PRINTED: 05/14/2024 FORM APPROVED OMB NO. 0938-0391

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMF	SURVEY
		315187	B. WING _			12/	20/2023
	ROVIDER OR SUPPLIER			13	REET ADDRESS, CITY, STATE, ZIP CODE 102 LAUREL OAK ROAD DORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code S	urvey was conducted by the	K	000			
K 281 SS=D	New Jersey Departments Survey and Field Oper 12/18/2023, was four with the requirements Medicare/Medicaid at Safety from Fire, and National Fire Protection Life Safety Code (LSC Health Care Occupared The facility is a 5-stor 80's, It is composed of facility is divided into generator does approbuilding. The fire spring electric fire pump that sprinkler vendor. The facility has 240 conthe survey the census Illumination of Means CFR(s): NFPA 101 Illumination of Means Illumination of means discharge, is arranged shall be either continuation capable of automatic intervention. 18.2.8, 19.2.8 This REQUIREMENT by: Based on observation provided documentation 12/18/2023, it was designed to the survey documentation 12/18/2023, it was designed as the requirements of the survey of th	ent of Health, Health Facility erations on 12/15/2023 and ad to be in noncompliance of for participation in a 42 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING and the extra two participations of the second of the extra two participations	K 2	281	No residents were negatively affect by the deficient practice. Additional light installed on first floor east exit stairwell 1/15/2024. Maintenance will audit all extensions.	it on	2/16/24
L ABORATORY I	NIDECTOR'S OR PROVINER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1		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

01/15/2024

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315187	B. WING _			12/	20/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ECHELON	I CARE & REHAB				302 LAUREL OAK ROAD		
				٧	OORHEES, NJ 08043		T
(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 281	Continued From page	÷ 1	K 2	281			
K 281	designated exit discharranged so that the funit did not result in a than 0.2 ft-candle in a accordance with NFP (2021 edition) Section 7.8.1.4 The evidence include During the survey ent AM, a request was mandaintenance (DOM) to facility layout which id and smoke compartmy provided layout identifully building with four (4) doors (illuminated exifacility for residents, viduring an evacuation Starting on 12/15/202 12/18/2023 in the preand Regional Plant O an inspection of the b During the two (2) day the surveyor observed discharge door that faillumination in the follows of the exit discharge door diexternal light. A review of an emerginal results in a control of the exit discharge door diexternal light.	rarges was provided and failure of any single lighting in illumination level of lass any designated area in A 101 Life Safety Code ins 7.8.1.1, 7.8.1.2 and is the following: rance on 12/15/2023 at 8:40 adde to the Director of the lentified the various rooms it lents. A review of the facility fied the facility is a five-story designated exit discharge it signs above doors) in the facility. 3 and continued on sence of the facility. 3 and continued on sence of the facility's DOM perations Director (RPOD), uilding was conducted. If you building tour of the facility do one designated exit is done designated exit is and to provide proper owing area: 11:48 AM, the surveyor first floor "East" stairwell scharge door had one ency evacuation diagram identified this exit discharge	K 2	281	stairwells to ensure proper light covera 2. All residents are at risk to be affect by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on requirement to have continuous light from backup light fixtures. 4. Maintenance director / Designee vaudit 3 exit stairwells weekly for 4 weel then Monthly for 3 Months. Findings with be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	om vill ks	
	posted in the corridor door as the primary a	identified this exit discharge					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		315187	B. WING		12/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
K 281	observations. On 12/18/2023 during	the finding at the time of the survey exit at M, the surveyor informed he Life Safety Code	K 28			
K 351 SS=D	Sprinkler System - Inc CFR(s): NFPA 101 Spinkler System - Ins 2012 EXISTING Nursing homes, and it construction type, are approved automatic is accordance with NFP Installation of Sprinkle In Type I and II construction in or local regulations pi In hospitals, sprinkler closets of patient slee of the closet does not sprinkler coverage corequired by NFPA 13 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19 19.4.2, 19.3.5.10, 9.7 This REQUIREMENT by: Based on observation	tallation nospitals where required by protected throughout by an sprinkler system in A 13, Standard for the er Systems. The ruction, alternative protection and to be substituted for a specific areas where state prohibit sprinklers. It is are not required in clothes are not required in clothes are properly as are not required in clothes are not required in clothes. The notion is a second of the notion of	K 35	No residents were negatively affect by the deficient practice. Ceiling tile	2/16/24	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G 01		(X3) DATE SURVEY COMPLETED
		315187	B. WING _			12/20/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY 1302 LAUREL OAK RO VOORHEES, NJ 080	DAD	12/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 351	Facility failed to proprequired by CMS regenvironment to all ar requirements of NFF 19.3.5.1, 9.7, 9.7.1.1 Association (NFPA) Systems 2012 Edition The deficient practice following, During the survey end AM, a request was not Maintenance (DOM) facility lay-out which and smoke compartry A review of the facility the facility is a five-sisleeping rooms on the floors. Starting on 12/15/20 12/18/2023, in the propression of the propression of the facility of the fac	determined that: The determined that: as a gulation §483.90(a) physical deas in accordance with the determined that accordance with the determined that accordance with the determined that according to provide a copy of the determined that according to provide a copy of the determined that according to the determined that according that according to the determined that according to the de	K3	installed in clea staff lounge, Re bathroom and 2 on 12/20.2023. rooms to ensure missing. 2. All resident by the deficient 3. Maintenance strequirement not the ceiling grid. 4. Maintenance audit 5 rooms coweeks then More Findings will be QAPI committee.	n laundry room, 3rd floor seident room #308 and floor soiled linen room Maintenance will audit are no ceiling tiles are at risk to be affect practice. The director in-serviced aff on 1/19/2024 on at to have any openings are director / Designee we weiling tiles weekly for 4 anthly for 3 Months. Submitted to the monther for 3 months who will be rinterventions as	om all ted in vill

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		315187	B. WING			12/	20/2023
	ROVIDER OR SUPPLIER		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)		(X5) COMPLETION DATE
K 351	area and not activate On 12/18/2023: 2) At approximately 9 Staff lounge the surve ceiling grid was missi tile. With the opening in the fire the heat would by area and not activate 3) At approximately 9 observed the inside of bathroom drop ceiling by 3' ceiling tile. With the opening in the fire the heat would by area and not activate 4) At approximately 9 observed the inside of room drop ceiling grid 4' ceiling tile. With the opening in the fire the heat would by area and not activate The RPOD and DOM the time of observation On 12/18/2023 during	pass the fire sprinkler in the the fire sprinkler system. 2:21 AM, inside the 3rd. floor eyor observed the droping one (1) 1' by 2' ceiling he ceiling, in the event of a pass the fire sprinkler in the the fire sprinkler system. 2:27 AM, the surveyor f Resident room #308's grid was missing one (1) 1' he ceiling, in the event of a pass the fire sprinkler in the the fire sprinkler system. 2:47 AM, the surveyor f the 2nd. floor Soiled Linen I was missing one (1) 2' by he ceiling, in the event of a pass the fire sprinkler in the the fire sprinkler system. 3:47 AM, the surveyor f the 2nd. floor Soiled Linen I was missing one (1) 2' by he ceiling, in the event of a pass the fire sprinkler in the the fire sprinkler system. 3:48 Confirmed the findings at ms. 49 the survey exit at M, the surveyor informed he Life Safety Code	K	351			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' ') MULTIPLE CONSTRUCTION BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315187	B. WING _			12	/20/2023	
	ROVIDER OR SUPPLIER		•	13	TREET ADDRESS, CITY, STATE, ZIP CODE 802 LAUREL OAK ROAD OORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 355 SS=E	CFR(s): NFPA 101 Portable Fire Extingual inspected, and main NFPA 10, Standard of Extinguishers. 18.3.5.12, 19.3.5.12 This REQUIREMEN by: Based on observation facility documentation 12/18/2023 in the promanagement, it was failed to: 1) Perform a month inspection for 7 of 3' observed and inspection for 7 of 3' observed and inspection for 4 observed, as required Association as required Association as required Association, Section 19.3 Fire Protection Association, Sections 6.1 N.J.A.C. 5:70. Reference #1 NFPA for portable fire extinuishers after at approximate ap	uishers ishers are selected, installed, tained in accordance with for Portable Fire NFPA 10 T is not met as evidenced on, interview and review of in on 12/15/2023 and esence of facility determined that the facility determined that the facility determined that the facility determined in portable fire extinguishers of 31 fire extinguishers end by National Fire Protection red by NFPA 101, 2012 a.5.12, 9.7.4.1 and National ciation (NFPA) 10, 2010 a.6.1.3.8.1 and 6.1.3.8.3 and a.10 Edition 2010 Standard in guishers reads: eintenance. Fire extinguishers shall be ally placed in service and imately 30-day intervals. Fire ee inspected at more frequent	K	355	1. No residents were negatively affect by the deficient practice. Inspected and tagged fire extinguishers located in the maintenance shop, first floor dining roc laundry room and in the basement fire alarm panel area. Fire extinguishers or 5th, 4th, 3rd and 2nd floor were lowere correct height on 2/1/2024. Maintenance audited all fire extinguishers December 21st to ensure no inspections are miss and are at correct height. 2. All residents are at risk to be affect by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on requirements for fire extinguishers to be inspected monthly and to be at correct height. 4. Maintenance director / Designee waudit 5 fire extinguishers weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the month QAPI committee for 3 months who will determine further interventions as needed.	d em, ed to ce r ing ted	2/9/24	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315187	B. WING			12/	20/2023
	ROVIDER OR SUPPLIER		•	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 302 LAUREL OAK ROAD OORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 355	was performed and the performing the inspected least monthly and that tag or label attached - 7.3.1.1.1 Fire extinution to maintenance at intryear at the time of hyspecifically indicated electronic notification. Reference #2 NFPA for portable fire exting - 6.1.3.8 Installation - 6.1.3.8.1 Fire extinution weight not exceeding that the top of the fire than five feet above the fire than five feet above the fire than five feet above the call of the fire than five feet above the folial shape of the fire than five feet above the folial shape of the fire than five feet above the folial shape of the fire than five feet above the folial shape of the fire than five feet above the folial shape of the fire than five feet above the facility lay-out which in the find smoke compartment of the facility lay-out which in and smoke compartment of the facility is a five-step basement. Starting on 12/15/2021 12/18/2023 in the present call the fire than five feet above the facility lay-out which in the fire than five feet above the facility lay-out which in the facility lay-out which in the facility is a five-step basement.	action shall be taken. ally, the date the inspection the initials of the person ction shall be recorded at the records shall be kept on a to the fire extinguishers. guishers shall be subjected the ervals of not more than one drostatic test, or when by an inspection or 10 Edition 2010 Standard guishers reads, and Height. The ending a gross and lbs. shall be installed so the extinguisher is not more the floor. The shall the clearance the hand portable fire floor be less than four The following: The following: The following at 8:40 The follow	К	3355			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315187	B. WING			12/	20/2023
	ROVIDER OR SUPPLIER			13	TREET ADDRESS, CITY, STATE, ZIP CODE 302 LAUREL OAK ROAD OORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 355	observed and inspect extinguishers that we 2023 in various location of the var	ur of the facility the surveyor ted thirty-one portable fire re annually inspected May ons with the following. 2:36 AM, the surveyor of the basement ur ABC-type portable fire on the floor. It is possible for the guishers. The DOM, are guishers. The DOM stated, inspection identified on the our fire extinguishers were at May 2023 with no in the four fire extinguishers were at May 2023 with no in the tags for June, ber, October and November is and November is a surveyor mercial Laundry area, one is a surveyor mercial Laundry area, one is a surveyor mercial that a surveyor ment fire Alarm panel area, inguisher was last annually	К	355			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315187	B. WING			12/	20/2023
	ROVIDER OR SUPPLIER		1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 302 LAUREL OAK ROAD OORHEES, NJ 08043	•	
(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 SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 355	#501) one ABC-Type appeared to be mount the surveyor measure center of the pressure be 5'- 6". 5) At approximately observed on the 4th. #401) one ABC-Type appeared to be mount the surveyor measure center of the pressure be 5'- 6". On 12/18/2023: 6) At approximately sobserved on the 3rd. #301) one ABC-Type appeared to be mount the surveyor measure center of the pressure be 5'- 6". 7) At approximately sobserved on the 2nd. #301) one ABC-Type appeared to be mount the surveyor measure center of the pressure be 5'- 6". 8) At approximately sobserved the inside of dining room, one ABC last annually inspected evidence of a monthly	floor (near Resident room fire extinguisher that ated too high. At that time, ed from the floor to the re indicating needle gauge to a strange of the extinguisher that ated too high. At that time, ed from the floor to the re indicating needle gauge to a strange of the extinguisher that ated too high. At that time, ed from the floor to the re indicating needle gauge to a strange of the extinguisher that ated too high. At that time, ed from the floor to the re indicating needle gauge to a strange of the extinguisher that ated too high. At that time, ed from the floor to the re indicating needle gauge to a strange of the 1st. floor Resident's control of the strange of the str	К	355			
	performed and docum November 2023.	nented on the tags for					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315187	B. WING			12/	20/2023
	ROVIDER OR SUPPLIER			13	REET ADDRESS, CITY, STATE, ZIP CODE 02 LAUREL OAK ROAD DORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 355	Continued From page	9	K	355			
	The RPOD and DOM the time of observation	confirmed the findings at ons.					
	On 12/18/2023 during approximately 1:10 P the Administrator of the deficiency.	M, the surveyor informed					
	NFPA 10 NJAC 8:39 -31.1 (c),	31.2 (e).					
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101		K	363			3/7/24
	required enclosures of hazardous areas resist and are made of 1 3/4 wood or other materia at least 20 minutes. It is smoke compartments the passage of smoke to rooms containing fill materials have positive latches are prohibited requirements do not a do not contain flamma? Clearance between becovering is not excee complying with 7.2.1. with a device capable when a force of 5 lbf impediment to the clot devices that release would are permitted.	idor openings in other than of vertical openings, exits, or set the passage of smoke 4 inch solid-bonded core al capable of resisting fire for cors in fully sprinklered are only required to resist e. Corridor doors and doors lammable or combustible we latching hardware. Roller I by CMS regulation. These apply to auxiliary spaces that able or combustible material. ottom of door and floor ding 1 inch. Powered doors 9 are permissible if provided to f keeping the door closed is applied. There is no using of the doors. Hold open when the door is pushed or Nonrated protective plates the permitted. Dutch doors the permitted. Door frames					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
	315187	B. WING _			12/:	20/2023
ROVIDER OR SUPPLIER		,	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
CARE & REHAR			13	802 LAUREL OAK ROAD		
TOAKE & KEHAB			V	OORHEES, NJ 08043		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI TAG	x			(X5) COMPLETION DATE
shall be labeled and materials in complian smoke compartment window assemblies a sprinklered compartmestrictions in area or frames in window assemblies as 19.3.6.3, 42 CFR Parand 485 Show in REMARKS of protection ratings, and etc. This REQUIREMENT by: Based on observation 12/18/2023 in the premanagement, it was failed to ensure that a inspected and tested passage of smoke in requirements of NFP. Section 19.3.6, 19.3. The evidence included During the survey en AM, a request was maintenance (DOM) facility lay-out which and smoke compartments of NFP. Section 19.3.6, 19.3. The survey en AM, a request was maintenance (DOM) facility lay-out which and smoke compartments of NFP. Section 19.3.6, 19.3. The survey en AM, a request was maintenance (DOM) facility lay-out which and smoke compartments of NFP. Section 19.3.6, 19.3.	made of steel or other ace with 8.3, unless the is sprinklered. Fixed fire are allowed per 8.3. In ments there are no fire resistance of glass or semblies. Its 403, 418, 460, 482, 483, details of doors such as fire atomatics closing devices, It is not met as evidenced on on 12/15/2023 and desence of facility determined that the facility 4 of 36 corridor doors, were able to resist the accordance with the A 101, 2012 LSC Edition, 6.3, 19.3.6.3.1 and 19.3.6.5. The sthe following: It rance on 12/15/2023 at 8:40 and to the Director of to provide a copy of the identified the various rooms ments. A review of the facility tified the facility is a the resident sleeping rooms on the 5th. floors.	K	363	by the deficient practice. Installed doorknob on housekeeping storage rod door, new door ordered for 5th floor traroom door on 2/8/2024, adjusted door room 503 on 1/11/2024, Corridor door closer was adjust on 1/11/2024. Maintenance audited all corridor doors 12/27/2024 to ensure they latch and do have excessive gaps. 2. All residents are at risk to be affect by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on requirements for corridor doors to proplatch and avoid excessive gaps. 4. Maintenance director / Designee vaudit 5 corridor doors weekly for 4 weethen Monthly for 3 Months. Findings with be submitted to the monthly QAPI committee for 3 months who will determine further interventions as	om ish to on ont ted erly vill	
				noodod.		
	Continued From pages shall be labeled and materials in compliar smoke compartment window assemblies a sprinklered compartmestrictions in area or frames in window assemblies as sprinklered compartment restrictions in area or frames in window assemblies as sprinklered compartmestrictions in area or frames in window assemblies as the second of the secon	TORRECTION 315187 ROVIDER OR SUPPLIER GEACH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 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	A BUILDI ROVIDER OR SUPPLIER I CARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 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 on 12/15/2023 and 12/18/2023 in the presence of facility management, it was determined that the facility failed to ensure that 4 of 36 corridor doors inspected and tested, 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. The evidence includes the following: During the survey entrance on 12/15/2023 at 8:40 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments. A review of the facility provided lay-out identified the facility is a five-story building with resident sleeping rooms on the 2nd., 3rd., 4th. and 5th. floors. Starting on 12/15/2023 and continued on 12/18/2023 in the presence of the facility's Regional Plant Operations Director (RPOD) and	TOARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 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 on 12/15/2023 and 12/18/2023 in the presence of facility management, it was determined that the facility failed to ensure that 4 of 36 corridor doors inspected and tested, 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. The evidence includes the following: During the survey entrance on 12/15/2023 at 8:40 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments. A review of the facility provided lay-out identified the facility is a five-story building with resident sleeping rooms on the 2nd., 3rd., 4th. and 5th. floors. Starting on 12/15/2023 and continued on 12/18/2023 in the presence of the facility's Regional Plant Operations Director (RPOD) and	TOURIDER OR SUPPLIER ICARE & REHAB SIMMAND STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 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 on 12/15/2023 and 12/18/2023 in the presence of facility management, it was determined that the facility failed to ensure that 4 of 36 corridor doors inspected and tested, were able to resist 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. The evidence includes the following: During the survey entrance on 12/15/2023 at 8.40, All, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments. A review of the facility provided lay-out identified the various rooms and smoke compartments. A review of the facility provided lay-out identified the various rooms and smoke compartments. A review of the facility provided lay-out which identified the various rooms and smoke compartments. A review of the facility provided lay-out identified the facility is a five-story building with resident sleeping rooms on the 2nd., 3rd., 4th. and 5th. floors.	TOMOBER OR SUPPLIER 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315187 1315188 13151887 13151887 13151884 1315184 131518

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G 01		(X3) DATE SURVEY COMPLETED		
		315187	B. WING _		12/20/2	023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE	
K 363	conducted. During the the surveyor perform thirty-six (36) doors in following results: On 12/15/2023: 1) At approximately observed on the base Housekeeping storage evidence of a door keep the thirty that door. This left an approximately observed allow fire gases to pass into the event of a fire. 2) At approximately observed and measure bottom half of the downwould allow fire, smooth pass into the exit according door had a fire. On 12/18/2023: 3) At approximately observed and measure corridor door had a fire door in the close fire, smoke and poise exit access corridor in the close fire fire fire fire fire fire fire fir	get two day tour of the facility and closure tests of the in the corridors with the get common corridor door had no nob. Inately 2-1/2 inch hole through a smoke and poisonous are exit access corridor in the get at a common corridor door oosition the surveyor or trash room corridor door oosition the surveyor ared a 1/2 inch gap along the or meeting the frame. This oke and poisonous gases to be corridor in the event of a graph of the corridor in the event of a graph of the corridor. This would allow onous gases to pass into the	K 3	63			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		315187	B. WING		12/20/2023
	ROVIDER OR SUPPLIER CARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
K 363	observations. On 12/18/2023 during approximately 1:10 Pl the Administrator of the deficiency. NJAC 8:39-31.1(c), 3	he findings at the time of the survey exit at M, the surveyor informed the Life Safety Code	K 36	3	
K 374 SS=E	CFR(s): NFPA 101 Subdivision of Buildin Doors 2012 EXISTING Doors in smoke barrie bonded wood-core do resists fire for 20 minuplates 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. 19.3.7.6, 19.3.7.8, 19 This REQUIREMENT by: Based on observation provided documentating 12/18/2023, it was de	g Spaces - Smoke Barrier g Spaces - Smoke Barrier ers are 1-3/4-inch thick solid fors or of construction that lates. Nonrated protective ght are permitted. Doors fixed fire window fixed fixed fire window fixe	K 37	No residents were negatively affe by the deficient practice. 4th floor doul smoke door by room# 417 was adjuste	ole ed
	failed to maintain smo	ke barrier doors to resist when completely closed for		to self close and 3rd floor double smol door by room #302 was adjusted to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
		315187	B. WING			12/20/2023	
ECHELON	ROVIDER OR SUPPLIER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 302 LAUREL OAK ROAD OORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 374	was identified for 2 of barrier doors tested a following: Reference 1: Life Safety Code 101 - 8.5.4.1, Doors in sropening, leaving only necessary for proper without louvers or gril bottom of a new door of an inch. During the survey end AM, a request was m Maintenance (DOM) facility lay-out which i and smoke compartm provided lay-out identifive-story building with the facility. Starting on 12/15/202 12/18/2023 in the pre Regional Plant Opera DOM, an inspection of conducted. During the performed a closure it smoke doors in the or results: On 12/15/2023: 1) At approximately test of the double smonext to Resident roon were released from the	ction. This deficient practice is 10 sets of corridor smoke and was evidenced by the set of corridor smoke and was evidenced by the set of corridors shall close the the minimum clearance operation, and shall be ls. The clearance under the shall be a maximum of 3/4 crance on 12/15/2023 at 8:40 adde to the Director of to provide a copy of the dentified the various rooms then. A review of the facility tified the facility is a set of the facility is and the smoke barrier walls in the smoke barrier walls in the surveyor the set of ten sets of double corridors with the following set of ten sets of double corridors with the following set of the sets of double corridors with the doors the magnetic hold open of self close into their frame,	K	374	eliminate gap when closed on 2/9/2024 Maintenance audited all Smoke Barrier Doors on 1/13/2024 to ensure they all close correctly. 2. Residents on 4th and 3rd floor are risk to be affected by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on requirements for Smoke Barrier Doors self close without any gaps between doors. 4. Maintenance director / Designee v audit 3 Smoke Barrier Doors weekly fo weeks then Monthly for 3 Months. Findings will be submitted to the month QAPI committee for 3 months who will determine further interventions as needed.	at to vill r 4	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315187	B. WING _			12/	20/2023
	ROVIDER OR SUPPLIER		•	13	TREET ADDRESS, CITY, STATE, ZIP CODE 802 LAUREL OAK ROAD OORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 374	between the meeting repeated two addition results. This would all fire and poisonous ga	nd measured a one inch gap	K:	374			
	On 12/18/2023: 2) At approximately 9:28 AM, during a closure test of the double smoke doors on the 3rd. floor next to Resident room #302, when the doors were released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measured a 1/4 inch gap between the meeting edge of the doors. This test was repeated two additional times with the same results.						
	poisonous gasses to compartment to anoth	transfer of smoke, fire and pass from one smoke her in the event of a fire. the findings at the time of					
	On 12/18/2023 during approximately 1:10 P the Administrator of the deficiency.	M, the surveyor informed					
	N.J.A.C. 8:39-31.1(c) HVAC CFR(s): NFPA 101	, 31.2(e)	K	521			2/9/24
	HVAC Heating, ventilation, a comply with 9.2 and s	and air conditioning shall shall be installed in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
		315187	B. WING _		1	2/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE	(X5) COMPLETION DATE	
K 521	Continued From page accordance with the specifications. 18.5.2.1, 19.5.2.1, 9.3	manufacturer's	K 5	21			
	This REQUIREMENT is not met as evidenced by: Based on observations on 12/15/2023 and 12/18/2023 in the presence of facility management, it was determined that the facility failed to: Ensure that the facility's ventilation systems were being properly maintained for 4 of 9 Resident bathroom exhaust systems and provide an exhaust system for 1 of 2 Staff bathrooms, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During the survey entrance on 12/15/2023 at 8:40 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments. A review of the facility provided lay-out identified the facility is a five-story building with Resident sleeping rooms on the 2nd., 3rd., 4th. and 5th. floors. Starting on 12/15/2023 and continued on 12/18/2023 in the presence of the facility's Regional Plant Operations Director (RPOD) and DOM, an inspection of the building was conducted. During the two day tour the surveyor inspected nine resident sleeping room bathrooms			1. No residents were negatively by the deficient practice. Exhaust ventilation in room #524, #422, #5 #223 will be fixed by 2/9/2024. Ex ventilation will be reconnected in 3 staff bathroom by 2/9/2024. Maint will audit all affected bathrooms densure they have no fumes trapped Maintenance audited all bathroom 1/13/2024 to ensure they have a functioning ventilation system.	526 and haust Brd floor enance aily to ed.		
				 All residents are at risk to be by the deficient practice. Maintenance director in-servi maintenance staff on 1/19/2024 o requirements for all bathrooms to ventilation system. Maintenance director / Designaudit 5 bathroom ventilation systeweekly for 4 weeks then Monthly Months. Findings will be submitted monthly QAPI committee for 3 mowho will determine further interveneeded. 	ced n have a nee will ms for 3 d to the nths		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION NG 01	, ,	(X3) DATE SURVEY COMPLETED		
		315187	B. WING _			12/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043	'	.==-	
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 521	were tested (by placitissue paper across to ventilation was present function properly in 4 the following location. On 12/15/2023: 1. At approximately room #524 bathroom system did not functional had no window with a This bathroom would ventilation. 2. At approximately room #526 bathroom system did not functional had no window with a This bathroom would ventilation. 3. At approximately room #422 bathroom system did not functional had no window with a This bathroom would ventilation. On 12/18/2023: 4. At approximately inside the 3rd. floor so conducted. There was system. The surveyo ventilation grill located bathroom. At that tim DOM, do you see an	athroom exhaust systems and a piece of single ply the grills to confirm ent), the exhaust did not of 9 resident bathrooms in its: 10:23 AM, inside Resident's and the exhaust on properly. This bathroom an area that would open. It rely on mechanical 10:26 AM, inside Resident's and area that would open. It rely on mechanical 11:10 AM, inside Resident's and area that would open. It rely on mechanical 11:10 AM, inside Resident's and area that would open. It rely on mechanical 11:10 AM, inside Resident's and area that would open. It rely on mechanical 11:10 AM, inside Resident's and area that would open. It rely on mechanical	K	521			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315187	B. WING _			12	/20/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
K 521	would open. This bath mechanical ventilation 5. At approximately 9 room #223 bathroom, system did not function had no window with a This bathroom would ventilation. The DOM confirmed to observations. On 12/18/2023 during approximately 1:10 P the Administrator of the deficiency.	exhaust was not o window with an area that nroom would rely on n. 0:56 AM, inside Resident's when tested the exhaust on properly. This bathroom in area that would open. rely on mechanical the findings at the time of in the survey exit at M, the surveyor informed	K	521			
K 541 SS=E	CFR(s): NFPA 101 Rubbish Chutes, Incir Chutes 2012 EXISTING (1) Any existing linen pneumatic rubbish and directly onto any corri resistive construction shall be provided with a fire protection rating shall comply with 9.5. (2) Any rubbish chute	nerators, and Laundry Chu nerators, and Laundry and trash chute, including d linen systems, that opens dor shall be sealed by fire to prevent further use or a fire door assembly having g of 1-hour. All new chutes or linen chute, including d linen systems, shall be	K	541			3/22/24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		315187	B. WING			12/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043	·		
(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 APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 541	in accordance with 9 (3) Any trash chute s collection room used protected in accordal laundry chutes permi room are protected by accordance with 19.3 (4) Existing fuel-fed in by fire resistive construse. 19.5.4, 9.5, 8.4, NFP This REQUIREMENT by: Based on observation 12/18/2023, it was defailed to ensure 4 of a closed and positively maintain the one-houl laundry chute doors. This deficient practice following findings: During the survey en AM, a request was my Maintenance (DOM) facility lay-out which and smoke comparting provided layout identification building with resident 3rd., 4th. and 5th. flow Starting on 12/15/2021 12/18/2023 in the presence of the presence of the conducted. During the conducted.	atic extinguishing protection .7. thall discharge into a trash for no other purpose and nee with 8.4. (Existing itted to discharge into same by automatic sprinklers in 3.5.9 or 19.3.5.7.) Incinerators shall be sealed truction to prevent further at 82 T is not met as evidenced one on 12/15/2023 and etermined that the facility 4 laundry chute access doors at latched into their frames to air fire protection rating of the was evidenced by the accept of the provide a copy of the identified the various rooms ments. A review of the facility if ified the facility is a five-story at sleeping rooms on the 2nd., ors. 23 and continued on esence of the facility's ations Director (RPOD) and	K 54	1. No residents were negatively by the deficient practice. Vendor contracted on 1/9/2024 to fix self laundry chute mechanism on 2nd and 5th floor. 2. All residents are at risk to be by the deficient practice. 3. Maintenance director in-serving maintenance staff on 1/19/2024 or requirements for all laundry chute have positive latch. 4. Maintenance director / Desig audit 3 laundry chutes weekly for then Monthly for 3 Months. Finding be submitted to the monthly QAP committee for 3 months who will determine further interventions as needed.	closing ,3rd, 4th affected iced on es to nee will 4 weeks ags will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315187	B. WING			12/	20/2023
	ROVIDER OR SUPPLIER		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 302 LAUREL OAK ROAD OORHEES, NJ 08043	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 541	the 5th floor laundry of The surveyor observer rated laundry chute of position. This left and inch opening. During the door did not close required to maintain to test was repeated two same results. 2. At approximately 1 inside the 4th. floor laconducted. During a conducted. During a conducted two additions results. On 12/18/2023: 3 At approximately 9 the 3rd. floor laundry During a closure test the chute door self-cleatch into its frame. The latching mechanis position. This test was times with the same results. 4. At approximately 9 inside the 2nd. floor laconducted. During a conducted. During a chute door, the chute positively latch into its frame.	0:12 AM, an inspection in chute room was conducted. Ed that the one-hour fire coor was in the opened approximately 18 inch by 18 a closure test of the door, and positively latch as the one-hour fire rating. This is additional times with the additional times with the additional times with the strang. This test was the stranger of the laundry door self-closed but did not a frame. This test was that times with the same are times with the same.	K	541			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING (E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		315187	B. WING		12/20/2023	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD /OORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
K 541	Continued From page	2 20	K 541			
	protected against the poisonous gases to p another floor in the ev					
	observations.	-				
	On 12/18/2023 during approximately 1:10 P the Administrator of the deficiency.	M, the surveyor informed				
	NFPA 101:2012 - 19.5 NJAC 8:39-31.2(e)	5.4 and 9.5				
K 911 SS=D	Electrical Systems - 0 CFR(s): NFPA 101	Other	K 911		2/16/24	
	Chapter 6 Electrical S are not addressed by are deficient. This info applicable Life Safety citation, should be inc Chapter 6 (NFPA 99) This REQUIREMENT by:	section any NFPA 99 Systems requirements that the provided K-Tags, but prmation, along with the Code or NFPA standard cluded on Form CMS-2567.		1. No residents were negatively affect	atod.	
	12/18/2023, in the premanagement, it was of failed to ensure that 1 located next to a wate was equipped with Gilnterrupter (GFCI) pro	determined that the facility of 12 electrical outlets er source (with-in six feet) round-Fault Circuit otection as required.		 No residents were negatively affect by the deficient practice. GFCI in salon repaired on 1/19/2024 to work as required. Maintenance will audit all GF to ensure they function correctly. All residents are at risk to be affect by the deficient practice. Maintenance director in-serviced 	CI	
	This deficient practice	e was evidenced by the		maintenance staff on 1/19/2024 on		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315187	B. WING			12	2/20/2023
NAME OF PROVIDER OR ECHELON CARE & F			•	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
Reference National 9.1.2 Ele equipme National are appropermitted NFPA 70 210.8 Gr for Personal (A) through circuit-in accessib (B) Other phase, 1 in location shall have protection (5) Sinks 1.8 M (6) During the AM, a ree Maintena facility late and smooth provided building to common floors.	ce: Fire Protectic ectrical Syste nt shall be in Electrical Co oved existing to be contin , ound-Fault Co onal, Ground shall be pro gh (C). The terrupter sha le location. er than Dwell 5- and 20- a ons specified re ground-fau n for persona s where red feet) of the co one survey en quest was m ance (DOM) yout which ic ke compartm layout identi with 128 Res areas on the on 12/15/202 23 in the pre	on Association (NFPA) 101, ems. Electrical wiring and accordance with NFPA 70, ode, unless such installations grinstallations, which shall be nued in service. Circuit-Interrupter Protection of default circuit-interruption for wided as required in 210.8 ground-fault in readily ling Units. All 125-volt, single empere receptacles installed in 210.8 (B) (1) through (8) ult circuit-interrupter	K	911	requirements for all GFCI to de-energistriggered. 4. Maintenance director / Designee vaudit 3 GFCI weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI commit for 3 months who will determine furthe interventions as needed.	will ttee	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
		315187	B. WING _			12/	20/2023
	ROVIDER OR SUPPLIER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 802 LAUREL OAK ROAD OORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI: TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
K 911 K 918 SS=D	surveyor observed ar outlets in wet (within with one electrical ou when tested in the followhen tested in the followhen tested in the followhen tested in the followhen tested with a Gathe GFCI electrical or required by code. The RPOD and DOM time of observation. On 12/18/2023 during approximately 1:10 Pthe Administrator of the Administrator of the Administrator of the Signature of the Administrator of the Administrator of the CFR(s): NFPA 101 Electrical Systems - ECFR(s): NFPA 101 Electrical Systems - EMaintenance and Tested Signature of the Administrator of the Adm	y tour of the facility, the not tested twelve electrical 6 feet of a sink) locations tlet that failed to de-energize flowing location: 11:39 AM, inside the GFCI electrical outlet of the hair washing sink FCI tester to de-energize, atlet did not de-energize as I confirmed the finding at the g the survey exit at M, the surveyor informed the Life Safety Code IFPA 70: -210.8 Essential Electric System		911			2/16/24
	and associated equip service within 10 second criterion is not met du process shall be prov	oment is capable of supplying onds. If the 10-second uring the monthly test, a rided to annually confirm this safety and critical branches.					

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G 01		(X3) DATE SURVEY COMPLETED	
		315187	B. WING		12/	/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
K 918	Continued From page Maintenance and tes transfer switches are with NFPA 110. Generator sets are in under load 30 minute day intervals, and exmonths for 4 continuounder load conditions simulated cold start a transfer of all EES loa competent personnel stored energy power accordance with NFF circuit breakers are in program for periodica components is estable manufacturer require maintenance and tes readily available. EES circuits are marked, reseparate from normathe possibility of dam source is a design coinstallations. 6.4.4, 6.5.4, 6.6.4 (NI	ting of the generator and performed in accordance spected weekly, exercised at 12 times a year in 20-40 ercised once every 36 ous hours. Scheduled test at include a complete and automatic or manual ads, and are conducted by and Maintenance and testing of sources (Type 3 EES) are in A 111. Main and feeder aspected annually, and a ally exercising the ished according to ments. Written records of ting are maintained and a led eadily identifiable, and led power circuits. Minimizing age of the emergency power insideration for new	K 91	<u> </u>			
	by: Based on interview a 12/15/2023 and 12/15 the facility failed to: - Exercise the one (1 least 30 minutes in 20 - Document the time transfer power to the 10-second time frame	is not met as evidenced and document review on 3/2023, it was determined emergency generator for at 0- to 40-day intervals; and needed by the generator to building was within the e, accordance National Fire in (NFPA) 99 and 110.		 No residents were negatively aff by the deficient practice. Load test completed on 12/29/2023. All residents are at risk to be aff by the deficient practice. Maintenance director in-services maintenance staff on 1/19/2024 on requirements to preform generator to a timely fashion and document logs correctly. Maintenance director / Designer 	ected d est in		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		315187	B. WING _			12	/20/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1302 LAUREL OAK ROAD VOORHEES, NJ 08043			12/20/2023		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION			
K 918	one of survey) at 8:44 Director of Maintenar an emergency generated an emergency generated ander a load monthly. The DOM told the surveyor asked to for the last 12 months. February, March, Al August, September, 2023) for review. At approximately 12: "Emergency Generated previous 12 months in documented monthly 12/30/2022, 1/31/2023 d/28/2023, 5/31/2023 Later at approximated mad to the DOM to prepare to monthly log told the surveyor that system. The surveyor logs for the last six methes a surveyor on 12/18 for review. On 12/18/2023 at approximated to the surveyor on 12/18 for review. On 12/18/2023 at approximated the surveyor on 12/18 for review. Logbook Documenta 6/30/2023, Transfer 15 seconds.	trance on 12/15/2023 (day 0 AM, the surveyor asked the nee (DOM) if the facility had ator and how often does the ency generator. Inveyor, yes they had a Diesel or, we run it weekly, we run or and keep a log book. In he DOM to provide the logs of (December 2022, January, poril, May, June, July, October and November 15 PM, a review of the or Monthly Log" for the dentified the following load dates: 23, 2/28/2023, 3/29/2023, 3, 6/30/2023 and 7/25/2023. In his the log was in the computer or made a request to print the sonths and provide them to 18/2023 (day two of survey) Droximately 9:00 AM, the solution of the log was interest of the solution of survey.	KS	918	audit the generator log weekly for 4 w then Monthly for 3 Months. Findings v be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315187	B. WING			12/20/2023	
NAME OF PROVIDER OR SUPPLIER ECHELON CARE & REHAB				13	TREET ADDRESS, CITY, STATE, ZIP CODE 302 LAUREL OAK ROAD OORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	1		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 918	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 or cool down time: 36 minutes 7/25/2023, Transfer Time to Emergency Power: 5 seconds. Run Time- does not include warm up or cool down time: 45 minutes 9/14/2023, Transfer Time to Emergency Power: NA Seconds. Run Time- does not include warm up or cool down time: NA Minutes 10/10/2023, Transfer Time to Emergency Power: 5 seconds. Run Time- does not include warm up or cool down time: 20 minutes 12/11/2023, Transfer Time to Emergency Power: NA Seconds. Run Time- does not include warm up or cool down time: NA Minutes There was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load tests were conducted every 20 to 40 days under load for 30 minutes since 7/25/2023. The RPOD and DOM confirmed the finding at the time of observation. On 12/18/2023 during the survey exit at approximately 1:10 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. NJAC 8:39-31.2(g)		ID PREFIX TAG				

ID Prefix

Reg.#

POST-CERTIFICATION REVISIT REPORT										
	ER / SUPPLIER / CLIA / CATION NUMBER Y1	MULTIPLE CONS A. Building 01 - B. Wing		LDING 01				Y2	DATE O 4/15/20	F REVISIT
NAME OF	NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE							CODE	•	
ECHELO	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).										
ITE	M	DATE	ITEM	1		DATE	ITEM			DATE
Y	1	Y5	Y4			Y5	Y4			Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 101	(Completed	Reg. #	NFPA 101		Completed
LSC	K0281	02/16/2024	LSC	K0351		02/16/2024	LSC	K0355		02/09/2024
ID Prefix		Correction	ID Prefix		(Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 101	(Completed	Reg. #	NFPA 101		Completed
LSC	K0363	03/07/2024	LSC	K0374		02/09/2024	LSC	K0521		02/09/2024
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 101	(Completed	Reg. #	NFPA 101		Completed
LSC	K0541	03/22/2024	LSC	K0911		02/16/2024	LSC	K0918		02/16/2024

LSC LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg.# Completed Reg. # Completed LSC LSC LSC **REVIEWED BY** SIGNATURE OF SURVEYOR **REVIEWED BY** DATE DATE STATE AGENCY (INITIALS) TITLE REVIEWED BY DATE DATE **REVIEWED BY** (INITIALS) CMS RO CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 12/20/2023 YES NO Form CMS - 2567B (09/92) EF (11/06) Page 1 of 1 EVENT ID: CURA22

ID Prefix

Reg. #

Correction

Completed

Correction

Completed

ID Prefix

Reg.#

Correction

Completed