	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION ()	(3) DATE SURVEY COMPLETED
		060412	B. WING		C 07/19/2023
IAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
AJESTIC	CENTER FOR REHAB	& SUB-ACUTE CAR	OPER PLAZA N, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
S 000	Initial Comments		S 000		
	COMPLAINT# 1657	31			
	CENSUS: 114				
	SAMPLE SIZE: 4				
	8:39, standards for lid Facilities. The facility Correction, including deficieny and ensure implemented. Failure result in enforcement the provisions of the	y Jersey Administrative code, censure of Long Term Care must submit a Plan of a completion date for each that the plan is to correct deficiencies may action in accordance with New Jersey Administrative r 43E, enforcement of			
S 765	8:39-9.2(a) Mandator	y Administration	S 765		7/21/23
	who holds a current N nursing home admini	e directed by an individual New Jersey license as a strator. The administrator ely responsible for all			
	by:	is not met as evidenced			
	review of pertinent fa 7/15/2023 and 7/16/2 the facility failed to er of record that held a	n, interviews, as well as cility documents, on 2023, it was determined that nsure it had an Administrator New Jersey license to a authority over all services		S765 Element One □ Corrective Actions " The facility had a designated New Jersey Licensed Administrator (LNHA) of Record was on vacation from July 10, 2023 through July 17, 2023. The	of
	DIRECTOR'S OR PROVIDER/3	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE

6899

If continuation sheet 1 of 6

STATEMEN	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL			
		060412	B. WING			C 19/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	T ADDRESS, CITY, STATE, ZIP CODE					
		тwo со	OPER PLAZA					
MAJESTI	CENTER FOR REHAB	& SUB-ACUTE CAR CAMDEI	N, NJ 08103					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE		
S 765	Continued From page	e 1	S 765					
3703	within the facility from This deficient practice following: On 7/15/23 at 1:06 P facility's designated A made to the NJ Depa The Administrator sta working at the facility acknowledged that th system was not funct exact date and time i At 5:37 PM, on the s observed a facility sta hallway carrying a pla thermometer. The su member and exchang member stated that h Director (ED) of the f employed there for o asked if he was the L Administrator (LNHA that he had a LNHA I and was awaiting rec surveyor asked him w was, and the Executi was "not sure" and th The ED stated that h administrator revealed	A 7/10/2023 to 7/15/2023. e is evidenced by the Administrator regarding a call artment of Health hotline. ated that he had only been of or two weeks and the facility's air conditioning tioning and was unsure of t started. ated day, the surveyor aff member walking up the astic, red dye analog urveyor stopped the staff ged introductions. The staff he was the Executive acility and had been nly two weeks. The surveyor iccensed Nursing Home ) of the facility, and he stated icense but not in New Jersey iprocity in New Jersey. The who the LNHA of the building ve Director stated that he nat he would have to check. e was the designated d spoken to the surveyor on		Executive Director referred to in the 2567 by the surveyor was a license. Nursing Home Administrator away Jersey reciprocity and was new to facility. In the absence of the dese LNHA the Regional LNHA licensed Jersey and the Director of Nursing overseeing the facility. "The Regional Licensed Nurse Administrator was not present in the facility on Saturday July 15, 2023 religious observances but did comfacility after sundown on July 15, coordinated purchase and placene portable air conditioner units, fanse monitoring of all resident rooms at common area air temperatures. Element Two 🗆 Identification of a Residents "All residents have the potent affected by this practice. Element Three 🗆 Systemic Chang." A permanent experienced Net Licensed Nursing Home Administ (previously hired) began employing July 17, 2023 as scheduled was of and is working directly with the Lin Nursing Home Administrator conse." The New Jersey Department was notified of both the previously designated New Jersey licensed administrator and provided with the license numbers as required upone Element Four 🗆 Quality Assurance." The credentials of the permanent experience during the administrator and provided with the license nursing home administrator and provide	sed signated din New g were ing Home the due to ne to the 2023 and nent of s, and nd t Risk ial to be ges ew Jersey rator nent on oriented censed sultant. of Health y facility nent neir n hire. se nent tor were w Jersey			

### New Jersey Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: С B. WING 060412 07/19/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA MAJESTIC CENTER FOR REHAB & SUB-ACUTE CAR CAMDEN, NJ 08103 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 765 S 765 Continued From page 2 New Jersey. S 870 8:39-9.4(e)(1) Mandatory Administration S 870 7/20/23 (e) The facility shall notify the Department immediately by telephone (609-633-8981, or 1-800-792-9770 after office hours), followed within 72 hours by written confirmation, of any of the following: 1. Interruption for three or more hours of physical plant services and/or other services essential to the health and safety of residents; This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on S 870 7/15/2023, it was determined that the facility Element One Corrective Actions failed to report to the New Jersey Department of A call was placed by the facility Health that the air condition system was not Executive Director to the New Jersey working properly to maintain the temperature at Department of Health complaint line on 81 degrees Fahrenheit. This deficient practice July 15, 2023 regarding the excessive was evidenced by the following: temperatures in some areas of the facility. The Director of Nursing followed up On 7/15/2023, during an on-site visit to the with formal notification of the New Jersey facility, the surveyor interviewed the Maintenance Department of Health of the status of the Director, who stated that the air condition system heat emergency in the facility later in the has not been working properly since 7/6/2023. day on July 15, 2023. The repair invoice dated 7/6/2023 revealed that Documentation was sent to the the facility called on 7/5/2023 to the vendor about Department of Health as required the air condition issue. The vendor did not come regarding the heat emergency at the on-site to the facility until 7/6/2023. facility. Element Two Identification of at Risk In an interview on the same day with the Residents

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
					С	
		060412	B. WING	07/19/2	2023	
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE		
AJESTIC	CENTER FOR REHAE	3 & SUB-ACUTE CAR	DOPER PLAZA N, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLE DATE
S 870	Continued From page	ge 3	S 870			
	conditioner problem reported to the DOH any documentation problem was reported	tor, he confirmed that the air with the facility was not I. The facility did not provided that this air conditioning ed to DOH and there was no ment indicating the event was t.		<ul> <li>All residents have the potential taffected by this practice.</li> <li>Element Three  Systemic Changes <ul> <li>The process for notification of the New Jersey Department of Health we interruptions in services occur was reviewed with the Director of Mainter Director of Nursing, and the Administ to ensure timely notification.</li> <li>The chain of command was reviet to ensure notification of a service interruption is reported timely to NJ Department of Health on weekends a off hours.</li> <li>A weekend Manager on Duty services. The weekend Manager on Duty services. The weekend Manager on will be responsible for notifying the fa administration and the New Jersey Department of Health as appropriate Element Four  Quality Assurance <ul> <li>A root cause analysis of the emergency management communication in the of future interruptions of services as required by Department of Health</li> </ul> </li> </ul></li></ul>	and hedule re tion of Duty acility s.	
S1090	8:39-13.1(c) Manda	tory Communication	S1090		7/	/20/23
		notify any family promptly of ting the health or safety of a				

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		060412	B. WING		07/19/2023		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
		тwo со	OPER PLAZA				
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CAR CAMDEN	N, NJ 08103				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF			
1710				DEFICIENCY)			
S1090	Continued From pag	e 4	S1090				
	by: Based interviews and was determined that	Γ is not met as evidenced d review of documentation, it the facility failed to promptly		S 1090 Element One □ Corrective Actions			
Conditioning units since 7/6/2023 as On 7/15/2023 and on-site to due to a was left on the De	since 7/6/2023 as ev On 7/15/2023 and 7/	ere not functioning properly ident by the following: 16/2023, the surveyors were		<ul> <li>Families were notified of the air conditioner repair issue by the social worker with communication document in the resident chart on July 16, 2023.</li> <li>The facility medical director was</li> </ul>			
	was left on the Depa	eat emergency event that rtment of Health hotline. utive Director, Director of		notified of the need for repair of the ai conditioning and evaluated the reside on July 17, 2023.			
	Interviews with Executive Director, Director of Nursing and Maintenance Director revealed the air conditioning systems and PTAC units were not fully functioning in resident care areas on the 2nd and 3rd floors since 7/6/2023 and at the present time. On 7/16/2023, in the presence of the Regional Administrator, the surveyors asked if families were notified about the air conditioning	ems and PTAC units were not sident care areas on the 2nd 7/6/2023 and at the present in the presence of the or, the surveyors asked if		<ul> <li>Residents were notified verbally of July 16, 2023 and additional scheduler Resident Council Meetings of the repart to the air conditioning units.</li> <li>Residents affected by increased temperatures were offered temporary room changes or temporary placement</li> </ul>	ed airs		
sy re	residential floors. The	at full capacity on the e Administrative staff could that families were notified.		<ul> <li>cool common areas, those that refuse move were provided with portable air conditioning units on July 15, 2023.</li> <li>Element Two          <ul> <li>Identification of at Ris Residents</li> <li>All residents have the potential to</li> </ul> </li> </ul>	k		
				affected by this practice. Element Three  Systemic Changes The facility Social Worker will not responsible parties of any interruption	ify		
				services that impacts residents as required by regulations. Notification v be documented with a record maintain	vill		
				in the resident medical record or by administration depending on delivery			
				method □ phone, email, and/or letter. " The facility Social Worker/design are notifying residents of potential hea	ee		
				waves and reminding residents of			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		060412	B. WING		C 07/19/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, ST	ATE, ZIP CODE			
	C CENTER FOR REHAE		OOPER PLAZA				
IAJESTI	CENTER FOR REHAE	CAMDE	N, NJ 08103				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
S1090	Continued From pag	pe 5	S1090				
51090	Continued From page	ge 5	51090	precautions to take when terr are extreme outside and to ear residents are able to control to temperature to their liking and for assistance. Element Four □ Quality Assu " The facility Social Worker will review 10 resident charts weeks then 10 charts weekly month to ensure documentati and resident□s notification if interruption of services should including problems with air co Results will be reported by th Worker weekly at the Quality meeting, then monthly for furt as needed.	hsure heir room d/or ask staff rance r/designee times two for one for one fon of family any d occur, onditioning. e Social Assurance		

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					D. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		PLETED		
		315205	B. WING				C 19/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	•			
				тм	O COOPER PLAZA				
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		CAMDEN, NJ 08103					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 000	INITIAL COMMENTS		F	000					
	COMPLAINT# 1657	31							
	CENSUS: 114								
	SAMPLE SIZE: 4								
	42 CFR PART 483, S	OT IN SUBSTANTIAL THE REQUIREMENTS OF UBPART B, FOR LONG TIES BASED ON THIS							
	The following immedi were identified for F6	ate jeopardy (IJ) situations 00, F658, and F835.							
		urrvey conducted 7/15/23 survey team identified the							
	F600 scope and seve	erity (s/s) of L:							
		F600 (Free from began on The the immediate situation on An acceptable written ceived on The Removal Plan on The							
	identifying and monitor room temperatures w systems on 2 of 2 res	nplement a system for oring residents and their then their air conditioning sident floors were known to functioning at full capacity, nperature was degrees Residents on							
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RF	I	TITLE		(X6) DATE		

Electronically Signed

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.

08/14/2023

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 11/22/2023 APPROVED ). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315205	B. WING				C 19/2023	
NAME OF P	ROVIDER 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TION SHOULD BE COMPLETI THE APPROPRIATE DATE		
F 000	both floors were comp as degrees Fahr failure to monitor roor the facility's ability to semergency event and emergency event and emergency response for their building. Resident #1, who was had known had no air corroom temperature exc Fahrenheit on hospitalized following Further, the facility's of not have the adequate automated external do on the top floor that The non-compliance for more than minimal had jeopardy. F658 scope and sevee The survey team idem jeopardy situation for Meet Professional Star began on the top floor written Removal Plan	blaining of an and apperatures reached as high enheit on The in temperatures impacted self-identify a subsequently activate their plan to prevent subsequently activate their an assessed change in code cart was identified to e supplies and the efibrillator (AED) had pads expired on subsequently activate for F600 remained on harm with the potential for rm that is not immediate F658 (Services Provided andards of Practice) which e facility was notified of the n subsequently activate their plan acceptable	F	000				

Facility ID: NJ60412

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	MENT OF HEALTH AN S FOR MEDICARE & I					FOR	D: 11/22/2023 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		315205	B. WING				C / <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE	TWO COOPER PLAZA CAMDEN, NJ 08103				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	The facility failed to id (Resident #1) who way manner that adheres nursing practice to as call the physician at the was verbalizing a char from the enviornment conditioning in the resis the resident's room the degrees Fahrenheit. Two LPN's and one R #1 stated that this way night shift LPN stated admitted to the stated admitted. The resident was senting admitted. The non-compliance for no actual the more than minimal has jeopardy. F835 scope and seven	acy was lifted on the solution of the solution	F	00			
	admitted to be service. The Nurse Practitione and assessed that this was not the r baseline and the resid and The resident was sen early morning hours of admitted. The non-compliance f more than minimal had jeopardy.	er arrived at 1:30 AM on d the resident and stated esident's and stated or dent had t to the hospital during the maximum and subsequently for F658 remained on harm with the potential for rrm that is not immediate					

Facility ID: NJ60412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
		315205	B. WING			C 07/19/2023	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			WO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	jeopardy situation for began on the immediate situation of written Removal Plan The surveyors verified The facility's Licensed Administrator (LNHA) residents on the heat-related emergen of monitoring and log when the air condition functioning at capacit the <b>service</b> , d.) identify provide the necessary protections to prevent illness, e.) identify and response plan when the rooms exceeded requited that that Director of N Director covering the had knowledge and c Emergency Prepared knowledge of where the was located when the heat-related emergent The non-compliance of more than minimal had	F835 (Administration) which facility was notified of the maximum An acceptable was received on the dathe Removal Plan on acy was lifted on the failed to: a.) safeguard the floor from a cy, b.) implement a system ging room temperatures hing was known to not be y on the resident units on s, c.) notify the New Jersey (NJDOH) of the disruption high-risk residents and y adequate cooling t avoidable heat-related d activate their emergency emperatures in resident tirements, and f.) ensure ursing (DON) and Executive facility on ompetence of the ness (EP) plan, including he most up-to-date EP Plan fir facility was in a cy.	F	000			
F 600 SS=L		Neglect	F	600			7/21/23
	§483.12 Freedom from	m Abuse, Neglect, and					

Facility ID: NJ60412

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 11/22/2023 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			TWO COOPER PLAZA				
WAJESTI	MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			c	CAMDEN, NJ 08103		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE	
F 600	Exploitation The resident has the ineglect, misappropriation as defined exploitation and resident's method. The facility for the excessively humid an explosively active excessively humid antipolation and for the HVAC malfunction of the HVAC malfu	right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced 31 a, interview, record review at facility documents, it was acility failed to: a.) identify ring their heat emergency dualized plan to prevent a event when their air and individual PTAC units at down or not working at full int adequate and sustaining educe the risk for serious to temperature checks when sident units were d residents were int at their emergency dentification of their air ion in degree outdoor immediate plan to correct	F	600	F 600 Element One Corrective Actions " All Residents in the facility includir Residents 1, 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, were immediately assessed by the medical director for heat related signs symptoms on Section Section Section 1, 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, were assessed by the Nurse Practitioner on Section Section 1, 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, were assessed every four hours through then ever shift through by licensed nurses for signs or symptoms heat illness. " Resident #1 was assessed by Nur Practitioner on All and was sent to the Emergency Room (ER) and subsequently admitted with a diagnosis . Resident #1 had been placed on Services on Section 1, 2000	and e ng very of se i s of	

Event ID: 5E8J11

Facility ID: NJ60412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 11/22/2023 MAPPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY IPLETED
		315205	B. WING			07	C 7/19/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	110/2020
				т	WO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	SUB-ACUTE CARE		C	AMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	Continued From page	5		600			
1 000		ng on 2 of 2 floors of the		000	" Roommate of Resident #1 was		
		loor).			assessed, offered a room change, of	or	
					temporary placement in a temperate		
		endent on staff and was			environment but the resident declin	ed a	
	-	ised Practical Nurse (LPN			room change and was provided with	а	
	#3) to have a known				portable air conditioner unit on		
	T	he resident complained to			" Additional carts were		
	the surveyor, '	and			purchased on and hy		
	<b>3</b>	nowledge of the resident's			stations were placed on each unit.		
		ons, the resident did not			" Residents were provided with e		
	-	onditioning or fan in their			ice throughout the day as needed s	arting	
	room and a room tem				on " The Licensed Nursing Home		
	degrees Fahrenheit o				Administrator (LNHA), Director of N	irsina	
	Resident #1 was asse	essed by a Nurse			(DON) and staff were re-educated of		
		sent to the Emergency			about emerge		
	Room due to a chang	e in			identifying at risk residents, maintai	ning	
					appropriate temperatures in facility,		
					reporting interruption of services to		
	The facility's negligen	exceed degrees with			Department of Health, and activatio Emergency Response Plan.	n of	
		alfunctioning HVAC system			" The maintenance director was		
		to implement measures to			re-educated on about		
		maintain the resident room			maintaining temperature logs of fac	lity	
	temperatures on the	floor from			temperatures.		
		ntervention placed all			" Nursing staff re-educated on Ju	-	
	residents at risk for from avoidable	, or			2023 about following procedure /po	icy for	
	resident room temper	illness when ature readings were			checking code cart and assessing functioning of Automatic External		
		degrees Fahrenheit on			Defibrillator (AED) and expiration da	ite of	
	the floor.				AED pads to be sure they are not e		
					Checking the AED and pads was a	ded to	
	Symptoms of				the code cart checklist and staff		
					re-educated.	10.16	
		when the body			<ul> <li>Nursing Staff re-educated on J 2023 about recognizing and assess</li> </ul>		
	temperature can	degrees F within			signs and symptoms of		
	minutes of	exposure,			illness and reporting to		

Event ID: 5E8J11

Facility ID: NJ60412

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/22/2023 MAPPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONS	TRUCTION	(X3) DAT	E SURVEY PLETED
		315205	B. WING _			07	C 7/ <b>19/2023</b>
NAME OF PF	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1 07	/13/2020
					OOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			EN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION () (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE D/ DEFICIENCY)		
F 600	Continued From page	6	F	500			
F 600	hospitalization and de Further, in the event t utilized during the em an unlocked code car cart was disorganized of the event of the event of devices despite it bein the nurse that day on floor had that ex was no system in place functioning and expira ensure in the event of equipment would be v life sustaining support The immediate jeopar continued through temperatures reached Fahrenheit. The facility notified of the immedi 7:02 PM. The facility plan on the superset	rse health consequences, ath. he code cart had to be ergency on the floor, t check revealed that the had an incorrect number cart, expired Narcan, and in addition, the in addition of	F	sup abr app " bind fror Adr re-e Res " mo Pra syn of c risk but syn of c risk but BIN plac ass illne	ervisor/designee any temperation ormalities and transferring resorregitate temperate areas. Emergency Preparedness Plated ders were placed on each unit, at lobby desk, nursing office and ministrators office. Staff were educated on the location of Em- sponse Plan in the binder. Temperature log was utilized nitor and track room temperature All residents were assessed I citioner on for some	sidents to an , and nd e nergency to ures on by nurse igns and and a list lentify at ncluded, dentify at to ings of a uly were	
	The evidence was as			"	lated. All residents were assessed a sumented on by facility Medica	I Director	
	called the facility's der regarding a call made Health hotline. The d stated that he had on facility for two weeks	and acknowledged that the		sen Hea " roo	as required in the ected plan of correction with re- at to the New Jersey Departme alth. All residents affected by incre m air temperatures were offere	sults ent of eased ed	
	facility's air conditionin functioning. He state	ng system was not d he was unsure of the			porary room changes or temp cement in cool common areas		

