STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING **01** B. WING _____	**01/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	**1302 LAUREL OAK ROAD** **VOORHEES, NJ 08043**

(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 01/24/22 and 01/25/22, 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 Occupancy The facility is a 5-story building that was built in 80's, It is composed of Type II protected. The facility is divided into 15- smoke zones. The generator does approximately 80% of the building. The fire sprinkler system utilizes an electric fire pump thats tested monthly by the fire sprinkler vendor. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/21/2022

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K 000	Continued From page 1 The facility has 240 certified beds. At the time of the survey the census was 187.	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 and interview on 01/25/22, the facility failed to provide automatic emergency illumination that would operate automatically along the means of egress, and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.8, 7.8.1.1, 7.8.1.2, 7.8.1.4. The deficient practice was evidenced by the following: At 12:38 PM, the surveyor, Assistant Maintenance staff member and Regional Plent Operations Director observed in the gazebo/smoking courtyard that at the egress/discharge gate with a keypad and keyed-lockset there was no emergency lighting at the lock or beyond the gate to the public way. The findings were verified by the Assistant Maintenance staff member and Regional Plant Operations Director at the times of the	K 281	K281 1)Regarding no lighting at lock or beyond the gate to the public way, Maintenance director immediately ordered a floodlight which will be put up to illuminate area around keypad lock and beyond the gate to the public way. 2)All residents have the potential to be affected by this deficient practice. Maintenance director installed the floodlight and there is now light illuminating the area around keypad lock and beyond the gate to the public way. 3)Maintenance Director conducted an audit of all other areas that may potentially require additional lighting and has found that all other areas have sufficient lighting. 4)Maintenance Director/Designee will conduct weekly audits times four weeks and then monthly thereafter for three months to ensure all areas have sufficient lighting. All findings will be bought up quarterly at the QA committee meeting.	2/23/22

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K 281	Continued From page 2 observation. The Administrator was informed of the findings at the Life Safety Code exit conference on 01/25/22.	K 281		
K 291 SS=D	NJAC 8:39-31.2(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 and interview on 01/25/22, it was determined that the facility failed to provide an operational battery backup emergency light above the emergency generator's transfer switches, 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 observed for 2 of 2 transfer switches and was evidenced by the following: 1. At 11:28 AM, the surveyor, Assistant Maintenance staff member and Regional Plant Operations Director, observed in the basement main electrical room, where the generator transfer switch was located, that no emergency lighting was provided. The wall switch was shut-off and a light remained on, but the fixture was not provided with a battery backup to the fixture. This finding was verified by the Assistant	K 291	K291 1) In regard to the lack of emergency lighting where the generator transfer switch is located. Electrician was called to install a battery-operated emergency light that will operate for minimum 90 minutes independent of facility electric and generator. 2) All residents have the potential to be affected by this deficient practice. Electrician installed the battery backup lights to provide emergency lighting independent of facility electric and generator 3) Maintenance Director/Designee will ensure that battery backup lights are working properly once installed. 4)Maintenance Director/Designee will conduct audits by monitoring lighting monthly for three months to ensure proper function of the battery backup. All findings will be bought up quarterly at the QA committee meeting.	2/23/22

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K 291	Continued From page 3 Maintenance staff member and Regional Plant Operations Director at the time of observation. The Administrator was notified of the above findings at the Life Safety Code exit conference on 01/25/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on surveyor's observation and interview on 01/25/22, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents and was evidenced by the findings noted below: At approximately 12:00 PM, the surveyor observed along with the Assistant Maintenance staff member and Regional Plant Operations Director, that the fire alarm annunciator panel indicated "trouble in system". The amber trouble	K 345	K345 1)Concerning fire alarm panel that was in trouble mode, Fire alarm company was immediately called to address issue. 2)All residents have the potential to be affected by this deficient practice. Fire alarm vendor determined that heat detector needs to be replaced. Alarm vendor installed new heat detector and fire alarm panel is running properly with all systems running as normal. 3)Maintenance conducted audits on all alarm panels in the facility and ensured all fire alarm panels are running properly. 4)Maintenance Director/Designee will	2/23/22

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K 345	Continued From page 4 light was activated in 2 of 2 panels observed. The annunciator panel indicated "trouble heat on the 5th floor dayroom bathroom." The alarm system was operating at the time of the finding. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70,National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. The Regional Plant Operations Director stated that the facility fire alarm vendor was scheduled to respond ASAP. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 01/25/22. NFPA 70 NFPA 72 NJAC 8:39-31.2(e)	K 345	conduct weekly checks on all fire panels weekly for four weeks and then monthly thereafter for three months. All findings will be reviewed quarterly at the QA committee meeting.	
K 353 SS=E	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		2/23/22

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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: Based on observation and interview on 01/25/22, it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. During a building tour from 09:30 AM, to 02:25 PM, the Surveyor, assistant Maintenance staff member and Regional Plant Operations Director, observed drop ceiling tiles missing and/or holes in the ceiling tiles (sheetrock) and bad cuts around the fire sprinkler heads in the following areas of the facility: Floor 4 resident scale area, broken ceiling tile and missing vent frame allowing approximately 2" opening around unfinished area. Floor 4 shower room, missing 3 ceiling tiles. Floor 3 resident room 308 ceiling tile not in place approximately 4' x 2'. Floor 2 resident room 214 bathroom ceiling approximately 2" ceiling opening around fire sprinkler head. Kitchen dish cleaning ceiling missing 3 approximately 4' x 2' tiles Kitchen fire suppression system with bad ceiling tile cuts around the conduit pipe.	K 353	K353 1)Concerning the drop ceiling tiles missing and/or holes in 4th floor resident scale area, fourth floor shower room, room 308, bathroom in room 214, kitchen dish cleaning area, kitchen fire suppression system, kitchen water storage closet. Maintenance immediately started working and repairing all mentioned ceiling tiles. 2)All residents had the ability to be affected by this deficient practice. Maintenance repaired and replaced all defected ceiling tiles. 3)Maintenance conducted an audit on all ceiling to ensure that there were no other ceiling tiles that needed to be repaired or replaced throughout the facility. 4)Maintenance Director/Designee will monitor and audit facility for any missing and/or damaged ceiling tiles weekly for four weeks and monthly for three months thereafter. All findings will be reviewed quarterly at QA committee meeting.	

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K 353	Continued From page 6 Kitchen water storage closet, broken ceiling tile, approximately 3' x 2'. The Assistant Maintenance staff member and Regional Plant Operations Director stated and confirmed the above findings during the building tour on 01/25/22. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 01/25/22.. NJAC 8:39-31.2(e)	K 353		
K 363 SS=E	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	K 363		2/23/22

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K 363	Continued From page 7 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 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 from 01/24/22 to 01/25/22, 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 not ensuring that room doors will close and latch 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 8 of 40 resident room door's and was evidenced by the following: From 01/24/22 to 01/25/22, during the building tour from 9:00 AM, to 1:00 PM, the surveyor, in the presence of the Assistant Maintenance staff member and Regional Plant Operations Director, observed that the doors to resident rooms, did not latch into the door frame in the following room	K 363	K363 1)Concerning the doors to resident□s rooms 503,431,409,222,219,216 and 215 that did not close and latch into the door frame. Maintenance was immediately called to inspect these doors. 2) All residents had the ability to be affected by this deficient practice. Maintenance Director determined that doors need new spring latches and/or levers. All required parts needed to fix doors were ordered. Maintenance Director will repair all mentioned doors once parts are received. 3)Maintenance Director audited all other doors throughout the facility and ensured that all other doors in the facility are latching closed properly. 4) Maintenance Director/Designee will audit and monitor all residents room doors weekly for three weeks and monthly for three months thereafter. All findings will	

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K 363	Continued From page 8 numbers: 503, 431, 409, 222, 221, 219, 216 and 215. An interview was conducted with the assistant Maintenance staff member who stated and confirmed that the above resident room doors, had hardware issues that prevented the doors from latching into there frame's properly. The Administrator was informed of the finding at the Life Safety Code exit conference on 01/25/22. NJAC 8:39-31.1(c), 31.2(e)	K 363	be reviewed quarterly at the QA committee meeting.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING 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. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 01/25/22 in the presence of the Assistant Maintenance staff member and Regional Plant Operations Director, it was determined that the facility failed to	K 374	K374 1) In regard to the facility□s failure to maintain smoke barrier doors to resist the transfer of smoke when completely	2/23/22

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K 374	Continued From page 9 maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 2 of 10 smoke barrier doors observed and was evidenced by the following: 1. At 11:15 AM, the surveyor observed that 1 of 2 smoke barrier doors by resident room 302 were blocked from fully closing due to the closing arm not attached to the door. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. This was confirmed when the fire alarm was activated on 01/25/22 at 12:37 PM to test the doors for proper operation. 2. At 01:20 PM, the surveyor observed that 1 of 2 smoke barrier doors by resident room 501 were blocked from fully closing by a stored resident wheel chair. When the open doors were activated, the door on the resident room 501 side was completely holding the door from closing due to the wheel chair blocking its release. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The assistant Maintenance staff member and Regional Plant Operations Director, confirmed the findings above. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference on 01/25/22. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374	closed, doors at room 302 not closing properly due to closing arm not being attached to door, and doors at room 502 not being able to close properly due to a wheelchair being in the way. Maintenance was immediately called to inspect fire doors. 2)All residents had the potential to be affected by this deficient practice. Wheelchair was immediately removed from blocking smoke doors at room 502. Closing arm for smoke doors at room 302 was immediately reattached and restored to proper function. 3)Maintenance audited all other smoke doors throughout the facility and ensured that they are closing properly. 4)Maintenance Director/ Designee will audit all smoke doors weekly for four weeks and then monthly for four months thereafter. All findings will be reviewed quarterly at the QA committee meeting.	

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K 521	Continued From page 10	K 521		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/25/22, in the presence of the facility assistant Maintenance staff member and Regional Plant Operations Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 3 of 29 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: While touring the building on 01/25/22, from approximately 10:30 AM to 1:30 PM, the surveyor, in the presence of the assistant Maintenance staff member and Plant Operations Director, observed that the ventilation in the following resident room bathrooms did not function: Resident Room's #214, 232 and 319 The surveyor requested that the Assistant	K 521	K521 1) In regard to ventilation in resident bathrooms not functioning in rooms 214,232,319. Maintenance was called to inspect exhaust fans in mentioned bathrooms. 2)All residents have the potential to be affected by this deficient practice. Maintenance reached out to electrical company to asses exhaust fans in mentioned rooms. Electric company was at the facility on 2/18/22 and determined that one of the main units was shut down causing this issue. electric company repaired mentioned unit and all units are now running properly. . 3)Maintenance Director audited all other exhaust fans in resident bathroom to ensure that they are functioning properly. 4) Maintenance Director/Designee will audit and monitor exhaust fans in resident bathrooms weekly for four weeks and monthly for three months thereafter. All findings will be reviewed quarterly at the	3/17/22

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K 521	Continued From page 11 Maintenance staff member, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Assistant Maintenance staff member, who confirmed that the exhaust vents in the above resident room bathrooms, were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference on 01/25/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1	K 521	QA committee meeting	
K 920 SS=E	NJAC 8:39-31.2(e) Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		2/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING **01** B. WING _____	**01/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	**1302 LAUREL OAK ROAD** **VOORHEES, NJ 08043**

(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 920	Continued From page 12 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/25/22, the facility did not prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was evidenced by the following: 1. At 09:40 AM, the surveyor and Assistant Maintenance staff member, observed in resident (private) room 501, that the duplex wall outlet on the left side of the entrance into the room, was missing its protective plate cover. The resident 4-draw dresser was blocking a part of the duplex wall outlet from being accessible. 2. At 10:20 AM, the surveyor and Assistant	K 920	K920 1) In regard to the facilities failure to prohibit the use of extension cords beyond temporary installation as a substitute for adequate wiring, which does not ensure the prevention of an electrical fire or electric shock hazard, which was found in rooms 501,212 and in the kitchen. Maintenance was immediately called to remove mentioned extension cords. 2) All residents have the potential to be affected by this deficient practice. All extension cords were immediately removed from above mentioned areas. 3)Maintenance Director audited other resident rooms and areas throughout the facility to ensure they were in compliance. 4) Maintance will audit facility weekly times four weeks and monthly times three months to ensure that no extension cords are being used beyond temporary installation. All findings will be reviewed and discussed quarterly at facility QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 920	Continued From page 13 Maintenance staff member, observed in resident room 212 doorside, that a brown household grade extension cord had electronics plugged into the 3 prong plug. The brown extension cord was then plugged into the duplex wall outlet by the resident bed. The brown extension cord was pinched and twisted from over use. 3. At 11:48 AM, the surveyor and Assistant Maintenance staff member and Regional Plant Operations Director observed in the kitchen at the windowside outside wall prep area that a portable window A/C unit was observed to have its GFCI plug installed into the drop ceiling. The Assistant Maintenance staff member then lifted the drop ceiling tile and observed the cord plugged into an orange extension cord. The orange extension cord was then traced for its plug. The plug for the orange extension cord was not located. The finding was verified by the Assistant Maintenance staff member and Regional Plant Operations Director at the time of the observations. The Administrator was notified of the findings at the Life Safety Code exit conference on 01/25/22.	K 920		
K 923 SS=E	NJAC 8:39-31.2(e) Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		2/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING **01** B. WING _____	**01/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 14 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview from 01/24/22 to 01/25/22, in the presence of the assistant maintenance staff and regional plant operations director, it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in	K 923	K923 1) In regard to Oxygen tanks that were found freestanding and not secured from tipping in room 505, and the two tanks found in oxygen room on third floor. All mentioned oxygen tanks were immediately placed in appropriate secure	

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	315187	A. BUILDING **01** B. WING _____	**01/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	**1302 LAUREL OAK ROAD** **VOORHEES, NJ 08043**

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K 923	Continued From page 15 accordance with NFPA 99. This deficient practice was identified for 3 of 14 portable oxygen cylinders and was evidenced by the following: 1. On 02/24/22 at 01:20 PM, the surveyor observed on floor #5 in resident room #506 that at the window side resident bed, a full O2 cylinder was observed to be free standing and not secured from tipping, rupture and damage. 2. On 02/25/22 at 11:00 AM, the surveyor observed in the floor #3 oxygen storage room that 2 of 13 oxygen cylinders were free standing and not secured from tipping, rupture and damage.The oxygen cylinders were observed to have approximately 500 PSI each. An interview was conducted with the Assistant Maintenance staff member and Regional Plant Operations Director, who stated that the cylinders must be individually secured from tipping, rupture and damage at all times in the facility. The Administrator was informed of the finding at the Life Safety Code exit conference on 01/25/22. NJAC 8:39-31.2(e) NFPA 99	K 923	holders to prevent from tipping. 2) All residents had the potential to be affected by this deficient practice. 3) Maintance audited resident rooms and oxygen rooms to ensure that all oxygen tanks were secure and not freestanding. 4) Maintance/designee will audit and monitor resident room and oxygen rooms weekly times four weeks and monthly times three months thereafter to ensure all oxygen tanks are secured in accordance with regulation. All finding will be reviewed quarterly at QA committee 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
315187 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/13/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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 K0281	02/23/2022	LSC K0291	02/23/2022	LSC K0345	02/23/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	02/23/2022	LSC K0363	02/23/2022	LSC K0374	02/23/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	03/17/2022	LSC K0920	02/23/2022	LSC K0923	02/23/2022
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	
1/31/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO