STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315223	A. BUILDING **01** B. WING _____	**04/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTER	**1059 EDINBURG ROAD** **HAMILTON, NJ 08690**

(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 04/07/11 and 04/08/22 and Hamilton Continuing Care 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. Hamilton Continuing Care is a single (1), Type III Protected building that was built in February 1986. The facility is divided into 8 smoke zones.	K 000		
K 291 SS=D	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 and interview on 4/07/2022, in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light above 1 of 1 emergency generator's transfer switch, independent of the building's electrical	K 291	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or	5/27/22

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

Electronically Signed | 05/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AVALON REHABILITATION AND HEALTHCARE CENTER	**1059 EDINBURG ROAD** **HAMILTON, NJ 08690**

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K 291	Continued From page 1 system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 04/07/2022, starting at 10:07 AM with the facility's Director of Support Services (DSS), a tour of the building was conducted. During the tour at 12:03 PM, an inspection inside the Main Electrical Room, where the emergency generator's transfer switch is located, was performed. The surveyor observed no evidence of a battery back up emergency light, inside the Main Electrical Room. The surveyor asked the DSS if there was a battery back-up emergency light for the transfer switch. The DSS told the surveyor there was not and clarified there was only one outside for the referenced generator. The finding was verified and confirmed by the DSS during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 04/08/2022. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility□s credible allegation of compliance as of 5/27/2022. One, actions taken for the situations identified: The Director of Support Services (DSS) immediately installed a battery backup emergency light above the facility□s 1 of 1 emergency generator□s transfer switch, independent of the facility□s electrical system and emergency generator. Two, identification of other residents who have the potential to be affected: -The facility recognizes that all residents have the potential to be affected from a battery backup emergency lighting perspective. Please refer to Sections One, Three and Four. Three, system changes and measures that will be made: The DSS will monitor new and revised guidelines for emergency lighting as set forth by the NFPA on an on-going and monthly basis. Four, monitoring mechanisms to assure compliance:	

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	315223	A. BUILDING **01** B. WING _____	**04/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTER	**1059 EDINBURG ROAD** **HAMILTON, NJ 08690**

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K 291	Continued From page 2	K 291	Via monthly physical plant rounds, the DSS will monitor the operation of the battery backup emergency light above the facility□s 1 of 1 emergency generator□s transfer switch as well as monitor new and revised guidelines for emergency lighting as set forth by the NFPA and report his findings of the facility□s compliance with current, revised and new rules related to emergency lighting on a quarterly basis at the facility□s quality assurance meeting.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 04/07/2022, in the presence of facility management, it was determined that the facility failed to maintain the integrity of the smoke barrier partitions for 2 of 7 smoke barrier walls. This deficient practice was evidenced by the	K 372	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of	5/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTER	**1059 EDINBURG ROAD** **HAMILTON, NJ 08690**

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K 372	Continued From page 3 following: On 04/07/2022, starting at 10:07 AM with the facility's Director of Support Services (DSS), a tour of the building was conducted. During the building tour the surveyor observed penetrations through smoke barrier walls ranging from two inches, up to 10 inches in diameter at the following locations: 1. At 10:04 AM, the surveyor observed a 2-inch diameter hole in a section of the smoke barrier wall, located directly above the corridor smoke/fire barrier doors and ceiling tiles by resident room #303. The hole was due to a section of metal conduit pipe which was not properly sealed. The surveyor utilized his power lock two-tape measure to send the tape measure through the conduit pipe, two feet, to the other side of the smoke barrier wall. 2. At 10:23 AM, the surveyor observed an approximately 2- inch by 10-inch penetration in the smoke barrier wall, located directly above the corridor smoke/fire doors and ceiling tiles in the corridor, between resident rooms #218 and #707. This hole was due to a section of wall board which was missing from the barrier wall. These penetrations were observed on both sides, through the smoke barrier walls, indicating that the area was not sealed closed to prevent smoke, fumes, and fire from passing through, to the other smoke compartment. The findings were verified and confirmed by the DSS during the observations.	K 372	Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility's credible allegation of compliance as of 5/27/2022. One, actions taken for the situations identified: The Director of Support Services (DSS) immediately sealed the 2 inch diameter penetration above resident room #303. The DSS immediately sealed the 2 inch by 10 inch penetration in the smoke barrier wall, located directly above the corridor smoke/fire doors and ceiling tiles in the corridor, between resident rooms #218 and #707. Two, identification of other residents who have the potential to be affected: -The facility recognizes that all residents have the potential to be affected from a fire safety and smoke barrier perspective. Please refer to Sections One, Three and Four. Three, system changes and measures that will be made: The DSS will monitor new and revised guidelines for smoke barrier requirements as set forth by the NFPA on an on-going and monthly basis. Four, monitoring mechanisms to assure	

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K 372	Continued From page 4 The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 04/08/2022. NJAC 8:39-31.2(e)	K 372	compliance: 1. Via monthly physical plant rounds, the DSS or designee will monitor and inspect smoke barrier walls for penetrations throughout the building and make appropriate repairs if necessary as well as monitor new and revised guidelines for smoke barrier requirements as set forth by the NFPA and report his findings of the facility□s compliance with current, revised and new rules related to smoke barriers on a quarterly basis at the facility□s quality assurance meeting.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315060 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/28/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0293	08/15/2022	LSC	K0351	08/15/2022	LSC	K0374	08/15/2022
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0912	08/15/2022	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/21/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO