STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 10/31/2022 and 11/01/2022 and Promedica Skilled Nursing at West Depthford was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Promedica Skilled Nursing at West Depthford is a two-story, Type II Protected building that was built in June 1987. The facility is divided into 9 smoke zones.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/31/2022, in the presence of facility management, it was determined that the facility failed provide a battery backup emergency light above 1 of 1 emergency generator transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following:	K 291	A. Back up battery emergency light was installed at the generator transfer switch in the main electrical room. B. Current residents have the potential of being affected by this practice. C. Nursing Home Administrator will educate Maintenance Director of the need to have a battery back up light at the emergency generators transfer switch in the main electrical room.	12/13/22

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

Electronically Signed | 11/16/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 291	Continued From page 1 On 10/31/2022 during the survey entrance at 09:52 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and if the facility had an emergency generator. The MD said, yes we have an emergency generator. During the building tour on 10/31/2022 with the facility MD at approximately 11:26 AM, an inspection inside the Main Electrical room where the emergency generator's transfer switch is located was performed. The surveyor observed no evidence of a battery back up emergency light in the room. At that time the surveyor asked the MD, "Do you have a battery back up emergency light in the room." The MD looked around and said, No, I don't see one. The MD confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference at 1:32 PM on 11/01/2022. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	D. Nursing Home Administrator or designee will conduct random audits monthly x3 to ensure a battery back up emergency light is present at the generator transfer switch in main electrical room. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	
K 311 SS=E	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.	K 311		12/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 311	Continued From page 2 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 on 10/31/2022 and 11/01/2022 in the presence of facility Management, it was determined that the facility failed to ensure that a.) 1 of 2 Laundry chute doors closed and positive latched into its frame and b) 1 of 8 exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This deficient practice was evidenced by the following, On 10/31/2022 starting at 10:13 AM and continued on 11/01/2022, a tour of the building in the presence of the Corporate Regional Maintenance (CRM) and Maintenance Director (MD) was performed. Along the two day tour when the surveyor performed a closure test of one (1) 1-1/2 hour fire rated doors leading into the stairwell and one (1) laundry chute door did not positive latch into their frames as required by code to maintain the fire rated construction in the following location, a.) On 10/31/2022 at approximately At 10:33 AM, a closure test of the second floor laundry chute door was performed. When the surveyor opened the chute door to a 90 degree opening to the frame and allowed the door to self-close, the door did not close and positive latch into its frame as required to maintain the fire rating.	K 311	A. Laundry Shute door was removed and wall sealed. Identified exit access stairwell door was fixed to ensure positive latch. B. Current residents have the potential of being affected by this practice. C. Nursing Home Administrator will educate Maintenance Director of the need to ensure doors positively latch. D. Maintenance Director will conduct random audits weekly x4 and monthly x2, to ensure laundry shute and exit access stairwell doors positively latch. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 311	Continued From page 3 The door left an approximately 1-1/2 inch opening to the frame. On 11/01/2022 at 9:44 AM, a second test of the second floor laundry chute door was performed. When the surveyor opened the chute door to a 90 degree opening to the frame and allowed the door to self-close, the door did not close and positive latch into its frame as required to maintain the fire rating. The door left an approximately 1-1/2 inch opening to the frame. This test was repeated two additional times with the same results. b.) On 10/31/2022 at approximately 10:20 AM, a closure test of the second floor exit access stairwell door next to Resident room #224 was performed. When the surveyor opened the door to a 90 degree opening to the frame and allowed the door to self-close, the door did not close and positive latch into its frame to maintain the fire rated construction. This test was repeated two additional times with the same results. On 11/01/2022 at approximately 9:47 AM, a second test of the second floor exit access stairwell door next to Resident room #224 was performed. When the surveyor opened the door to a 90 degree opening to the frame and allowed the door to self-close the door did not close and positive latch into its frame to maintain the fire rated construction. This test was repeated two additional times with the same results. The fire rated doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to pass from one floor to	K 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 311	Continued From page 4 another floor and enter the exit stairwell in the event of a fire. The MD confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference at 1:32 PM on 11/01/2022. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation on 10/31/2022 and 11/01/2022, in the presence of facility	K 353	A. Ceiling tiles replaced in Kitchen's HVAC room and Boiler room. Commercial	12/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 353	Continued From page 5 management, it was determined that the facility failed to maintain the sprinkler system by ensuring that the ceiling was fire/ smoke resistant in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. This deficient practice was evidenced by the following: On 10/31/2022 (day one of survey) during the survey entrance at 09:52 AM, a request was made to the Administrator 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 10/31/2022 at 10:13 AM and continued on 11/01/2022 in the presence of the Corporate Regional Maintenance (CRM) and facility MD a tour of the building was conducted. The surveyor observed the following areas that failed to maintain the facility's ceiling for the proper activation of the fire sprinkler system, 1) At 11:15 AM, in the Main Kitchen's Heating, Ventilation and Air Conditioning (HVAC) mechanical room the surveyor observed one ceiling tile missing with one (1) down pendant type fire sprinkler head in the open ceiling grid. This would allow for the passage of heat and smoke into the space above which would delay the activation of the fire sprinkler system. 2) At 11:27 AM, in the Boiler room the surveyor observed one (1) 2 feet by 4 feet ceiling tile missing with one (1) down pendant type fire sprinkler head in the open ceiling grid.	K 353	laundry room ceiling was repaired. Wall fire sprinkler by commercial dryer 3 was cleaned. B. Current residents have the potential of being affected by this practice. C. Nursing Home Administrator will educate Maintenance Director of the need to ensure ceiling tiles are present, ceiling wallboards do not have penetrations, and laundry room sprinkler heads are kept free from dust. D. Maintenance Director will conduct random audits weekly x4 and monthly x2, to ensure ceiling tiles are present, ceiling wallboards do not have penetrations, and laundry room sprinkler heads are kept free from dust. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 353	Continued From page 6 This would allow for the passage of heat and smoke into the space above which would delay the activation of the fire sprinkler system. 3) At 11:34 AM, in the Commercial Laundry room the surveyor observed an approximately ten (10) inch by ten (10) inch hole in the rooms wallboard ceiling. This would allow for the passage of heat and smoke into the space above which would delay the activation of the fire sprinkler system. 4) At 11:37 AM, in the Commercial Laundry room behind the three (3) commercial dryer, the surveyor observed one side wall fire sprinkler head had a large amount of dust covering the sprinkler head. With the sprinkler covered in dust this would delay the activation of the fire sprinkler in the event of a fire. The CRM and MD confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference at 1:32 PM on 11/01/2022. NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1.	K 353		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid	K 374		12/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 374	Continued From page 7 bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations interview and review of facility provided documentation on 10/31/2022 and 11/01/2022, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 3 of 7 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a door shall be a maximum of 3/4 of an inch. On 10/31/2022 during the survey entrance at 09:52 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility A review of the facility provided lay-out identified that there are two (2) sets of corridor double	K 374	A. Identified smoke barrier corridor doors by 109 and 107 were repaired. B. Current residents have the potential to be affected by this practice. C. Nursing Home Administrator will educate Maintenance Director of the need to ensure the bottom of smoke barrier corridor doors are not more than 3/4 of an inch when self-closed into their frame. D. Maintenance Director will conduct random audits weekly x4 and monthly x2, to ensure the bottom of smoke barrier corridor doors are not more than 3/4 of an inch when self-closed into their frame. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 374	Continued From page 8 smoke doors on the 2nd. floor and four (4) sets of corridor smoke doors on the 1st. floor. On 10/31/2022 and 11/01/2022, in the presence of the Corporate Regional Maintenance (CRM) and facility MD a tour of the facility was conducted. Along the two day tour the surveyor performed closure tests of the six (6) sets of smoke barrier doors in the corridors with the following results. On 11/01/2022, 1) At 9:57 AM, one set of double smoke doors next to Resident room #109, when both doors were release from their magnetic hold open devices and allowed to self close into their frame, the surveyor observed a gap along the bottom of the doors that appeared to be larger than 3/4 of an inch. The surveyor utilized a tape measure and recorded a 1-1/4 inch gap on the bottom of the smoke doors. At that time the CRM told the surveyor there use to be a carpet on the floor in the corridors and it was removed. 2) At 10:33 AM, one set of double smoke doors next to Resident room #107 and Resident room #108, when both doors were release from their magnetic hold open devices and allowed to self close into their frame, the surveyor observed a gap along the bottom of the doors that appeared to be larger than 3/4 of an inch. The surveyor utilized a tape measure and recorded a 1-1/8 inch gap on the bottom of the smoke doors. That would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The CRM and MD confirmed the findings at the time of observations.	K 374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 374	Continued From page 9 The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference at 1:32 PM on 11/01/2022. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 10/31/2022 and 11/01/2022, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 4 of 10 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During the survey entrance 10/31/2022 at 9:52 AM, a request was made to the facility's Administrator and Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms in the facility.	K 521	A. Exhaust systems in identified resident bathrooms 138, 140, 137, and 132 were repaired and are functional. B. Current residents have the potential to be affected by this practice. C. Nursing Home Administrator will educate Maintenance Director on the need to ensure resident bathroom exhausts are functional. D. Maintenance Director will conduct random audits of 10 resident bathrooms weekly x4 and monthly x2, to ensure exhausts are functional. Results will be provided to the Quality Assessment and	12/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 521	Continued From page 10 Starting at 10:13 AM, in the presence of the facility's MD, during the building tour, an inspection of 10 Resident rooms was performed. This inspection identified that when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 4 of 10 resident bathrooms in the following locations: 1. At 12:07 PM, inside Resident room #138 bathroom, when tested the exhaust system did not function properly. At that time, the surveyor informed the MD that the exhaust system did not function properly. 2. At 12:10 PM, inside Resident room #140 bathroom, when tested the exhaust system did not function properly. 3. At 12:12 PM, inside Resident room #137 bathroom, when tested the exhaust system did not function properly. 4. At 12:16 PM, inside Resident room #132 bathroom, when tested the exhaust system did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. This finding was verified by the facility's Maintenance Director of at the time of inspection. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference at 1:32 PM on 11/01/2022.	K 521	Assurance Committee monthly for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 521	Continued From page 11 NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
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 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	K 918		12/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 12 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/ 31/ 2022, in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 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. This deficient practice was evidenced by the following: On 10/31/2022 during the survey entrance at 09:52 AM, a request was made to the Administrator and Maintenance Director (MD) if the facility had an emergency generator. The MD said, yes we have an emergency generator. During the building tour on 10/31/2022 with the facility MD at approximately 11:31 AM, an inspection outside of the building where the 175 KW Diesel Emergency Generator is located was performed. At that time the surveyor asked the MD, where is the remote emergency shut off for the generator. The MD told the surveyor, There is no remote emergency shut off. The surveyor observed that the emergency shut off was located on the generator's control panel. The MD confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit	K 918	A. Remote manual stop station was installed. B. Current residents have the potential to be affected by this practice. C. Nursing Home Administrator will educate Maintenance Director on the need to ensure a remote shut off is available for the emergency generator. D. Maintenance Director will conduct random audits monthly x3, to ensure a remote shut off is available for the emergency generator. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**11/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - WEST DEPTFORD	**550 JESSUP ROAD** **WEST DEPTFORD, NJ 08066**

(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 13 conference at 1:32 PM on 11/01/2022. 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		