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 _____	**12/20/2023**

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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/15/2023 and 12/18/2023, 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 has 240 certified beds. At the time of the survey the census was 223.	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 observations and review of facility provided documentation on 12/15/2023 and 12/18/2023, it was determined that the facility failed to ensure continuous illumination for 1 of 4	K 281	1. No residents were negatively affected by the deficient practice. Additional light installed on first floor east exit stairwell on 1/15/2024. Maintenance will audit all exit	2/16/24

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

Electronically Signed | 01/15/2024

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K 281	Continued From page 1 designated exit discharges was provided and arranged so that the failure of any single lighting unit did not result in an illumination level of lass than 0.2 ft-candle in any designated area in accordance with NFPA 101 Life Safety Code (2021 edition) Sections 7.8.1.1, 7.8.1.2 and 7.8.1.4 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 layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified the facility is a five-story building with four (4) designated exit discharge doors (illuminated exit signs above doors) in the facility for residents,visitors and staff to use during an evacuation in the facility. Starting on 12/15/2023 and continued on 12/18/2023 in the presence of the facility's DOM and Regional Plant Operations Director (RPOD), an inspection of the building was conducted. During the two (2) day building tour of the facility the surveyor observed one designated exit discharge door that failed to provide proper illumination in the following area: On 12/18/2023: 1) At approximately 11:48 AM, the surveyor observed outside the first floor "East" stairwell exit discharge door discharge door had one external light. A review of an emergency evacuation diagram posted in the corridor identified this exit discharge door as the primary and or secondary exit discharge door for residents, visitors and staff to	K 281	stairwells to ensure proper light coverage. 2. All residents are at risk to be affected 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 will audit 3 exit stairwells weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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K 281	Continued From page 2 use during an evacuation in the facility. The DOM confirmed the finding at the time of observations. On 12/18/2023 during the survey exit at approximately 1:10 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. N.J.A.C. 8:39 -31.2 (e) NFPA 101 2012 -19.2.8	K 281		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 12/15/2023 and	K 351	1. No residents were negatively affected by the deficient practice. Ceiling tile	2/16/24

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K 351	Continued From page 3 12/18/2023, in the presence of facility management it was determined that: The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The 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 identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a five-story (5)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 (2) day tour the of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 12/15/2023: 1) At approximately 10:22 AM, inside the 5th. floor Clean Linen room the surveyor observed the drop ceiling grid was missing one (1) 1' by 2' ceiling tiles. With the opening in the ceiling, in the event of a	K 351	installed in clean laundry room, 3rd floor staff lounge, Resident room #308 bathroom and 2nd floor soiled linen room on 12/20.2023. Maintenance will audit all rooms to ensure no ceiling tiles are missing. 2. All residents are at risk to be affected by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on requirement not to have any openings in the ceiling grid. 4. Maintenance director / Designee will audit 5 rooms ceiling tiles weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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K 351	Continued From page 4 fire the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system. On 12/18/2023: 2) At approximately 9:21 AM, inside the 3rd. floor Staff lounge the surveyor observed the drop ceiling grid was missing one (1) 1' by 2' ceiling tile. With the opening in the ceiling, in the event of a fire the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system. 3) At approximately 9:27 AM, the surveyor observed the inside of Resident room #308's bathroom drop ceiling grid was missing one (1) 1' by 3' ceiling tile. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 4) At approximately 9:47 AM, the surveyor observed the inside of the 2nd. floor Soiled Linen room drop ceiling grid was missing one (1) 2' by 4' ceiling tile. With the opening in the ceiling, in the event of a fire the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system. The RPOD and DOM confirmed the findings at the time of observations. On 12/18/2023 during the survey exit at approximately 1:10 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		

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K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 12/15/2023 and 12/18/2023 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly visual examination inspection for 7 of 31 portable fire extinguishers observed and inspected. 2) Install portable fire extinguishers within the required height for 4 of 31 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads: - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i),	K 355	1. No residents were negatively affected by the deficient practice. Inspected and tagged fire extinguishers located in the maintenance shop, first floor dining room, laundry room and in the basement fire alarm panel area. Fire extinguishers on 5th, 4th, 3rd and 2nd floor were lowered to correct height on 2/1/2024. Maintenance audited all fire extinguishers December 21st to ensure no inspections are missing and are at correct height. 2. All residents are at risk to be affected 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 will audit 5 fire extinguishers weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	2/9/24

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K 355	Continued From page 6 immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than one year at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lbs. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than four inches. The findings include 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 a basement. 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	K 355		

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K 355	Continued From page 7 conducted. During the two day tour of the facility the surveyor observed and inspected thirty-one portable fire extinguishers that were annually inspected May 2023 in various locations with the following. On 12/15/2023: 1) At approximately 9:36 AM, the surveyor observed the inside of the basement Maintenance shop four ABC-type portable fire extinguishers stored on the floor. At this time the surveyor asked the DOM, are these spare fire extinguishers. The DOM stated, yes they are. Further inspection identified on the tags attached to the four fire extinguishers were last annually inspected May 2023 with no evidence of a monthly visual examination being performed and documented on the tags for June, July, August, September, October and November 2023. 2) At approximately 9:48 AM, the surveyor observed in the Commercial Laundry area, one ABC-type fire extinguisher was last annually inspected May 2023 with no evidence of a monthly visual examination being performed and documented on the tags for July and August 2023. 3) At approximately 9:51 AM, the surveyor observed in the Basement Fire Alarm panel area, one ABC-type fire extinguisher was last annually inspected May 2023 with no evidence of a monthly visual examination being performed and documented on the tags for July and August 2023. 4) At approximately 10:55 AM, the surveyor	K 355		

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K 355	Continued From page 8 observed on the 5th. floor (near Resident room #501) one ABC-Type fire extinguisher that appeared to be mounted too high. At that time, the surveyor measured from the floor to the center of the pressure indicating needle gauge to be 5'- 6". 5) At approximately 11:35 AM, the surveyor observed on the 4th. floor (near Resident room #401) one ABC-Type fire extinguisher that appeared to be mounted too high. At that time, the surveyor measured from the floor to the center of the pressure indicating needle gauge to be 5'- 6". On 12/18/2023: 6) At approximately 9:35 AM, the surveyor observed on the 3rd. floor (near Resident room #301) one ABC-Type fire extinguisher that appeared to be mounted too high. At that time, the surveyor measured from the floor to the center of the pressure indicating needle gauge to be 5'- 6". 7) At approximately 9:35 AM, the surveyor observed on the 2nd. floor (near Resident room #301) one ABC-Type fire extinguisher that appeared to be mounted too high. At that time, the surveyor measured from the floor to the center of the pressure indicating needle gauge to be 5'- 4". 8) At approximately 11:56 AM, the surveyor observed the inside of the 1st. floor Resident's dining room, one ABC-Type fire extinguisher was last annually inspected May 2023 with no evidence of a monthly visual examination being performed and documented on the tags for November 2023.	K 355		

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K 355	Continued From page 9 The RPOD and DOM confirmed the findings at the time of observations. On 12/18/2023 during the survey exit at approximately 1:10 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		3/7/24

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K 363	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 DOM, an inspection of the building was	K 363	1. No residents were negatively affected by the deficient practice. Installed doorknob on housekeeping storage room door, new door ordered for 5th floor trash room door on 2/8/2024, adjusted door to room 503 on 1/11/2024, Corridor door closer was adjust on 1/11/2024. Maintenance audited all corridor doors on 12/27/2024 to ensure they latch and dont have excessive gaps. 2. All residents are at risk to be affected by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on requirements for corridor doors to properly latch and avoid excessive gaps. 4. Maintenance director / Designee will audit 5 corridor doors weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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K 363	Continued From page 11 conducted. During the two day tour of the facility the surveyor performed closure tests of the thirty-six (36) doors in the corridors with the following results: On 12/15/2023: 1) At approximately 9:25 AM, the surveyor observed on the basement level that the Housekeeping storage room corridor door had no evidence of a door knob. This left an approximately 2-1/2 inch hole through the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 10:00 AM, the surveyor observed the 5th. floor trash room corridor door when in the closed position the surveyor observed and measured a 1/2 inch gap along the bottom half of the door meeting the frame. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. On 12/18/2023: 3) At approximately 8:59 AM, the surveyor observed and measured Resident room #503 corridor door had a 1/4 inch gap along the top of the door in the closed position. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 4) At approximately 9:50 AM, the surveyor observed and measured a 1/2 inch gap along the corridor doors meeting edge to the frame in the closed position. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the	K 363		

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(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 363	Continued From page 12 event of a fire. The DOM confirmed the findings at the time of observations. 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 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
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 and review of facility provided documentation on 12/15/2023 and 12/18/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for	K 374	1. No residents were negatively affected by the deficient practice. 4th floor double smoke door by room# 417 was adjusted to self close and 3rd floor double smoke door by room #302 was adjusted to	2/9/24

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	315187	A. BUILDING **01** B. WING _____	**12/20/2023**

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K 374	Continued From page 13 fire and smoke protection. This deficient practice was identified for 2 of 10 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. 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 ten smoke barrier walls in the facility. 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 performed a closure test of ten sets of double smoke doors in the corridors with the following results: On 12/15/2023: 1) At approximately 11:10 AM, during a closure test of the double smoke doors on the 4th. floor next to Resident room #417, when the doors were released from the magnetic hold open device and allowed to self close into their frame, one door did not close into its frame. The	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 at 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 to self close without any gaps between doors. 4. Maintenance director / Designee will audit 3 Smoke Barrier Doors weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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K 374	Continued From page 14 surveyor observed and measured a one inch gap between the meeting edges. This test was repeated two additional times with the same results. 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. 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. 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 DOM confirmed the findings at the time of observations. On 12/18/2023 during the survey exit at approximately 1:10 PM, the surveyor informed the Administrator of the Life Safety Code deficiency.	K 374		
K 521 SS=E	N.J.A.C. 8:39-31.1(c), 31.2(e) HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in	K 521		2/9/24

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K 521	Continued From page 15 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 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	K 521	1. No residents were negatively affected by the deficient practice. Exhaust ventilation in room #524, #422, #526 and #223 will be fixed by 2/9/2024. Exhaust ventilation will be reconnected in 3rd floor staff bathroom by 2/9/2024. Maintenance will audit all affected bathrooms daily to ensure they have no fumes trapped. Maintenance audited all bathrooms on 1/13/2024 to ensure they have a functioning ventilation system. 2. All residents are at risk to be affected by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on requirements for all bathrooms to have a ventilation system. 4. Maintenance director / Designee will audit 5 bathroom ventilation systems weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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K 521	Continued From page 16 and two staff bathrooms. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation was present), the exhaust did not function properly in 4 of 9 resident bathrooms in the following locations: On 12/15/2023: 1. At approximately 10:23 AM, inside Resident's room #524 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:26 AM, inside Resident's room #526 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 11:10 AM, inside Resident's room #422 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. On 12/18/2023: 4. At approximately 9:15 AM, an inspection inside the 3rd. floor Staff bathroom was conducted. There was no evidence of an exhaust system. The surveyor observed a 6 inch by 6 inch ventilation grill located on the floor in the bathroom. At that time, the surveyor asked the DOM, do you see an exhaust in the bathroom. The DOM told the surveyor that the ceiling tile	K 521		

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K 521	Continued From page 17 was replaced and the exhaust was not reconnected. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 9:56 AM, inside Resident's room #223 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The DOM confirmed the findings at the time of observations. On 12/18/2023 during the survey exit at approximately 1:10 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 541 SS=E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be	K 541		3/22/24

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K 541	Continued From page 18 provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observations on 12/15/2023 and 12/18/2023, it was determined that the facility failed to ensure 4 of 4 laundry chute access doors closed and positively latched into their frames to maintain the one-hour fire protection rating of laundry chute doors. This deficient practice was evidenced by the following findings: 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 layout 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 performed a closure test of four laundry chute	K 541	1. No residents were negatively affected by the deficient practice. Vendor contracted on 1/9/2024 to fix self closing laundry chute mechanism on 2nd,3rd, 4th and 5th floor. 2. All residents are at risk to be affected by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on requirements for all laundry chutes to have positive latch. 4. Maintenance director / Designee will audit 3 laundry chutes weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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K 541	Continued From page 19 doors with the following results: On 12/15/2023: 1. At approximately 10:12 AM, an inspection in the 5th floor laundry chute room was conducted. The surveyor observed that the one-hour fire rated laundry chute door was in the opened position. This left an approximately 18 inch by 18 inch opening. During a closure test of the door, the door did not close and positively latch as required to maintain the one-hour fire rating. This test was repeated two additional times with the same results. 2. At approximately 11:02 AM, an inspection inside the 4th. floor laundry chute room was conducted. During a closure test of the laundry chute door, the chute door self-closed but did not positively latch into its frame. This test was repeated two additional times with the same results. On 12/18/2023: 3 At approximately 9:06 AM, an inspection inside the 3rd. floor laundry chute room was conducted. During a closure test of the laundry chute door, the chute door self-closed but did not positively latch into its frame. The surveyor observed that the latching mechanism was locked in the open position. This test was repeated two additional times with the same results. 4. At approximately 9:45 AM, an inspection inside the 2nd. floor laundry chute room was conducted. During a closure test of the laundry chute door, the chute door self-closed but did not positively latch into its frame. This test was repeated two additional times with the same results.	K 541		

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K 541	Continued From page 20 The building's four laundry chute doors were not protected against the passage of smoke, fire and poisonous gases to pass from one floor to another floor in the event of a fire. The DOM confirmed the findings at the time of observations. On 12/18/2023 during the survey exit at approximately 1:10 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. NFPA 101:2012 - 19.5.4 and 9.5 NJAC 8:39-31.2(e)	K 541		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) 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 1 of 12 electrical outlets located next to a water source (with-in six feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the	K 911	1. No residents were negatively affected by the deficient practice. GFCI in salon repaired on 1/19/2024 to work as required. Maintenance will audit all GFCI to ensure they function correctly. 2. All residents are at risk to be affected by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on	2/16/24

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K 911	Continued From page 21 following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. 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 layout which identified the various rooms and smoke compartments. A review of the facility provided layout identified the facility is a five-story building with 128 Resident sleeping rooms and common areas on the 1st. 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	K 911	requirements for all GFCI to de-energize if triggered. 4. Maintenance director / Designee will audit 3 GFCI weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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K 911	Continued From page 22 DOM, an inspection of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested twelve electrical outlets in wet (within 6 feet of a sink) locations with one electrical outlet that failed to de-energize when tested in the following location: On 12/18/2023: 1. At approximately 11:39 AM, inside the resident's salon, one GFCI electrical outlet located 24" to the left of the hair washing sink when tested with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. 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 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918		2/16/24

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K 918	Continued From page 23 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and document review on 12/15/2023 and 12/18/2023, it was determined the facility failed to: - Exercise the one (1) emergency generator for at least 30 minutes in 20- to 40-day intervals; and - Document the time needed by the generator to transfer power to the building was within the 10-second time frame, accordance National Fire Protection Association (NFPA) 99 and 110. Findings included:	K 918	1. No residents were negatively affected by the deficient practice. Load test completed on 12/29/2023. 2. All residents are at risk to be affected by the deficient practice. 3. Maintenance director in-serviced maintenance staff on 1/19/2024 on requirements to preform generator test in a timely fashion and document logs correctly. 4. Maintenance director / Designee will	

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K 918	Continued From page 24 During the survey entrance on 12/15/2023 (day one of survey) at 8:40 AM, the surveyor asked the Director of Maintenance (DOM) if the facility had an emergency generator and how often does the facility run the emergency generator. The DOM told the surveyor, yes they had a Diesel Emergency Generator, we run it weekly, we run under a load monthly and keep a log book. The surveyor asked the DOM to provide the logs for the last 12 months (December 2022, January, February, March, April, May, June, July, August, September, October and November 2023) for review. At approximately 12:15 PM, a review of the "Emergency Generator Monthly Log" for the previous 12 months identified the following documented monthly load dates: 12/30/2022, 1/31/2023, 2/28/2023, 3/29/2023, 4/28/2023, 5/31/2023, 6/30/2023 and 7/25/2023. Later at approximately 1:30 PM, a request was mad to the DOM to provide any additional generator monthly logs. At that time the DOM told the surveyor that the log was in the computer system. The surveyor made a request to print the logs for the last six months and provide them to the surveyor on 12/18/2023 (day two of survey) for review. On 12/18/2023 at approximately 9:00 AM, the DOM provided the following printed generator log sheets that read in part: Logbook Documentation: 6/30/2023, Transfer Time to Emergency Power: 5 seconds. Run Time- does not include warm up	K 918	audit the generator log weekly for 4 weeks then Monthly for 3 Months. Findings will 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	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING **01** B. WING _____	**12/20/2023**

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 918	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)	K 918		

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	4/15/2024 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	02/16/2024	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
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	
12/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO