| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315068 | A. BUILDING **02**<br>B. WING _____ | **04/20/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **DWELLSIDE CARE AND REHAB** | **3025 CHAPEL AVENUE WEST**<br>**CHERRY HILL, NJ 08002** |

| (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 |
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| K 000 | INITIAL COMMENTS<br><br>The nursing home building construction was stated to be 1970s with no current major renovations. It is a two story building Type II (000) construction with three Type V (000) one-story wings that were built off of the main two-story building.The wings are identifyed as resident rooms 102-117, center core utilities and resident rooms 137-159. The building is fully sprinklered, including the three Type V wood frame one-story attics. The facility generator is out of service and the facility currently utillizes a temporary generator attached to a trailer. The facility provided a document dated: 11/29/22 indicating a new generator will be installed from the facility vendor. The provided proposal indicates a new 210 KW diesel will be installed: dated 10/14/22 but the proposal was for the previous ownership. No documentation was provided under the new ownership name. The facility was asked if they applied for a waiver for the temporary generator that is currently in operation for over a year, no further documents were provided as of the LSC exit conference on 04/11/23. The building is divided into 11-smoke zones.<br><br>There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life<br><br>The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and | K 000 | | |

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

Electronically Signed | 05/11/2023

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.

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| K 000 | Continued From page 1<br>maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.<br><br>The facility has 162 certified beds. At the time of the survey the census was 129.<br><br>The temporary generator does approximately 50% of the building as per the Maintenance Director.<br><br>On 04/11/23 the Administrator was asked to provide a waiver for the temporary generator installation (over one year in operation). As of 04/14/23 no further documentation was provided indicating a waiver was applied for.<br><br>The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by: | K 000 | | |
| K 211 SS=F | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and documentation review | K 211 | K211 | 5/22/23 |

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| K 211 | Continued From page 2<br>on 04/11/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was identified for 12 of 12 fire doors documented on the provided facility floor plans and was evidenced by the following:<br><br>On 04/10/23 at approximately 9:45 AM, the surveyor asked the MD, to provide the annual testing requirements for fire door assemblies. The MD stated that currently the facility did not document the required annual testing of the fire door's in accordance with NFPA 80 and NFPA 105 Standard for Smoke Doors Assemblies and other Opening Protectives.<br><br>The MD confirmed that currently no fire door annual inspection report could be produced at the time of survey.<br><br>The Administrator was informed of the finding's at the Life Safety Code Exit Conference on 04/11/23.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 80 and 105: Standard for fire doors assemblies and other opening protectives<br>NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8<br>S&C 17-38-LSC<br>NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1 | K 211 | What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected by the deficient practice.<br><br>12 out of 12 doors fire doors were identified as not having an annual inspection.<br><br>The 12 identified doors were inspected upon identification.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents have the potential to be affected by affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>The Administrator provided re-education to the Maintenance Director on April 11th, 2023, regarding the importance of checking corridor fire doors annually and documenting findings.<br><br>The Director of Maintenance implemented an audit tool to check corridor fire doors annually reporting any issues to the Administrator. | |

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| K 211 | Continued From page 3 | K 211 | How will the corrective action be monitored to ensure the deficient practice will not recure?<br><br>The Administrator and/ or designee will report annual audits to the Quality Assurance Performance Improvement Committee (QAPI) meeting Annually. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 281 SS=E | Illumination of Means of Egress<br>CFR(s): NFPA 101<br><br>Illumination of Means of Egress<br>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.<br>18.2.8, 19.2.8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/10/23 in the presence of facility Maintenance Director (MD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 4 of 10 occupied access areas observed and was evidenced by the following:<br><br>1). At 11:14 AM, the surveyor in the presence of the MD, observed in the exit/egress corridor by the Physical Therapy room that 5-wall light switches shutoff all the lighting. The area was not | K 281 | K281<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected by the deficient practice.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>Residents have the potential to be | 5/22/23 |

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| K 281 | Continued From page 4<br>provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention.<br><br>2). At 11:18 AM, the surveyor in the presence of the MD, observed in the exit/egress corridor by the occupied B-wing dining room that 4-wall light switches shutoff all the lighting.<br>The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention.<br><br>3). At 11:31 AM, the surveyor in the presence of the MD, observed in the occupied (3-residents) A-wing day room that 4-wall switches shut-off all the lighting. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention.<br><br>4). At 01:05 PM, the surveyor in the presence of the MD, observed in the occupied (10-residents) floor-2 dayroom that 5-wall switches shut-off all the lighting. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention.<br><br>The Maintenance Director confirmed the finding's at the time of observations.<br><br>The Administrator was informed of these findings at the Life Safety Code survey exit conference on 04/11/23.<br><br>NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2)<br>NJAC 8:39-31.2(e) | K 281 | affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>The Administrator provided education to the Maintenance Director on April 12, 2023, ensuring facility provides emergency illumination that would operate automatically along the means of egress without manual intervention.<br><br>The Maintenance Director requested Contractor quotes to completed emergency illumination of the following areas:<br>• Physical therapy room- 5 wall light switch<br>• B Wing dining room- 4 wall light switch<br>• A Wing day room- 4 wall light switch<br>• Second floor day room- 5 wall light switch<br><br>On May 5th, 2023, Prime Electric toured the facility and specific areas cited. Prime Electric provided an estimate for the work on May 9th, 2023. Date is pending for work completion.<br><br>The Maintenance Director will provide the Administrator with weekly updates as reported regarding the anticipated timeframe for work completion of emergency illumination.<br><br>How will the corrective action be | |

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| K 281 | Continued From page 5 | K 281 | monitored to ensure the deficient practice will not recure?<br><br>The Administrator and/ or designee will report updates for anticipated work completion to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly until work is completed. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 293 SS=E | Exit Signage<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview conducted on 04/10/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide exit signs that included a continuous illumination indicator showing the direction of travel, in every location, where the direction of travel to reach the nearest exit was not apparent, in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 4 of 12 exit signs observed and was evidenced by the following: | K 293 | K293<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected by the deficient practice.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what | 5/22/23 |

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| K 293 | Continued From page 6<br><br>1). At 10:00 AM, the surveyor and MD observed that the exit sign by resident room 129 did not have any illumination.<br><br>2). At 11:50 AM, the surveyor and MD observed that the set of smoke doors when closed by resident rooms 126 and 127 did not provide an illuminated exit sign. The closed set of door's blocked the exit sign at the end of the corridor from being viewed in the event of an emergency evacuation.<br><br>3). At 12:15 PM, the surveyor and MD observed the exit sign by the facility time clock did not have any illumination.<br><br>4). At 12:28 PM, the surveyor and MD observed that the set of smoke doors by resident rooms 107 and 108 did not provide an illuminated exit sign. The closed set of door's blocked the exit sign at the end of the corridor from being viewed in the event of an emergency evacuation.<br><br>The findings were verified by the MD at the time of the observations.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 04/11/23.<br><br>NJAC 8:39-31.2(e)<br>NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. | K 293 | corrective action will be taken?<br><br>All residents have the potential to be affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>The Administrator provided education to the Maintenance Director on April 12, 2023,ensuring the facility provides exit signs that include a continuous illumination indicator showing the direction of travel to reach the nearest exit.<br><br>The Maintenance Director requested Contractor quotes to complete emergency illumination exit signs in the following identified areas:<br>• Exit sign by resident room 129<br>• Set of smoke doors when closed by resident rooms 126/127<br>• Exit sign by the facility time clock<br>• Set of smoke doors by residents rooms 107/108<br><br>On May 5th, 2023, Prime Electric toured the facility and specific areas cited. Prime Electric provided an estimate for the work on May 9th, 2023. The date is pending for work completion. The Maintenance Director will provide the Administrator with weekly updates as reported regarding the anticipated timeframe for work completion of exit signs.<br><br>How will the corrective action be | |

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| K 293 | Continued From page 7 | K 293 | monitored to ensure the deficient practice will not recure?<br>The Administrator and/ or designee will report updates for anticipated work completion to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly until work is completed. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 321 SS=D | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms | K 321 | | 5/22/23 |

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| K 321 | Continued From page 8<br>(exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/11/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7.<br><br>This deficient practiced was identified for 1 of 1 hazardous area Dutch doors and was evidenced by the following:<br><br>At 12:08 PM, the surveyor observed the unrated wooden Dutch-door to the kitchen, that the top leaf was lacked a latching device for positively latching into the frame and the door was not provided with an astragal between the top and bottom leaves. The unrated wooden Dutch door was not provided with an auto-closing device and the wood was comprimised in areas to deem it not smoke resistant.<br><br>NFPA 101 2012 edition Life Safety Code 19.3.6.3.13 Dutch doors shall be permitted where they conform to 19.3.6.3 and meet all of the criteria.<br><br>The MD confirmed the findings at the time of the observations. | K 321 | K321<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected by the deficient practice.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents have the potential to be affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>The Administrator provided education to the Maintenance Director on April 12, 2023, ensuring that fire-rated doors are installed to hazardous areas were self-closing, labeled, with separation by smoke resisting partitions.<br><br>The Maintenance Director requested Contractor quotes to replace identified wooden dutch-door to the kitchen. | |

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| K 321 | Continued From page 9<br>The Administrator was notified of the findings at the Life Safety exit conference on 04/11/23.<br><br>NJAC 8:39-31.2 (e)<br>Life Safety Code 101-2012 edition | K 321 | On May 9th, 2023, facility placed an online request to the Cherry Hill Township requesting fire safety plans for the facility as we are looking to replace the wooden dutch door to the kitchen.<br>The date is pending for work completion. The Maintenance Director will provide the Administrator with weekly updates as reported regarding the anticipated timeframe for work completion of door replacement.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br><br>The Administrator and/ or designee will report updates for anticipated work completion to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly until work is completed. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads | |
| K 341 SS=E | Fire Alarm System - Installation<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed | K 341 | | 5/22/23 |

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| K 341 | Continued From page 10<br>at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/11/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to install supervised smoke/heat detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. This deficient practice was observed in 1 of 1 kitchen areas and was evidenced by the following:<br><br>At 12:08 PM, the surveyor and MD observed that the facility failed to provide supervised smoke detection in the kitchen. The surveyor observed no evidence of a smoke detector within 20-feet of the meat/dairy cooking system as required by code.<br><br>The MD confirmed the finding during the kitchen observation. No further information was provided.<br><br>The Administrator was notified of the finding at the Life Safety Code exit conference on 04/11/23.<br><br>NJAC 8:39 -31.2 (a)<br>NFPA 101 2012 edition Life Safety Code 19.3.2.5.3(12) | K 341 | K341<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected by the deficient practice.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents have the potential to be affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>The Administrator provided education to the Maintenance Director on April 12, 2023, ensuring facility installs supervised smoke/heat detection in required areas.<br><br>On May 9th, 2023, the Maintenance | |

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|---|---|---|---|
| | 315068 | A. BUILDING **02**<br>B. WING _____ | **04/20/2023** |

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| K 341 | Continued From page 11 | K 341 | Director installed 3 smoke detectors in the kitchen.<br><br>The Maintenance Director added the new kitchen smoke detectors to the preventative maintenance log utilizing the facility Inspection Report to ensure documentation of proper functioning and will audit the added smoke detectors quarterly.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br><br>The Administrator and/ or designee will report results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 342 SS=E | Fire Alarm System - Initiation<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Initiation<br>Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, | K 342 | | 5/22/23 |

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| K 342 | Continued From page 12<br>and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/11/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 2 of 2 enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9<br><br>The deficient practice was evidenced by the following:<br><br>From approximately 9:30 AM to 1:30 PM the surveyor and the MD, observed in the enclosed courtyards, no evidence of a fire alarm notification (horn/strobe) device in the following enclosed courtyards:<br><br>1). Low-side A-wing<br>2). Low-side B-wing<br><br>An interview was conducted during the observation's and the surveyor asked the MD, if there was a horn/strobe, tied into the fire alarm system within courtyards A & B wing. The MD confirmed that currently there are no horn/strobe devices tied into the fire alarm system in the enclosed courtyard's observed.<br><br>The Administrator was notified of the findings at the Life Safety Code exit conference on 04/11/2023. | K 342 | K342<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected by the deficient practice.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents have the potential to be affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>The Administrator provided education on April 12, 2023, to the Maintenance Director ensuring that fire alarm notification by audible and visible signals are present in required areas.<br><br>On May 9th, 2023, the Maintenance Director requested Contractor quotes to install fire alarm notification devices (horn/strobe) in the low-side A wing courtyard and in the low-side B wing courtyard. | |

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| K 342 | Continued From page 13<br>NJAC 8:39-31.2(a)<br>NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 | K 342 | The date is pending for work completion. The Maintenance Director will provide the Administrator with weekly updates as reported regarding the anticipated timeframe for work completion of installation of alarm notification devices.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br><br>The Administrator and/ or designee will report updates for anticipated work completion to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly until work is completed. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 347 SS=F | Smoke Detection<br>CFR(s): NFPA 101<br><br>Smoke Detection<br>2012 EXISTING<br>Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.<br>19.3.4.5.2<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and documentation review on 04/10/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that there was a testing, maintenance, and battery replacement program to ensure proper | K 347 | K347<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected | 5/22/23 |

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| K 347 | Continued From page 14<br>operation of the battery operated smoke detectors as per NFPA 72.<br><br>This deficient practice was evidenced for 50 of 50 observed battery operated smoke detectors in resident rooms and evidenced by the following:<br><br>A tour of the facility from 9:30 AM, to approximately 2:00 PM, revealed that the facility resident rooms were provided with battery operated smoke detectors. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance and testing documentation, for the testing of the detectors for battery replacement (including the make, model, installation date, type of battery and replacement date). The Maintenance Director provided a "smoke detector check list" indicating room numbers and installation date only, no testing of the function of the smoke detectors were listed.<br><br>In an interview during the observation's, the facility's Maintenance Director, stated that there was no documentation other than a "smoke detector check list " indicating room numbers and date of installation.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 04/11/23 and confirmed the document provided room numbers and date of installation only. The Administrator further confirmed that the battery operated smoke detectors were not tested, inspected, and maintained in accordance with the manufacturer's recommendations.<br><br>NJAC 8:39-31.2(e)<br>NFPA 101 Life Safety Code 2012 edition 19.3.6.1, | K 347 | by the deficient practice.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents have the potential to be affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>On April 12, 2023, the Administrator re-educated the Maintenance staff on the importance of documenting the testing, maintenance, and battery replacement for resident room smoke detectors on A wing and B wing.<br><br>On May 10th, 2023, the Director of Maintenance implemented a testing, maintenance, and battery replacement checklist to ensure proper functioning of resident room smoke detectors on A wing and B wing and will audit the smoke detectors quarterly.<br><br>On May 11th, 2023, the Maintenance Department completed audits of all A wing and B wing resident room smoke detectors.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure? | |

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| K 347 | Continued From page 15<br>19.3.4.5.2 | K 347 | The Administrator and/ or designee will report results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 363 SS=F | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>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 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire | K 363 | | 5/22/23 |

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| K 363 | Continued From page 16<br>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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/10/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.<br><br>This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place.<br><br>This deficient practice was further identified in 34 of 50 resident room doors observed and was evidenced by the following:<br><br>During the building tour from 9:15 AM to 2:00 PM, the surveyor in the presence of the MD and Administrator toured the facility and observed the following:<br><br>Resident Room doors:<br><br># 104 door will not latch into frame, top warped<br># 105 door warped at the top, approximately 1/4" gap | K 363 | K363<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>The following resident rooms were identified as being affected by the deficient practice: 104, 105, 106, #110, #111, #115, #120, #126, #135, #136, #137, #138, #142, #144, #145, #148, #150, #153, #156, #157, #159, #202, #219, #220, #225, #227, #232, and #236.<br><br>The following room door numbers identified do not exist at the facility #244, #246, #250, #314, and #329.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All residents have the potential to be affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to | |

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| K 363 | Continued From page 17<br># 106 door does not latch into frame<br># 110 door does not latch into frame<br># 111 door warped at the top, approximately 1/4" gap<br># 115 door does not latch into frame<br># 120 door warped at the top, approximately 1/4" gap<br># 126 door warped at the top, approximately 1/4" gap<br># 135 door will not latch into frame<br># 136 door warped at the top, approximately 1/4" gap<br># 137 door rubs into its frame<br># 138 door will not latch into frame<br># 142 door will not latch into frame<br># 144 door warped at the top, approximately 1/4" gap<br># 145 door does not latch into frame<br># 146 door has loose hardware<br># 148 door does not latch into frame<br># 150 door does not latch into frame<br># 153 door does not latch into frame<br># 156 door does not latch into frame, door swings closed<br># 157 door frame strike-plate missing.<br># 159 door rubs into frame<br># 202 door will not latch into frame, wooden door comprimised<br># 219 door warped at the top, approximately 1/4" gap<br># 220 door warped at the top, approximately 1/4" gap<br># 225 door warped at the top, approximately 1/4" gap<br># 227 missing latch in frame, door rubs into frame<br># 232 door warped at the top, approximately 1/4" gap<br># 236 door will not latch into frame<br># 244 door will not latch | K 363 | ensure the deficient practice will not recur?<br><br>The Administrator provided education to the Director of Maintenance on April 12, 2023, ensuring that corridor doors are able to resist the passage of smoke.<br><br>The Maintenance Director requested Contractor quotes to replace identified resident room fire doors.<br><br>On May 9th, 2023, facility placed an online request to the Cherry Hill Township requesting fire safety plans for the facility as we are looking to replace resident room fire doors.<br><br>The Maintenance Director will provide the Administrator with weekly updates as reported regarding the anticipated timeframe for installation of the resident room fire doors.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br><br>The Administrator and/ or designee will report updates for anticipated work completion to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly until work is completed. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |

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| K 363 | Continued From page 18<br># 246 door rubs on frame<br># 250 top of door when closed 1/2" opening<br># 314 loose hardware<br># 329 door rubs on frame<br><br>At the time of observations, the surveyor interviewed the MD, who stated and confirmed the above findings.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 04/11/23.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>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 521 SS=F | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/10/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure resident bathroom ventilation systems were adequately maintained and operating in optimal condition, in accordance with the National Fire Protection Association (NFPA) 90 A. This deficient practice was identified for all resident | K 521 | K521<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>The following resident room bathrooms were identified as not having a working ventilation system in the resident | 5/22/23 |

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| K 521 | Continued From page 19<br>room bathrooms vents observed and was evidenced by the following:<br><br>At 11:55 AM, during a tour of the building, the surveyor with the MD, toured the facility and observed that the ventilation<br>systems did not function when the MD applied a piece of single-ply toilet tissue paper across the upper wall grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation.<br><br>The resident room bathrooms were identified as: 201 to 236 on floor #2, 101 to 128 and 136 to 159 on floor #1.<br><br>An interview was conducted with the MD during the observations, and he confirmed the findings. The MD stated the roof unit may have a bad motor and/or a broken fan belt. He stated currently the facility ventilation system in resident rooms was not functioning and the facility did not have a ventilation inspection log or operating check list to provide.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 04/11/23.<br><br>NFPA 90 A Standard for the installation of ventilating systems<br>NFPA 101-2012 -19.5.2.1 section 9.2.1 and 9.2.2<br>NJAC 8:39-31.2(e) | K 521 | bathroom: #201, #236, #101, #128, #136 and #159.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>Resident bathrooms have the potential to be affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>The Administrator provided education on April 12, 2023, to the Director of Maintenance ensuring that resident bathroom ventilation systems are adequately maintained and operating in optimal condition.<br><br>The Maintenance Director requested Contractor quotes to install ventilation system in resident bathrooms on B wing and Saltzman.<br><br>The Director of Maintenance implemented a ventilation inspection log/checklist ensuring proper and functioning ventilation system in resident bathrooms.<br><br>On May 10th, 2023, Elite Contractors along with a Mechanical Engineer from Concord Engineering, toured the facility and specific areas cited, who will provide new drawings/plans to install a new make-up roof unit. Quote and date is | |

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| K 521 | Continued From page 20 | K 521 | pending for work completion. The Maintenance Director will provide the Administrator with weekly updates as reported regarding the anticipated timeframe for work completion of emergency illumination.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br><br>The Administrator and/ or designee will report updates for anticipated work completion to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly until work is completed. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 911 SS=F | Electrical Systems - Other<br>CFR(s): NFPA 101<br><br>Electrical Systems - Other<br>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.<br>Chapter 6 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/10/23, in the presence of the Maintenance Director (MD), the facility did not ensure guarding of live parts of electrical equipment and controls with unlocked panels in resident accessible areas in | K 911 | K911<br><br>What corrective action will be accomplished for those residents affected by the deficient practice? | 5/22/23 |

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| K 911 | Continued From page 21<br>accordance with NFPA 101, 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas for 10 of 16 electrical panels observed.<br><br>While touring the building from 9:30 AM, to 2:30 PM, the<br>surveyor and Maintenance Director (MD), observed open electrical wall panels throughout the facility, that were not locked. The open panels were located in the following exit/egress corridor's of the facility:<br><br>Floor #2 exit/egress corridor<br>Floor #1 A-wing exit/egress corridor<br>Floor #1 B-wing exit/egress corridor<br><br>The observations were confirmed by the MD during the tour of the facility.<br><br>The Administrator was informed of the finding's at the Life Safety Code exit conference on 04/11/23.<br><br>NJAC 8:39-31.2(e)<br>NFPA 70, 99 | K 911 | No residents were identified to be affected by the deficient practice.<br><br>Open electrical panels were identified on floor #2 exit/egress corridor, Floor #1 A wing exit/egress corridor and Floor #1 B wing exit/egress corridor.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>Residents located in the identified areas have the potential to be affected by the deficient practice.<br><br>On April 14th, 2023, the Director of Maintenance completed securing the identified electrical panels.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>On April 12, 2023, the Administrator re-educated the Maintenance Department on the importance of guarding live parts of electrical equipment and controls by locking panels in resident accessible areas.<br><br>On May 10th, 2023, the Director of Maintenance implemented and completed an audit of all electrical equipment control panels to ensure they were locked in resident accessible areas. | |

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| K 911 | Continued From page 22 | K 911 | The Director of Maintenance or designee will audit weekly the electrical equipment control panels to ensure they are locked and will report findings to the administrator.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br>The Administrator and/ or designee will report results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 916 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Alarm Annunciator<br>A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.<br>6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview conducted on 04/11/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that the facility's emergency generator annunciator (one of one) was fully | K 916 | K916<br><br>What corrective action will be accomplished for those residents affected by the deficient practice? | 5/22/23 |

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| K 916 | Continued From page 23<br>functional as evidenced by the following:<br><br>At 11:47 AM, in the presence of the MD, the surveyor observed on floor-1, that the generator annunciator panel at the A-wing nurse station, when tested by the MD, was observed to not be hooked up to the temporary (over 1-year in operation) generator. The MD indicated the annunciator panel was operating correctly and could not provide any further information.<br><br>The Administrator was informed of the finding at the Life Safety Code exit conference on 04/11/23.<br><br>NJAC 8:39-31.2(e)<br>Alarm Annunciator.<br>6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) | K 916 | No residents were identified to be affected by the deficient practice.<br><br>It was identified that the emergency generator annunciator was not functioning.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>Residents have the potential to be affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>On April 12th, 2023, The Administrator re-educated the Maintenance Department on the importance of ensuring the generator annunciator was always functioning.<br><br>On April 12th, 2023, The Maintenance Director contacted P3Generator Service reporting the malfunction of the annunciator panel.<br><br>On May 9th, 2023, P3Generator reported the repair of the annunciator panel is all inclusive of the pending replacement of the generator. P3Generator confirmed receipt of the signed proposals and deposit by facilities corporate office. Date is pending for work completion. | |

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| K 916 | Continued From page 24 | K 916 | The Maintenance Director will provide the Administrator with weekly updates as reported regarding the anticipated timeframe for installation of the generator which will include a new annunciator panel.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br>The Administrator and/ or designee will report updates for anticipated work completion to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly until work is completed. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>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 | K 918 | | 5/22/23 |

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| K 918 | Continued From page 25<br>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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/11/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure a remote manual stop station for one of one generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following:<br><br>At 1:05 PM, the surveyor and MD observed the exterior 125 KW (kilowatt) temporary diesel generator. There was no remote manual stop station observed outside the area of the generator location.<br><br>An interview was conducted during the time of the observation with the MD, who stated and confirmed that the exterior generator did not have | K 918 | K918<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected by the deficient practice.<br><br>The Generator was identified as not being equipped with a remote manual stop station.<br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>Residents have the potential to be affected by the deficient practice. | |

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| K 918 | Continued From page 26<br>a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current temporary generator in service.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 04/11/2023.<br><br>NJAC 8:39-31.2(e), 31.2(g)<br>NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. | K 918 | What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>The Director of Maintenance with provide education to management/supervisors on the generator emergency stop procedure upon installation of the stop button. Date of installation is pending.<br>The Maintenance Director will audit monthly generator checks to ensure integrity of the remote manual stop upon installation.<br><br>The Maintenance Director will provide the Administrator with weekly updates as reported regarding the anticipated timeframe for work completion of the remote manual stop station.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br>The Administrator and/ or designee will report updates for anticipated work completion to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly until work is completed. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 920 SS=E | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords | K 920 | | 5/22/23 |

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| K 920 | Continued From page 27<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/11/23, in the presence of the Maintenance Director, the facility failed to prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard.<br><br>This deficient practice was idenitified in 5 of 5 extension cords observed and was evidenced by | K 920 | K920<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected by the deficient practice.<br><br>One black extension cord was identified in the floor 2 dayroom electrical closet. The Maintenance Director immediately removed the extension cord.<br><br>A black extension cord was identified to be installed into the drop ceiling tiles in the | |

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| K 920 | Continued From page 28<br>the following:<br><br>1). At 10:19 AM, the surveyor and Maintenance Director observed in the floor 2 day room electrical closet that one (1)black extension cord was plugged into a duplex wall outlet. The yellow plug installed on the black extension cord was not the original plug. The modified extension cord was then installed into the drop ceiling feeding an unknown source.<br><br>The Maintenance Director indicated he was not sure who modified the extension cord and why it was installed into the drop ceiling.<br><br>2). At 11:40 AM, the surveyor and Maintenance Director, observed in the main kitchen that four (4) black extension cords were supplying power to 4-kitchen appliances. The black extension cords were observed to be installed into the drop ceiling tiles and plugged into an unknown power source in the ceiling.<br><br>The finding was verified by the Maintenance Director at the time of the observations, where he stated and confirmed that extensions cords were not a substitute for fixed wiring installed into the ceiling and then to an unknown power source.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference on 04/11/23.<br><br>Extension cords are not used as a substitute for fixed wiring of a structure.<br><br>NJAC 8:39-31.2(e)<br>NJAC 8:39-31.7(g) | K 920 | main kitchen supplying power to 4 kitchen appliances. The Maintenance Director contacted contractors to properly install fixed wiring to the power supply.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>Residents have the potential to be affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>On April 12, 2023, the Administrator provide education to the Maintenance Department on the importance of not utilizing extension cords as a substitute for fixed wiring installation.<br>On May 5th, 2023, Prime Electric toured the facility and specific areas cited. Prime Electric provided an estimate for the work on May 9th, 2023. Date is pending for work completion.<br><br>The Maintenance Director will provide the Administrator with weekly updates as reported regarding the anticipated timeframe for work completion of emergency illumination.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br>The Administrator and/ or designee will | |

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| K 920 | Continued From page 29 | K 920 | report updates for anticipated work completion to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023 and then monthly until work is completed. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |
| K 923 SS=F | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." | K 923 | | 5/22/23 |

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| K 923 | Continued From page 30<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 04/11/23 in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide storage of cylinders outdoors in an enclosure, secured against unauthorized entry, protected against extremes of weather and from the ground beneath to prevent rusting in accordance with NPFA 99, 2012 Edition Sections 11.3.1, 11.3.2, 11.3.3 and 11.3.4. The deficient practice was evidenced for one of one outdoor oxygen cylinder storage areas observed.<br><br>At 10:49 AM, the surveyor and MD observed outside the facility (off the kitchen area), that 19 portable oxygen cylinders were being stored directly on the ground in a cage unprotected against extremes of weather and from the ground beneath to prevent rust.<br><br>The findings were verified by the Maintenance Director at the time of the observation.<br><br>It was noted that this deficiency was cited on 03/31/2017 at this facility.<br><br>The Administrator was informed of the finding at the Life Safety Code exit conference on 04/11/23. | K 923 | K923<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>No residents were identified to be affected by the deficient practice.<br><br>It was identified that 19 portable oxygen cylinders were stored outside directly on the ground in a cage unprotected again extremes of weather rand from the ground beneath to prevent rust.<br><br>The Maintenance Director relocated the portable oxygen cylinders to an outdoor enclosed area, protected against extremes of weather and from the ground beneath to prevent rusting.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>Residents have the potential to be affected by the deficient practice. | |

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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 923 | Continued From page 31<br>NJAC 8:39-31.2(e)<br>NFPA 99 | K 923 | The Maintenance Director relocated the portable oxygen cylinders to an outdoor enclosed area, protected against extremes of weather and from the ground beneath to prevent rusting.<br><br>What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?<br><br>On April 12, 2023, the Administrator re-educated the Maintenance Department on the importance of storing portable oxygen cylinders in an outdoor enclosed area, protected against extremes of weather and from the ground beneath to prevent rusting.<br><br>The Director of Maintenance or designee will audit weekly x4 weeks and then 2x a week for 2 months that portable oxygen cylinders are stored in an outdoor enclosed area, protected against extremes of weather and from the ground beneath to prevent rusting, weekly x4 weeks and then 2x a week for 2 months.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recure?<br>The Administrator and/ or designee will report results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315068 | A. BUILDING **02**<br>B. WING _____ | **04/20/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **DWELLSIDE CARE AND REHAB** | **3025 CHAPEL AVENUE WEST**<br>**CHERRY HILL, NJ 08002** |

| (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 |
|---|---|---|---|---|
| | | | | |

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 |
|---|---|---|
| 315068 Y1 | A. Building 02 - JEWISH GERIATRIC<br>B. Wing Y2 | 6/8/2023 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DWELLSIDE CARE AND REHAB | 3025 CHAPEL AVENUE WEST<br>CHERRY HILL, NJ 08002 |

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 K0211 | 05/22/2023 | LSC K0281 | 05/22/2023 | LSC K0293 | 05/22/2023 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0321 | 05/22/2023 | LSC K0341 | 05/22/2023 | LSC K0342 | 05/22/2023 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0347 | 05/22/2023 | LSC K0363 | 05/22/2023 | LSC K0521 | 05/22/2023 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0911 | 05/22/2023 | LSC K0916 | 05/22/2023 | LSC K0918 | 05/22/2023 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # | Completed |
| LSC K0920 | 05/22/2023 | LSC K0923 | 05/22/2023 | 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 | |
|---|---|
| 4/20/2023 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |