STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315205	A. BUILDING **01** B. WING ___	**03/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	**TWO COOPER PLAZA** **CAMDEN, NJ 08103**

(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 03/08/2023 and 03/09/2023 and Majestic Center Rehab. and Sub-Acute Care was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Majestic Center Rehab. and Sub-Acute Care is a Three-story, Type I Fire Resistant building that was built in January 1980. The facility is divided into 8 smoke zones. The facility has one Diesel emergency generator.	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/08/2023 in the presence of facility management, it was determined that the facility failed to: 1.) Provide a battery backup emergency light above one (1) of one (1) emergency generator transfer switch, independent of the building's electrical system and emergency generator and 2.) provide a functioning battery back up emergency light above the emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1.	K 291	K291 Element One - Corrective Action: The facility installed a battery backup emergency light above the emergency generator transfer switch. The light is independent of the building's electrical system and emergency generator. The facility repaired the battery backup emergency light located above the emergency generator. The installation of the new light and the repair of the existing	3/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/02/2023

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 291	Continued From page 1 This deficient practice was evidenced by the following: On 03/08/2023 (day one of life safety code survey), during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD). The surveyor asked if the facility had an Emergency Generator. The LMDS told the surveyor, "yes we a Diesel Generator". Starting at approximately 10:05 AM on 03/08/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted. On 03/08/2023: 1.) At approximately 11:07 AM, an inspection in the basement, where the emergency generator was located was performed. The surveyor observed one battery back up emergency light mounted on the wall above the emergency generator. A request was made to the LMSD to press the test button on the emergency light. When the LMDs pressed the test button, the light did not function properly. 2.) At approximately 11:09 AM, an inspection inside the main electrical room where the emergency generator's transfer switch was located was performed. The surveyor observed no evidence of a battery back up emergency light for the generator's transfer switch. At this time the surveyor made a request to the LMDS and asked, do you have a battery back up emergency light in here for the generator transfer	K 291	light were completed. Element Two - Identification of Other Residents: The facility inspected and tested all of the battery backup emergency lights located in the facility in order to identify other lights that may have been affected by the deficient practice. All the lights were found to be operational. Element Three - Systemic Change: The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. The emergency lighting system is to be inspected monthly as part of the facility's preventative maintenance program. The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect the emergency lights monthly, document all inspections, and make timely repairs when necessary. Element Four - Quality Assurance: The facility's Administrator or designee shall inspect the facility's emergency lights weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, for a period of three months, the Administrator or designee shall review the monthly	

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K 291	Continued From page 2 switch? The LMDS told the surveyor, "No". The LMDS and MD confirmed the finding at the time of observation. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	preventative maintenance inspection logs completed by the Maintenance Director. Any required repairs will be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review the facility's emergency lighting as part of the QAPI process. Completion Date: 3/31/2023	
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 03/08/2023 and 03/09/2023, in the presence of facility Management it was determined that the facility failed to ensure that one (1) of 11 exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following,	K 311	K311 Element One - Corrective Actions: The facility repaired the [redacted] floor stairway [redacted] corridor exit access door. The door now latches properly into its frame. The facility inspected and tested all of the corridor exit access doors leading into exit stairways in order to identify other doorways that may be affected by the	3/31/23

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K 311

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On 03/08/2023 (day one of the life safety code survey), during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility was a three-story building with a basement. There are three (3) exit stairways with two (2) stairways going to the basement.

Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted.
Along the two (2) day tour the surveyor performed a closure test of eleven [redacted] corridor exit access doors leading into exit stairways with the following results,

1.) On 03/08/2023 at approximately 12:15 PM, during a closure test of the [redacted] floor stairway [redacted] corridor exit access door, the door did not positive latch into its frame. This test was repeated two additional times with the same results.
The surveyor observed that door had no means to positive latch.

The stairwell doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire.

The LMDS and MD confirmed the finding at the

K 311

same deficient practice. All doors were found to be working properly, latching into their door frames.

Element Two - Identification of at Risk Residents:
All residents have the potential to be affected by this practice.

Element Three Systemic Change:
The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. Emergency exits and corridor exit access doors are to be inspected monthly as part of the facility's preventative maintenance program.

The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect all emergency exits and corridor exit access doors monthly. Specifically, the Maintenance Director was instructed to test all such doors to ensure that the doors latch properly into their door frames. The inspections and any required repairs are to be documented and retained for further review.

Element Four - Quality Assurance:
The facility's Administrator or designee shall inspect the facility's emergency exits and corridor exit access doors weekly for a period of four weeks, and then monthly

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K 311	Continued From page 4 time. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023 at approximately 12:50 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311	for a period of three months to ascertain the effectiveness of the preventive measures. In addition, for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director to determine that the emergency exits and corridor exit access doors were inspected and any required repairs were completed timely. Any required repairs will be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review the facility's emergency exits and corridor access doors as part of the QAPI process. Completion Date: 3/31/23	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		3/31/23

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K 321	Continued From page 5 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 03/08/2023 and 03/09/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, 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. This deficient practiced was evidenced by the following: On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms in the facility. A review of the facility provided lay-out identified the facility is a three-story building with a	K 321	K321 Element One - Corrective Actions: The facility reconnected the automatic door closure found on the Dietician's room corridor door. The facility installed an automatic door closure on the corridor door of the Environmental Services room. Both repairs were completed. The two rooms now have self closing corridor doors. The Dietician and Environmental Service Director received in-service training from the Administrator regarding their respective areas, and were instructed that the doors must remain self-closing and at no time should the doorways be left opened to the corridor. The facility inspected and tested all of the corridor exit access doors located in hazardous areas including the basement, boiler rooms, laundry and soiled linen	

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K 321

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basement.

Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted.
Along the tour of the facility, in the presence of the LMDS and MD the surveyor observed the following hazardous areas that failed to have smoke resisting doors:

1.) On 03/08/2023 at approximately 10:15 AM, an inspection in the basement level Dieticians room was performed. The surveyor observed that this room connected to the Environmental Services room.
The surveyor observed that the Dieticians corridor doors automatic door closure had been disconnected.
The corridor door for the Environmental Services room had no automatic door closure.
The surveyor observed in both rooms multiple combustible cardboard boxes and multiple diaper boxes.
The surveyor observed both corridor doors had no means to self-close and the both connected rooms were larger than 50 square feet each.

With these corridor doors not self-closing this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.

The LMDS and MD confirmed the finding at the time of observation.

The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023.

K 321

rooms, maintenance and repair areas, paint storage areas, trash collection rooms, and combustible storage areas, in order to identify other doorways that may be affected. All doors were found to be working properly, with automatic self-closing door closures.

Element Two - Identification of at Risk Residents:
All residents have the potential to be affected by this practice.

Element Three Systemic Change
The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. Doorways in hazardous areas are to be inspected monthly as part of the facility's preventative maintenance program.

The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect all corridor access doors located in hazardous areas monthly. Specifically, the Maintenance Director was instructed to inspect and test all such doors to ensure that the doors are self closing and latch properly into their door frames. The inspections and any required repairs are to be documented and retained for further review.

Element Four - Quality Assurance:

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K 321	Continued From page 7 NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	The facility's Administrator or designee shall inspect the facility's corridor access doors located in hazardous areas weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director to determine that the doors were inspected and any required repairs were completed timely. Any items needing repair will be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review the facility's corridor access doors located in hazardous areas as part of the QAPI process. Completion Date: 3/31/23	
K 351 SS=F	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.	K 351		3/31/23

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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, interview and review of facility provided documentation on 03/08/2023 and 03/09/2023, in the presence of facility management it was determined that: 1.) the Facility failed to properly install sprinklers, 2.) the Facility failed to ensure sidewall spray sprinklers were installed at the bottom of the elevator hoist-way not more than two (2) ft (0.61m) above the floor of the pit that contained combustible hydraulic fluids, 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, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy.

The deficient practice is evidenced by the following,

On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke

K 351

K351
Element One - Corrective Action:
The facility contracted with its fire sprinkler provider to install the required fire sprinkler escheon caps in the following rooms/areas:
" Basement level Maintenance Shop bathroom
" Resident Room [redacted] bathroom
" [redacted]
" [redacted] Floor Soiled Utility room
" [redacted] Floor Housekeeping closet
" Physical Therapy ADL suite

The facility contracted with its fire sprinkler provider for the installation of fire sprinkler protection in the Emergency Generator room and in Elevator #1 hoist-way.

Element Two - Identification of Other Residents:
The facility inspected all rooms and areas in order to identify other rooms and areas that may have missing fire sprinkler escheon caps. All rooms and areas were found to have the escheon caps with no gaps in the ceiling tiles.

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K 351	Continued From page 9 compartments in the facility. A review of the facility provided lay-out identified there are three (3) floors and a basement in the facility. Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted. Along the two day tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 03/08/2023: 1.) At approximately 10:18 AM, the surveyor observed inside the basement level Maintenance shop bathroom one fire sprinkler had no escheon cap. This left an approximately 3/8 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 2.) At approximately 11:02 AM, an inspection inside the basement level Emergency Generator room was performed. The surveyor observed no evidence of fire sprinkler protection inside the 18' by 20'-6" generator room. At this time the surveyor made a request to the LMDS, "Do you see any fire sprinkler coverage in this room?" The LMDS looked up and around the room and said, "No". 3.) At approximately 11:54 AM, the surveyor observed inside Resident room [redacted] bathroom one fire sprinkler had no escheon cap. This left an approximately 1/4 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler	K 351	The facility inspected all rooms and areas to identify other rooms and areas that may not have fire sprinklers. All rooms were and were found to have fire sprinklers. Element Three - Systemic Changes: The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. Rooms and areas are inspected at least quarterly in order to identify needed repairs. Sprinkler heads are observed during the room inspections to determine that the sprinkler heads are free from dust and dirt and that escheon caps are in place to eliminate gaps in ceiling tiles. The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect all rooms and areas quarterly. As part of the inspection process, the Maintenance Director is to observe sprinkler heads and escheon caps to ensure that the sprinkler heads are free from dust and dirt and the escheon caps are in place to eliminate any gaps between the sprinkler head and ceiling tiles. The inspections and any required repairs are to be documented and retained for further review. Element Four - Quality Assurance: The facility's Administrator or designee shall on a randomly selected basis,	

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K 351	Continued From page 10 in the area and not activate the fire sprinkler system. 4.) At approximately 12:17 PM, the surveyor observed inside the [redacted]. floor [redacted] closet one fire sprinkler had no escheon cap. This left an approximately 3/8 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. On 03/09/2023: 5.) At approximately 10:54 AM, during a tour of the building the surveyor observed an elevator contracted mechanic had the outer elevator doors on the basement level in the open position while he was working inside elevator [redacted] hoist-way. The surveyor observed that there were not fire sprinklers at the bottom of the hoist-way. At this time the surveyor asked the elevator mechanic, "Are there fire sprinklers at the top or bottom of the elevator hoist-way?" The elevator mechanic told the surveyor, "no there is only smoke detection". 6.) At approximately 11:10 AM, the surveyor observed inside the [redacted] floor Soiled Utility room one fire sprinkler that had no escheon cap. This left an approximately 3/8 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 7.) At approximately 11:55 AM, the surveyor observed inside the [redacted] floor Housekeeping closet one fire sprinkler had no escheon cap. This left an approximately 3/8 of an inch gap in the ceiling	K 351	inspect ten rooms or areas in the facility weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, monthly for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director pertaining to fire safety. Any required repairs will be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review sprinkler heads and escheon caps throughout the facility as part of the QAPI process. Completion Date: 3/31/2023	

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	315205	A. BUILDING **01** B. WING	**03/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	**TWO COOPER PLAZA** **CAMDEN, NJ 08103**

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K 351	Continued From page 11 tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 8.) At approximately 12:35 PM, the surveyor observed inside the Physical Therapy ADL suite bathroom one fire sprinkler had no escheon cap. This left an approximately 1/4 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. The LMDS confirmed the finding at the time. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023 at approximately 12:50 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
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 and review of facility documentation on 03/08/2023 and 03/09/2023 in the presence of facility management, it was determined that the facility failed to: 1.) perform a	K 355	K355 Element One - Corrective Action: The facility contracted with its fire safety provider to perform an annual inspection	3/31/23

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K 355 Continued From page 12

monthly examination for 18 of 25 portable fire extinguishers, 2.) maintain one (1) of 25 portable fire extinguisher in proper working condition, 3.) perform Hydrostatic testing for one (1) of 25 fire extinguishers,
as required by National Fire Protection Association 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 thereafter 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), 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 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification.

The findings include the following:

On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to

K 355

and maintenance of its portable fire extinguishers. Inspection was completed.

The facility inspected all portable fire extinguishers and recorded the inspection on a label attached to the fire extinguishers. All extinguishers were found to be properly charged and ready for use with the following exceptions:
" The ABC type extinguisher in the corridor that was last inspected in April 2018 was removed from service and replaced with a new ABC type extinguisher.
" The ABC type extinguisher near the corridor smoke doors and last Hydrostatic tested April 2014 was removed and replaced with a new ABC type extinguisher.
" The ABC type extinguisher FI, E-18 was removed during the life safety inspection and replaced with a charged ABC type extinguisher.

All portable fire extinguishers were inspected during the Life Safety Inspection by the surveyor together with facility maintenance staff. No other portable fire extinguishers were identified to be effected.

Element Two - Identification of Other Residents:
All residents have the potential to be affected by this practice.

Element Three Systemic Change
The facility's Administrator and Lead Maintenance Director reviewed the

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the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted.
Along the two day tour of the facility the surveyor observed and inspected twenty five (25) portable fire extinguishers with twenty-four (24) extinguishers that were last annually inspected April 2022 in various locations with the following issues identified:

On 03/08/2023:
On the Basement level,
1.) One ABC Type fire extinguisher, facility identification number (FI), E-4 in the elevator mechanical room was missing monthly visual examination performed and documented for May, June, July, August, September, October, November, December 2022 and January 2023.

2.) One ABC Type fire extinguisher in the corridor was last annually inspected April 2018.

3.) One ABC Type fire extinguisher near stairwell two (2) was missing a monthly examination for October 2022.

4.) One ABC Type fire extinguisher in the Boiler room was missing a monthly examination for October 2022.

5.) One ABC Type fire extinguisher FI, E-7 was missing a monthly examination for October 2022.

K 355

facility's policies and procedures pertaining to preventative maintenance. Portable fire extinguishers are inspected monthly in order to identify any extinguishers that need to be replaced.

The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect all portable fire extinguishers monthly at approximately 30 day intervals, and to record such inspections by recording the date and the initials of the person performing the inspection on a label attached to the fire extinguishers. The Maintenance Director was instructed to replace fire extinguishers found with insufficient charge and return such to the facility's fire safety provider. The Maintenance Director is responsible to arrange annual inspections of the fire extinguishers with the fire safety provider.

Element Four - Quality Assurance:
The facility's Administrator or designee shall on a randomly selected basis, inspect ten portable fire extinguishers weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director, specifically the monthly inspection logs for

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K 355	Continued From page 14 On the Third floor, 6.) One ABC Type fire extinguisher near the corridor smoke doors was last Hydrostatic tested April 2014 and missing a monthly examination for October 2022. 7.) One ABC Type fire extinguisher FI, E-23 was missing a monthly examination for October 2022. 8.) One ABC Type fire extinguisher FI, E-25 was missing a monthly examination for October 2022. 9.) One ABC Type fire extinguisher in the corridor near stairwell one (1) was missing a monthly examination for October 2022. 10.) One ABC Type fire extinguisher at the Nursing Station was missing a monthly examination for October 2022. On 03/09/2023: On the Second floor, 11.) One ABC Type fire extinguisher FI, E-20 was missing a monthly examination for October 2022. 12.) One ABC Type fire extinguisher FI, E-18 pressure indicating needle was in the "RED" discharge zone on the pressure gauge and was missing a monthly examination for October 2022. This fire extinguisher would not function properly in the event of a fire. At this time the surveyor requested that the MD replace the fire extinguisher with an available facility spare fire extinguisher. On the First floor, 13.) One ABC Type fire extinguisher FI, E-13 was	K 355	the fire extinguishers. Any required findings shall be corrected immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review fire extinguishers throughout the facility as part of the QAPI process. Completion Date: 3/31/23	

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K 355	Continued From page 15 missing a monthly examination for May 2022 and June 2022. 14.) One ABC Type fire extinguisher FI, E-12 was missing a monthly examination for June 2022. 15.) One ABC Type fire extinguisher FI, E-14 was missing a monthly examination for October 2022. 16.) One Class "K" Wet Chemical" extinguisher in the kitchen was missing a monthly examination for November and December 2022. 17.) One ABC Type fire extinguisher FI, E-16 was missing a monthly examination for May and June 2022. 18.) One ABC Type fire extinguisher FI, E-11 was missing a monthly examination for October 2022. 19.) One ABC Type fire extinguisher FI, E-9 was missing a monthly examination for October 2022. The LMDS confirmed the finding at the time. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's	K 521		3/31/23

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K 521	Continued From page 16 specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 03/08/2023 and 03/09/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were: 1.) being properly maintained for three (3) of seven (7) Resident bathroom exhaust systems and 2.) provide a bathroom exhaust system for one (1) of seven (7) Resident bathrooms, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. The surveyor also requested mow many Resident sleeping rooms were in the facility. The MD told the surveyor that there are sixty-four (64) Resident sleeping rooms. A review of the facility provided lay-out identified that the facility was a three-story building with sixty-four (64) Resident sleeping rooms.	K 521	K521 Element One - Corrective Action: The facility repaired the bathroom exhaust system for resident rooms [redacted] [redacted], and [redacted]. Element Two - Identification of at Risk Residents: All Residents have the potential to be affected by this practice. Element Three - Systemic Changes: The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. The bathroom exhaust systems are inspected at least quarterly as part of the resident room quarterly inspections. The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect the exhaust systems located in the resident rooms during the quarterly resident room inspections to verify that the exhaust systems are operating properly. Any exhaust system not working	

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K 521	Continued From page 17 Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted. Along the two (2) day building tour the surveyor inspected seven (7) Resident sleeping rooms. 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 3 of 7 resident bathrooms in the following locations: On 03/08/2023, 1.) At approximately 11:35 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the LMDS and MD that 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 11:38 AM, inside Resident room [redacted] 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 11:54 AM, inside Resident room [redacted], the surveyor observed no evidence of an exhaust system in the bathroom. At this time the surveyor asked the LMDS, "Do you see an exhaust system in the bathroom?" The LMDS looked up and around the bathroom and said, "No". The surveyor observed that the bathroom had no window with an area that would open.	K 521	properly should be reported to the Administrator so that appropriate repairs can be arranged. Element Four - Quality Assurance: The facility's Administrator or designee shall on a randomly selected basis, inspect ten exhaust systems in resident rooms weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, monthly for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director, specifically the resident room inspection logs to determine if the bathroom exhaust systems are inspected and working properly. Any required repairs shall be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review the bathroom exhaust systems throughout the facility as part of the QAPI process. Completion Date: 3/31/23	

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K 521	Continued From page 18 This bathroom would rely on mechanical ventilation. 4.) At approximately 12:01 PM, inside Resident room [redacted] 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 LMDS and MD confirmed the finding at the time of observation. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 911 SS=E	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 observation on 03/08/2023 and 03/09/2023, in the presence of facility management, it was determined that the facility failed to ensure that two (2) of 11 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection.	K 911	K911 Element One - Corrective Action: The facility replaced the Ground-Fault Circuit Interrupter (GFCI) electrical outlets located to the right of the sink in the Maintenance Shop bathroom and located to the right of the sink in the [redacted] Floor Day/Dining Room.	3/31/23

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K 911

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This deficient practice was evidenced by the following:

Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) a tour of the facility was conducted.

During tour, the surveyor observed and tested eleven (11) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following,

1.) On 03/08/2023 at approximately 10:18 AM, the surveyor observed inside the basement level Maintenance shop bathroom, one (1) GFCI electrical outlet to the right of a sink in the room. When the surveyor tested the GFCI electrical outlet with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code.

2.) On 03/08/2023 at approximately 11:48 AM, the surveyor observed inside the [redacted] floor Day/ Dining room a Duplex electrical outlet sixteen (16") inches to the right of a sink. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code.

The LMDS and MD confirmed the finding at the time of observation.

The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023.

K 911

The facility inspected all GFCI electrical outlets to identify other GFCI outlets that may have been affected. All GFCI outlets were found to be operating properly.

Element Two - Identification of Other Residents:
All residents have the potential to be affected by this practice.

Element Three Systemic Change
The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. GFCI electrical outlets are inspected at least quarterly as part of the facility's resident rooms and other areas quarterly inspections.

The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect the GFCI electrical outlets located in the residents' rooms and other areas throughout the facility during the quarterly room inspections. The Maintenance Director was instructed to use a GFCI tester to de-energize the outlet during testing and replace any non-operating GFCI outlets.

Element Four - Quality Assurance
The facility's Administrator or designee shall on a randomly selected basis,

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K 911	Continued From page 20 NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	inspect ten GFCI electrical outlets weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, monthly for a period of three months, the Administrator or designee shall review the preventative maintenance inspection logs completed by the Maintenance Director, specifically the resident room inspection logs to determine if the GFCI outlets were inspected and working properly. Any needed repairs shall be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review GFCI electrical outlets throughout the facility as part of the QAPI process. Completion Date: 3/31/23	
K 918 SS=E	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. 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	K 918		3/31/23

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MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	**TWO COOPER PLAZA** **CAMDEN, NJ 08103**

(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 21 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 observation and interview on 03/08/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for one (1) of 1 emergency generator 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 was evidenced by the following: On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which	K 918	K918 Element One - Corrective Action: The facility installed a remote Emergency Stop button for the emergency generator. Element Two - Identification of Other Residents: All residents have the potential to be affected by this issue. The facility has one emergency generator. No other emergency generators are on-site. Therefore all emergency generators are affected by this deficient practice. Element Three - Preventive Measures: The facility's Administrator and Lead Maintenance Director reviewed the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315205	A. BUILDING **01** B. WING ______	**03/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 22 identifies the various rooms and smoke compartments in the facility. The surveyor also asked if the facility had an Emergency Generator. The LMDS told the surveyor, yes we a Diesel Generator. Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted. On 03/08/2023 at approximately 11:07 AM, an inspection in the basement, where the emergency generator was located was performed. The surveyor observed no evidence of a remote Emergency Stop button for the Emergency Generator. At this time a request was made to the LMDS, do you have a remote Emergency Stop button for the generator. The LMDS told the surveyor, "There is no E-stop." The LMDS and MD confirmed the finding at the time of observation. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	facility's policies and procedures pertaining to operation of the emergency generator. The policies and procedures were amended to include the recently installed Emergency Stop button. The Emergency Stop button will be tested during the semi-annual independent inspection of the emergency generator by the facility's emergency generator provider. The Administrator, Lead Maintenance Director, and recently hired Maintenance Director received in-service training regarding the installation and proper use of the emergency generator's remote Emergency Stop button by the facility's contracted emergency generator provider. Testing of the remote Emergency Stop button shall be completed during the semi-annual generator inspections conducted by the contracted provider. Element Four - Quality Assurance: The facility's Administrator or designee shall review the semi-annual emergency generator inspection reports to verify that the remote Emergency Stop button was tested and worked properly, as well as to identify other aspects of the emergency generator that may require repair or service. In addition, the Administrator or designee shall inspected monthly for six months, the facility's monthly emergency generator records to determine the facility's compliance with its policies and procedures and required regulations. Any repairs will be completed immediately. Thereafter the members of the Quality	

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	315205	A. BUILDING **01** B. WING ___	**03/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 23	K 918	Assurance Performance Improvement (QAPI) committee shall review the emergency generator logs and records as part of the QAPI process. Completion Date: 03/31/2023	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315205	A. Building 01 - MAIN BUILDING 01 B. Wing	4/27/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	TWO COOPER PLAZA CAMDEN, NJ 08103

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 Reg. # NFPA 101 LSC K0291	Correction Completed 03/31/2023	ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 03/31/2023	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 03/31/2023
ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 03/31/2023	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 03/31/2023	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 03/31/2023
ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 03/31/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 03/31/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
3/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO