler heads had an ch gap, allowing hot gasses sprinkler into the space 18 AM, the surveyor ing supply room, by resident fire sprinkler heads had an ch gap, allowing hot gasses sprinkler into the space 1:25 AM, the surveyor corridor, by resident rooms a concealed cover was a sprinkler heads leaving an gap, allowing hot gasses sprinkler into the space 1:29 AM, the surveyor Unit nurses' station, that the ga screw and dropped on a approximately 1/2 inch gap, and smoke past the sprinkler	K 35	sprinkler head outside resident row was fixed to. The sprinkler head not drops ½ inch allowing hot gasses smoke past the sprinkler into the sabove. The sheetrock was replace boiler room/maintenance office. The Facilities Manager completed all the tasks except The Fire Sprinkle Selnc. fixed the sprinkler in the activit room. All of these were completed 7, 2021. The Facility Manager and maintent department were educated on matthe sprinkler system. This education 100% completion date of July 9, 2. The Facility Manager/designee will conduct weekly audits for 4 weeks monthly to ensure that the sprinkle system is maintained properly. The results of these audits will be prested the QAPI committee, which meets monthly for review and revision as deemed necessary.	o long and space ed in the he nese rvice, ties I by July sance intaining on had a 021. Il sthen er ne eneted to

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	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED		
		315231	B. WING _			06/	/25/2021
	ROVIDER OR SUPPLIER ON HEALTH CARE CENT	TER		53	TREET ADDRESS, CITY, STATE, ZIP CODE 85 EGG HARBOR ROAD EWELL, NJ 08080	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 353	Continued From page	9	K	353			
K 374 SS=D	observed, outside resconcealed fire sprinkly approximately 1/2 incommode past the sprinkly approximately 1/2 incommode past the sprinkly approximately 1/2 incommode past the sprinkly approximately sheetrock was removed to gasses and smoke space above. The findings were observations. The administrator was the Life Safety Code of the NJAC 8:39-31.2(e) Subdivision of Building CFR(s): NFPA 101 Subdivision of Building Doors 2012 EXISTING Doors in smoke barries bonded wood-core do resists fire for 20 minus plates of unlimited he are permitted to have assemblies per 8.5. Dautomatic-closing, do are not required to swegress travel. Door of clear width of 32 inchedoors.	er head dropped th, allowing hot gasses and kler into the space above. 2: 38 PM, the surveyor r room/ maintenance office, 76 inch x 4 inch piece of red from the ceiling, allowing re past the sprinkler into the served and verified by the r at the time of the s notified of the findings at exit conference on 06/17/21. In g Spaces - Smoke Barrie The served and service are 1-3/4-inch thick solid fors or of construction that for a treative into the service are 1-3/4-inch thick solid fors or of construction that for a treative into the service int	K	374			7/9/21

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 0	1	COMPLETED
		315231	B. WING		06/25/2021
	ROVIDER OR SUPPLIER ON HEALTH CARE CEN	ITER	5	TREET ADDRESS, CITY, STATE, ZIP CODE 35 EGG HARBOR ROAD EWELL, NJ 08080	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
K 374	This REQUIREMEN by: Based on observation of 16/21 to 06/17/21 facility failed to provious that completely closs smoke, flame or gass accordance with NF Section 19.3.7, 19.3 8.5.4, 8.5.4.1. This deficient practice sets of smoke doors was evidenced by the set of smoke doors was evidenced by the set of smoke floor of the set of smoke floor of the set of smoke doors was evidenced by the set of smoke of smoke of smoke floor of the set of smoke floor of smoke floor of the set of smoke floor of smoke floo	on and interview from I, it was determined that the ide smoke barrier wall doors ed to resist the passage of ses during a fire in PA 101, 2012 LSC Edition, .7.1, 19.3.7.8, 8.5, 8.5.2, The was observed for 2 of 6 areviewed for closure and the following: 10:21 AM, the surveyor the set of smoke-doors by and , an approximately on the top meeting edges thes) of the door, preventing it resistive. 10:28 AM, the surveyor the set of smoke-doors by an approximately 1/4 inch gap of edges of the door, eing smoke resistive. 10:21 AM, the surveyor the set of smoke-doors by an approximately 1/4 inch gap of edges of the door, eing smoke resistive.	K 374	This Plan of Correction constitutes Jefferson Health Care Center □s (the Center) written allegation of compliar for the deficiencies cited. However, submission of this Plan of Correction not an admission that a deficiency ex or that one was cited correctly. This is of Correction is submitted to meet requirements established by federal is state law. It is the practice of the facility to ensu- compliance with the Subdivision of building spaces for smoke barrier do This practice was not met by failing to provide smoke barrier wall doors that completely close to resist the passag smoke, flame or gases during a fire. All residents are at risk to be affected this practice. The ¼ inch gap was immediately close on the set of smoke barrier doors by resident rooms and and and and and by to activities office. The Facility Manager and maintenan department were educated on ensuri that smoke barrier wall doors are completely closed to resist the passa smoke, flame, or gases during a fire. education had a 100% completion da July 9, 2021. The Facility Manager/designee will conduct weekly audits for 4 weeks th monthly to ensure all smoke barrier wall	is distists Plan and and are ors. or the of de of de of This sate of

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
		315231	B. WING	 -		06/25/2021
NAME OF PROVIDER OR SUPPLIER JEFFERSON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 535 EGG HARBOR ROAD SEWELL, NJ 08080		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 374	Continued From page	e 11	K 37	doors are completely resistant passage of smoke. The result audits will be presented to the committee, which meets month review and revision as deemed necessary.	s of these QAPI nly for	