Event ID: 5E8J11

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		ID HUMAN SERVICES			FOF	ED: 11/22/202 RM APPROVE O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		315205	B. WING	07	C 7/19/2023		
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		10/2020	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		VO COOPER PLAZA AMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	stated that some part	started not working. He s of the facility had air resident areas were limited.	F 600	and			
	temperature readings replied that he was no numbers or temperatu asked if any residents	in the facility, and he ot sure of any exact ure ranges. The surveyor s have been affected and he		" Facility rented six 5-ton po conditioner rentals and placed 2 floor in hallways/common areas	2 on each s on <b>s</b>		
	the building. He adde fans and water station assessing residents.	e, because he was not in ed that they purchased 15 ns, and that they were He stated that they could to a cooler area but that		<ul> <li>Temperatures were monitor hours until facility temperatures maintained at temperatures per x 72 hours, then every shift inder All Residents and responsi</li> </ul>	s r regulation efinitely.		
	there were no vacant functioning air conditi available resident roo			were notified about the heat em and provided with the option to rooms to a cooler location if des Element Two  □ Identification of	nergency change sired.		
	stated that they were conditioner unit availa following their Emerge	utilizing every working air		Residents All Residents have the potential affected by this practice. Element Three  Systemic Cha	ential to be		
	a resident has a chan signs/symptoms that of care, the physician	ge in condition or other would warrant a higher level would be notified. He added		" The main air conditioning u repaired and working without is the facility common areas and r	units were sue and resident		
		aintenance and Regional vare and were working on		rooms within acceptable tempe range on <b>Exercise</b> . The de of health was informed of the re " PTAC units on special order	epartment epairs.		
	three separate times	designated Administrator to request additional		installed as received in resident the interim every resident room to have a portable air condition	i continues er unit		
	he did not answer or	their heat emergency, but return the voicemail's left.		easily controlled by residents a that have maintained appropria temperatures.	te air		
	facility and spoke to a the front desk regardi	M, the surveyor called the Security Guard (SG #1) at ng a call made to the NJ hotline. The surveyor asked		The Emergency Preparedr was updated by the facility adm with the Administrator and Direc Nursing consultants input. St	ninistrator ctor of		
	the security guard if h	e could connect this		received re-education about ch	anges in		

Facility ID: NJ60412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/20 M APPROV D. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				E SURVEY PLETED
		315205	B. WING	B. WING			/ <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			WO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 600	Continued From page	2 8	F	600			
		nd he attempted for each	•	000	the plan.		
		At that time, the surveyor			" The DON consultant assisted with	n	
		Nursing Supervisor, and			re-evaluating each resident and creati		
		re was no nurse supervisor			unit based triage list based on acuity l		
	or maintenance work				in the event of an emergency. The		
		at the resident census today			interdisciplinary team including unit		
	was and that the	re was no functioning air			managers and nursing management v	vere	
	conditioner on both th				involved in the process.		
	at least	and that the facility is			" New code carts were purchased a		
		culate the air. The surveyor			placed on each unit with a checklist of	:	
		ortable air conditioners in			contents and expiration dates and is		
		guard indicated that there			checked daily. The is installed b		
		ause it was "hot in the			the code cart and its function and pad	S	
	-	ed if he was aware of any			are included on the checklist. " Staff received re-education about		
		egarding the issue, he dents are complaining it is					
		re." The surveyor asked if			communicating air temperature conce to the supervisor for immediate action		
		om temperatures, and he			Staff have been re-educated in checki		
		as taking room temperatures			room air temperatures and the use of	ng	
	that he was aware of,				portable air conditioner units and PTA	c	
		ss. The surveyor followed			units.	0	
		fied any local authorities			" The Director of Nursing consultar	nt	
		uation, and the security			attends clinical meetings and has		
	guard stated that he d				re-educated the Director of nursing an	d	
	notifying any police, f				the nursing management team of their		
		nent (OEM) if the residents			role and responsibilities during emerge		
		being hot when the air			situations.		
		vorking. The surveyor asked			" The permanent Licensed Nursing		
	-	dents that had to go to the			Home Administrator (LNHA) of Record	k	
		e heat, and the security			began employment on		
	guard stated that he				replacing the temporary LNHA and the	e	
		e. He was unable to provide			executive director.		
		phone numbers of the			" The consultant Administrator and		
		nce or any key personnel that			consultant Director of Nursing began	h.,	
	would be able to spea	ak to the issue any further.			services on as required		
	0 7/1E/00 -1 5:00 D	M the even entry of at			the directed plan of correction and are		
		M, the surveyor arrived at			onsite a minimum of 40 hours includin	g	
		nnounced visit to investigate			weekends and off-shifts.	~~~	
	the issue regarding th	ie maitunctioning air			" The contracted security guards w	ere	

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		ND HUMAN SERVICES			PRINTED: 11/22/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		315205	B. WING		07/19/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		TWO COOPER PLAZA	
				CAMDEN, NJ 08103	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 600	Continued From page	o 0	F 60		
1 000			F 600		
		at the facility. The surveyor		instructed to report concerns	
		utdoor temperature at that Fahrenheit and the weather		temperatures to the Adminis Director of Nursing, Mainter	
		d. The surveyor entered		or Supervisor dependent on	
		by and noted a heavy duty		Element Three  Systemic	
		across the floor with a long		" A weekend Manager or	-
	extension cord. The	surveyor observed a		schedule was implemented,	, and a list of
	Security Guard (SG #	#2) at the front desk and the		responsibilities provided to e	each manager
	-	G #2 about the fan on the		that includes proper notifica	
		hat he didn't know why it was		reporting of any systems iss	
		lged that it was not there for		Element Four  Quality Ass	
		on. The surveyor asked if		" Unit Manager/designee	-
		sue with maintaining air building, and the SG #2		emergency triage acuity list with resident changes in cor	
		know anything as he just		add new admissions. Chan	
		was filling in for someone		conditions are discussed at	-
	else.			meetings.	
				" The Assistant Director of	of Nursing
	At 5:07 PM, the surve	eyor interviewed the		(ADON)/ designee will audit	<b>u</b>
		pervisor (RN/S) who stated		emergency triage acuity lists	
	that he started the sh	ift at 3 PM and that he took		weekly for four weeks and the	hen monthly
		e supervisor. At that time,		for two months to be sure th	
	the RN/S didn't want	-		updated and reflect each re	
		and called the Director of		acuity level. Findings will be	
	Nursing (DON).			the monthly quality assurant	
	At 5:00 DM the surv	ever conducted a phone		performance improvement r action as appropriate.	neering for
		eyor conducted a phone DN. The DON stated that the		" The Maintenance Direct	tor/designee
		e building was not functioning		will monitor room and comm	0
		sue, and it had to be shut		temperatures every two hou	
		cility had implemented		then every shift x 14 days a	
		d ice in response. She		thereafter with no stop date.	-
	stated that she "did n	ot know the mechanics of		reported to the administrato	r and emailed
		jional Maintenance was		daily to the department heal	
	-	e issue." She stated that he		substantial compliance is ac	
		f right now looking at the		Results are also shared at the	
		ey had been working on		Quality Assurance Performa	
	resolving it since			Improvement (QAPI) meetin	ng for action
	because there was n	o air conditioning in the		as appropriate.	

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	E CONSTRUCTION	(X3) I	3 NO. 0938-039
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		0	COMPLETED
		045005				С
		315205	B. WING			07/19/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	, ,	
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE		TWO COOPER PLAZA CAMDEN, NJ 08103		
	CLIMMA DV C					0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 600	Continued From pag	e 10	F 60			
	affected the kitchen resident areas. She the weather was goin purchased fans and resident units just as also added that a nu her that the building The surveyor asked issue occurred that r system, and the DOI date. She could not issues within the res residents told her it v complained" to her. purchased fans yest why they purchased not hot indoors and i functioning on the ur it was because they hot outside today an an added "precaution she had been on the difference in air temp replied that "I'm tropi like the rest." The DO been a bit warm, but	the DON when the sparking equired the shut down of the N could not speak to an exact speak to air conditioning ident units adding no vas hot and "no one		random daily ro staff to confirm assure the com are discussed y daily and in age Quality Assuran Improvement (f action as appro " The Direct audit 5 random records for sign related illness of and monthly x at clinical meet appropriate. R aggregate at th Assurance Per (QAPI) meeting needed. " The Assist Nursing/design carts to ensure stocked, and A Defibrillator par days, weekly x	tor of Nursing/designee will a at-risk residents medical ns and symptoms of heat daily x 7 days, weekly x 4 2. Findings are discussed tings and acted upon as desults are shared in ne weekly Quality formance Improvement g for further action as tant Director of nee will monitor all code they are adequately sutomatic External ds are not expired daily x 7 4 weeks and monthly sults will be provided to the sing and shared at the	
	returned to the facilit about the status of the The surveyor asked and the DON stated far hallway that was they put all the fans. were any fans broug	nce purchased the fans and y today to find out more he air conditioning system. what floors were affected, that it was only the form affected which was where The surveyor asked if there ht to the second floor, and there were "no fans on the				

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/22/2023 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315205	B. WING			_		C 19/2023
NAME OF PI	ROVIDER OR SUPPLIER		<b>I</b>	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•••	
	CENTER FOR REHAB			Т	WO COOPER PLAZA			
WAJESTIC	CENTER FOR REHAD	SUB-ACUTE CARE		С	AMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	any temperature check resident units and the know about any room done. At 5:19 PM, the surver Floor. Upon entering the noticeably warm and surveyor interviewed at (LPN #1) who was in he works the evening conditioner within the some of the resident in do not have functioning rooms. He stated that residents do not have rooms, no residents the directly about the floor and the LPN know about that. The the air conditioning has the LPN #1 stated, "si season." The surveyous the season meant, and of summer. The surveyous the season meant and a con- the season m	urveyor asked if there were exist being done on any of the PDON stated that she didn't temperature checks being eyor toured the <b>second</b> the unit, the unit felt humid. At that time, the a Licensed Practical Nurse the hallway and stated that shift and that the air facility "broke" and that rooms on the second floor ng air conditioning in their twhile some of the e air conditioning in their tave complained to him . The surveyor asked if adings were being taken on #1 stated that he doesn't e surveyor asked how long as not been functioning, and ince the start of this or clarified what the start of d he stated since the start eyor observed a fan at the cooler with water. eyor observed Resident #4 in oom. The resident's . The surveyor that the room ted ' <b>surveyor</b> that the room ted ' <b>surveyor</b> that the room ted ' <b>surveyor</b> that the room	F	600				
	resident units and the know about any room done. At 5:19 PM, the surver Floor. Upon entering a noticeably warm and surveyor interviewed a (LPN #1) who was in he works the evening conditioner within the some of the resident of do not have functioning rooms. He stated that residents do not have functioning rooms. He stated that residents do not have functioning the floor and the LPN whow about that. The the air conditioning has the LPN #1 stated, "si season." The surveyor the season meant, an of summer. The surveyor the season meant, and of summer. The surveyor the season meant, and for summer. The surveyor the season meant and for the season meant and fo	DON stated that she didn't temperature checks being ever toured the <b>second</b> the unit, the unit felt humid. At that time, the a Licensed Practical Nurse the hallway and stated that shift and that the air facility "broke" and that rooms on the second floor ng air conditioning in their twhile some of the air conditioning in their ave complained to him . The surveyor asked if adings were being taken on #1 stated that he doesn't e surveyor asked how long as not been functioning, and ince the start of this or clarified what the start of d he stated since the start eyor observed a fan at the cooler with water. eyor observed Resident #4 in oom. The resident's . The surveyor felt that the the surveyor that the room ted 's the surveyor that the room ted 's the surveyor that the room ted 's the surveyor that the room						

Facility ID: NJ60412

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	ICAID SERVICES					APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	315205	B. WING _				C 19/2023
NAME OF PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2020
MAJESTIC CENTER FOR REHAB & SUI	B-ACUTE CARE			TWO COOPER PLAZA		
				CAMDEN, NJ 08103		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600 Continued From page 12 The resident stated that evincluding the nurse. The stated that the roommate generated that the room of Resident strated that and a conditioning and the LPN stresident's PTAC unit was room. The LPN #1 attempt unit by playing with the switurn it on again, but there were the vent. The LPN #1 corn no air conditioner and no froom belonging to Resident acknowledged that the roommated that it was "Stress to the actur room. At 5:27 PM, the surveyor i unsampled Resident #6 wi na wheelchair in their roombox fan on the floor, and the the the the the the floor, and the the the floor the surveyor asked if staff knewas broken, and the resident "Everyone knows it's hot in "Everyone knows it's hot in "Everyone knows it's hot in the tree the surveyone street the surveyone street the the term for the term for the term for the surveyon asked if staff knewas broken, and the resident "Everyone knows it's hot in the tree the surveyone knows it's hot in the tree the floor.	surveyor asked what the issue, and the resident got a small fan, but that ident #4 stated that ." The surveyor to air coming out of the ditioner (PTAC) unit in ite the unit indicating brought LPN #1 into the asked about the air #1 stated that the not functioning in their pted to adjust the PTAC vitches and attempted to was no air coming from ted that "it's not nfirmed that there was fan in the side of the nt #4. The LPN #1 on was "very warm" but ual temperature of the interviewed an vho was observed to be om. There was a small he room felt very warm. the resident who stated ." The resident stated room had been broken o his/her granddaughter ne which helped. The ew that the PTAC unit lent replied that	F	600			

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	surveyor asked about the resident replied th resident asked that the was coming from the air was warm and not coldest setting. The s both felt the vent, con statement. The resid- been checking room to in their room. The resid- been checking room to in their room. The resid- been checking room to in their room. The resid- was provided ice. The surveyor continue observed that room conditioner unit in the At 5:33 PM, the surve Resident #8 in their room that their air condition had been broken for co been making an effort stated that the facility instead. The surveyor toward the resident. At that time, the surveyor toward the resident. At that time, the surveyor toward the resident. At that time, the surveyor toward the resident else "" and to deliver ice but that the for it. The resident else "" and to blocking air from circu- side of the room. The did not get a fan, "but resident reported that	when it would be fixed and hat no one told them. The e surveyor feel the air that PTAC unit stating that the cold despite it being on the surveyor and the resident firming the resident's ent denied that anyone had emperatures on the floor or sident stated that he/she ed to tour the unit and had a portable air ir room. Pyor observed Unsampled form. The resident stated er PTAC unit in their room days and that nobody had to fix it. The resident delivered water and ice r observed a fan positioned eyor observed the resident's d Resident #7 who stated, hat staff were supposed to ey only bring it if he/she asks aborated that it was hot observed the roommate's e closed curtain which was ulating into the resident's e resident stated that he/she my roommate does." The	F	600			

Facility ID: NJ60412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315205	B. WING				C / <b>19/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	their room has been to At 5:37 PM, the surver member walking up the red dye analog therm stopped the staff men- introductions. The sta- was the Executive Dir had been employed the acknowledged that he Administrator that spo- phone. The surveyor Licensed Nursing Hor the facility, and he sta- license but not in New was awaiting recipro- surveyor asked him w was, and the Executive was "not sure" and the He stated that he was temperature on the flo- on the back end of the room state and the the degrees Fahrenheit, state thermometers are "hat temperature. The survey was how the facility w on the floor, and he state indoor air temperature have to go find it. At 5:41 PM, the survey	that the air conditioner in proken for a few days. eyor observed a facility staff he hallway carrying a plastic, ometer. The surveyor nber and exchanged aff member stated that he rector (ED) of the facility and here for only two weeks, he e was the designated oke to the surveyor today by asked if he was the me Administrator (LNHA) of ated that he had a LNHA v Jersey He stated that he sity in New Jersey. The who the LNHA of the building ve Director stated that he at he would have to check. Is currently taking a bor using the floor hallway near onfirmed that the usermometer was reading stating that the analog ard to tell" an exact rveyor asked the ED if that vas checking temperatures tated he was only using the urily, and that he believed emperature gun for checking es. He stated that he would	F	600			
	Continued From page The resident reported their room has been to At 5:37 PM, the surve member walking up the red dye analog therm stopped the staff men- introductions. The state was the Executive Dire had been employed the acknowledged that he Administrator that spo- phone. The surveyor Licensed Nursing Hore the facility, and he state license but not in New was awaiting reciproce surveyor asked him w was, and the Executive was "not sure" and the He stated that he was temperature on the floc temperature on the floc temperature on the floc temperature. The survey was how the facility w on the floor, and he state that they had an air te- indoor air temperature have to go find it. At 5:41 PM, the survey LPN (LPN #2) walking	e 14 that the air conditioner in proken for a few days. eyor observed a facility staff he hallway carrying a plastic, ometer. The surveyor nber and exchanged aff member stated that he rector (ED) of the facility and here for only two weeks, he e was the designated oke to the surveyor today by asked if he was the me Administrator (LNHA) of ated that he had a LNHA v Jersey He stated that he sity in New Jersey. The who the LNHA of the building ve Director stated that he at he would have to check. a currently taking a bor using the floor hallway near onfirmed that the usermometer was reading stating that the analog ard to tell" an exact rveyor asked the ED if that vas checking temperatures tated he was only using the urily, and that he believed emperature gun for checking es. He stated that he would			DEFICIENCY)		

Facility ID: NJ60412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	had worked at the fac surveyor asked her al the unit, and the LPN and "it feels pretty coor She stated there have with the air conditioned that was why there we and in resident rooms she did not know what readings were and hat temperatures. The LI anyone takes the term "They don't show there the only thing she had residents by checking that she could ask the touch their skin to det and if so, she could re- location. At 5:48 PM, the ED re- with the room temper thermometer gun. Thin the room belonging who resided near the stated to the surveyor "The resident has conditioner in their roo stated that he will hav were just purchased. At 5:50 PM, the ED to temperatures were no Fahrenheit (F) accord ED took the following floor:	willity for wears. The bout the use of the fans on #2 stated, "I don't get hot" ol right now" on the unit. e been issues on the floor ers for a little while now, but ere fans throughout the unit 5. The LPN #2 stated that it the room temperature id not seen staff take room PN #2 explained that if peratures of the room, m to me." She stated that d to do different was to give be, and monitor the g in on them. She stated e residents how they feel, ermine if their skin was hot, elocate them to a cooler eturned to the floor ature dual laser, infrared the ED took the temperature to Unsampled Resident #9 window. The resident and ED that '	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 11/22/2023 APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315205	B. WING			C 07/19/2023	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	or air conditioner in the 2. Room degra air conditioner in the r 3. Room degra 3. Room degra 3. Room degra 4. Room degra 4. Room degra 5. So PM, the survey room of Resident #4 v conditioner or fan and complained of it being PM. The room temped degrees F. The ED s warm." The surveyor was for this resident a floor, and he stated the more fans. He acknow residents had fans an room and that the out was currently degr to when the air conditioner issues how long there had be and the ED wasn't su the ED that the DON no fans in use on the there were fans cleard and couldn't speak to there were no fans in except that maybe sh an air conditioner issues At 5:59 PM, the survey Director of Maintenan he had only been em approximately four mo The DoM stated that the	rees F. There was no fan or room. rees F. grees F. grees F. grees F. egrees F. eyror and ED returned to the where there was no air the resident had for the resident so the hat he would try and bring wledged that not all d air conditioning in their door temperature reading rees F. He could not speak ioner and PTAC units would ents. The surveyor asked een fans on the form floor re. The surveyor informed had stated that there were floor. He stated that y in use on the form floor, e didn't know that there was use on the second floor, e didn't know that there was use on the floor.	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		315205	B. WING			C 07/19/2023		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	the facility had several beginning of one of the systems. It also an "air handler w floor." He com floor, the air conditioner system required the entire air to be shut off The DoM stated that to 6th to address the pro- processed until yeste was for several or so to The surveyor request that diagnostic visit fre- findings. He stated the it, but that he would lo did. At that time, the survey was holding a clipboar a hand-written headin list of resident rooms dated. The surveyor a list, and he stated that but that he had been malfunctioning PTAC and had made a list. this list about two wear replacing the units. T were three rooms that rooms and that those rooms he f with new ones and th PTAC units that "did r process of replacing to because he was "only asked what has been	al bids out since the , since there was a leak in le added that there was ith a bad condenser for the tinued, that in addition to the floor had an issue with the n causing "sparking" which conditioning system on "or there would be a fire." they received a bid on July oblem, but it was not rday on for a and the bid to diagnose the problem. ed documented evidence of om the company and the hat he didn't have a copy of ook into finding out if anyone eyor observed that the DoM and loose leaf paper with a written under it. It was not asked the DoM about the t he has not HVAC licensed, working on changing the units in the resident rooms He stated that he started eks ago when he began the list indicated that there t had "new" PTAC units, . The DoM confirmed had replaced the PTAC units at the other for ooms had not work." He stated that the them had been going slow y one person." The surveyor	F	600				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/22/202 FORM APPROVEI OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315205	B. WING		C 07/19/2023
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE
				TWO COOPER PLAZA	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		CAMDEN, NJ 08103	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 600	purchased ten portab put some of them in r the purchase of 30 fa a receipt of the purch other than purchasing air conditioner units, regarding the malfund he added that he purch water at anything else. The handlers won't be fixe there was no definitiv only been processed he should be checkin indicated he did check it read degrees F is surveyor asked when and he could not spe- if he kept any logs of the air conditioning sy malfunctioning or not the DoM stated that t temperature logs. He kept a room temperature how the facility was n with temperatures if t over a given period o The DoM stated that generally cooler than	the DoM stated that they ble air conditioner units and resident rooms, in addition to ns. The surveyor requested ases. The surveyor asked g 30 fans and ten portable what had been doing ctioned air conditioning and chased four to five jugs of yesterday and 12 bags of at he had not been doing DoM stated that the air ed for a few days but that e date because the bid had yesterday. He stated that g room temperatures, and k a temperature earlier and in a resident area. The e and when that was taken, ak to it. The surveyor asked temperature readings while ystem had been working at full capacity and here were no room e stated that the last time he ture log was "about a month to the former administrator DoM confirmed there were logs and could not speak to nonitoring for compliance hey were not checking them f time and recording them. the resident rooms were the hallways, but the DoM e any documented evidence	F 60		
		eyor continued to interview that he does not routinely			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		315205	B. WING				C / <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	check room temperati thermostats on each temperatures needed and that he looks at the everyday." He stated above degrees F, temperatures of the re- surveyor and the DoM reading on the file unit. The thermostat At 6:11 PM, the surve floor thermost was serving the front double doors, read a F. The thermostat for reading degrees F At 6:13 PM, the surve no ice in the cooler, a Aide (CNA #1) stated out ice to the resident to replenish what was and surveyor observe for the entire for F. At 6:16 PM, the DoM he only works for the nursing staff shou- temperatures on wee to how or when they to (This did not correspond LPN #1 and LPN #2 wo not aware of staff taki- were they involved in At 6:18 PM, the surve	ures, but that he uses the floor to determine if to be checked on the floors he thermostats "all day that if the thermostats read he would go and take esident rooms. The A checked the thermostat or which is not a resident read degrees F. eyor and the DoM went to the tat. The thermostat which end degrees F. eyor observed that there was hack end of degrees back end of degrees back end of degrees tas and that she would have is in the cooler. The DoM ed the thermostat that was unit which read degrees stated to the surveyor that and that ld be taking room kends. He could not speak take room temperatures nor	F	600			

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMF	E SURVEY PLETED
		315205	B. WING				C / <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	warm and humid in the observed with the Do the ice cooler. The se observed the thermose of which indic degrees F, and the bas thermostat read it was At 6:25 PM, the DoM unit. At that the the thermostat had no because the system h sparking. He stated the heavy duty relay were sparking. He stated the heavy duty relay were sparking. He stated down on because the switch acknowledged that be this was why there was A review of the weath Camden, New Jersey outdoor temperatures 7/6/23: 91 degrees F, 7/7/23: 91 degrees F, 7/10/23: 85 degrees F, 7/11/23: 89 degrees F 7/11/23: 91 degrees F 7/11/23: 91 degrees F 7/11/23: 92 degrees F 7/11/23: 92 degrees F At 6:29 PM, upon ent air on the unit was ve	eyor felt the floor to be very ne hallways. The surveyor M that there was no ice in urveyor and the DoM stat reading for the front end ated a reading of ack end of tack end o	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2020
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 600	toured the wii beads of sweat drippi The DoM acknowledg uncomfortable on this their rooms and some Indoor temperature of the following: Indoor temperature of the following: Indoor temperature of the following: Indoor temperature of the following: Indoor temperature of degr air conditioner on in the residents were in bed stated that the air cor and he turned the PT, surveyor attempted to that room but the resident that room but the resident that room but the resident the temperatures on the the temperatures on the the temperatures on the the heat situation on the she was assigned she just had to do anythe the heat situation on the she was assigned she just had to pass of basic resident care. So encourage hydration turgor if a resident be otherwise there was re had to do. The surve had to be hospitalized	As the surveyor and DoM ng, the surveyor noted ng from the DoM forehead. ged that it was very hot and a unit, yet residents were in a were in the hallways. hecks began and revealed egrees F. ees F. there was no fan or he resident's room and both in their room. The DoM additioner was not turned on AC air conditioner on. The b interview the residents in dents who were both to the surveyor. Both to the surveyor. Both to the surveyor. Both to the surveyor. Both to the temperatures, and ing different in response to the unit, and she stated that residents this shift and that point and she stated that residents this shift and that both the temperatures, and ing different in response to the unit, and she stated that residents this shift and that point and take vital signs and skin comes confused, but nothing different that she yor asked if any residents d due to a change in ated that there were no	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		315205	B. WING				_ 19/2023	
NAME OF P	ROVIDER OR SUPPLIER		- 1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			WO COOPER PLAZA CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	22	F	600				
	of Unsampled Reside degrees F. The resid bed in the room by the conditioner. The roor orange fan on the floo bed and the window. produced by the fan w bed and not reaching #10. The window was surveyor attempted to the resident appeared interviewed. At that the resident's room and the resident's body temper rate was beats per was and and the p on room air. The LPN #3 count a respir the room with the vita At that time, the LPN resident (Resident #1 Support ar the hall. At approximately 6:38 to interview residents observed unsampled . The !" The resident adding that he/s	ent was a second of an and no air n by the window had an or positioned between the Any airflow that was being vas getting blocked by the the unsampled Resident s slightly open. The o interview the resident, but d second of vital signs. The erature was second F, the heart r minute, the blood pressure ulse oxygenation status was a surveyor did not see the ratory rate and she exited I sign machine. #3 stated that there was a ) who had known d resided a few doors down B PM, the surveyor continued on second f, The surveyor Resident #11, who was e resident stated that their room is broken. (This not on the DoM list of						

Facility ID: NJ60412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/2023 MAPPROVED D. 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY		
		315205	B. WING				C 19/2023		
NAME OF P	ROVIDER 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			ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 600	and because utilize their . The resid they were provided ic ice to give out yester he/she didn't think the added that "I "At that to the LPN #3 to reques the resident's cup to g and stated that " "The LPN #3 on their bedside table room. The resident st "She stated that " She stated that " stated, " surveyor observed " and the resident surveyor asked the resident would put it back on a observed the resident	d to state that he/she had of the heat, he/she had to with an ent stated that sometimes e, but the facility didn't have day. The resident stated that ey had ice today either, and ime, the resident called for t for ice. The LPN #3 took get ice, and she returned b put the resident's cup back and left the resident's ated to the surveyor, hat they may get ice in the it. PM, the surveyor observed ext to the window. The man the room felt hot. The nd no air conditioning in the nterviewed the resident at ident stated, ident began to . At that time the resident from the wall, not wearing the sident if he/she utilized ent responded that he/she and wear it. The surveyor	F	60					

Event ID: 5E8J11

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315205	B. WING				C 19/2023
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	was no fan or air cond Resident #1 was know known The resident stated he At 6:58 PM, the surver room temperature of a floor which felt cool. ambulatory residents stated that the "air co The temperature react time, the ED stated the person" and that reside this heat and not wan stated that as long as okay, they have a right if their health deterior they would remove the the ED why they would health deteriorated be the issue for each resis temperatures, and the to be proactive and ne want to move, they do inquired how the facill resident's rooms at ar for those that may no cannot verbalize it, ar provide ice, or the state for their face to cool the provide fans, and som portable air conditionit that not all residents f malfunctioning air cor and within the unit. He	e resident confirmed there ditioning in their room, yet wn by LPN #3 to have e/she would call the nurse. e/she wou	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES			F	ORM APPROVED NO. 0938-0391			
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) D	DATE SURVEY OMPLETED			
		315205	B. WING			C 07/19/2023			
NAME OF PI	ROVIDER 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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
F 600	Continued From page	25	F 6	00					
	the room of unsample bed. There was still r airflow of a floor fan w roommates bed. The indicated degrees At 7:00 PM, the surve room of Resident #20 The resident's bed was to the window and PT resident's bed acting resident's bedside tab	eyor and the ED went to the who was in bed and awake. as against the wall adjacent 'AC unit. There was a large floor adjacent to the							
	PTAC unit was turned observed the DoM tur Only a small amount from it. There was no The surveyor and the interview the resident were soft and inaudib the temperature of the degrees F. The	he resident's reach. The d on from when the surveyor rn it on around 6:30 PM. of warm air was flowing o fan in the resident's room. ED both attempted to but the resident's words le. At that time, the ED took e resident's room which read surveyor asked the ED o of the situation where ble to be effectively							
	, and water within reach. T surveyor's concerns. how the facility chose and portable air cond Resident #2 and his/h afforded a method to in their room when the	ir conditioning, no fan, was d did not have access to he ED acknowledged the The surveyor asked about to prioritize the use of fans itioner units and why her roommate was not maintain the temperatures ey could not speak up. The e surveyor's questions and degrees was too hot for							

Facility ID: NJ60412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED		
		315205	B. WING				C / <b>19/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>					
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 600	the residents, and that the recreation room. know if doctors were check or should check situation. He stated t asking if the residents are hot. At that time, the surve about if he found out facility, and the ED stat their name yet, but the in the building today w and it was the At approximately 7:05 the DON's office with her office which was a The DON provided th LNHA on record and a where he is, and that didn't answer the pho and his religious she only started work the DON continued th DoM informed her on conditioner issue and She stated that there temperatures and the needed replacement if its been replaced." was aware of a therm F and a room that wa fans and hydration sta	At they would move them to The ED stated that he didn't called or how often nurses k the vital signs in this hat the staff go around s are feeling okay or if they eyor followed up with the ED who the LNHA is of the ated that he did not have e reason the LNHA was not was because it was a he religious	F	600				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRU			(X3) DATE COMP	
		315205	B. WING					, 19/2023
NAME OF P	ROVIDER OR SUPPLIER		1	STREET AD	DRESS, CITY, STATE, ZIP CODE			
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			PER PLAZA , NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 600	outside the next day. acknowledged that the temperature logs and anyone to take and log acknowledged that if monitored and logged of and action for the of temperatures, especial temperatures were of the second and thin with the DON and ED complaining of it bein were sweating. The I residents were "comfa and didn't want to lead that no residents com- heat. The surveyor a wait until the resident responding to the lack control in their facility speak to it, insisting the comfortable. The DO interruption in air com- reported to the NJDO NJDOH had reached The DON stated that temperature requirem degrees F. She state aware that the air cor down on the survey Department of Health	The DON and ED ere were no room that they never instructed og temperatures. They temperatures were not d, there can't be knowledge out of range indoor ally when outdoor degrees F. Temperatures rd floors were discussed and the residents g hot, humid and that they DON began stating that the ortable" and "not in distress" ve their rooms. She stated uplained to her about the sked the DON if she would s were in distress before k of adequate temperature , and the DON could not hat the residents were N acknowledged that the ditioning service wasn't H until today after the out to her. she believed the room nent was not to exceed ed that she she was not nditioner system was shut	F	500				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/2023 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		315205	B. WING	_		07/	C 19/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		10/2020
				т	WO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		c	CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	were known to not be functioning at full cap summer months, inclu degrees F outside, fai residents to ensure th temperature control to related emergency, w sufficient cooling area residents on both floo risk situation that requ Emergency Response Emergency Managem The ED stated he wor the local OEM and no At 7:46 PM, the surve unit and interviewed t who stated, "	the air conditioning systems operational or not acity during the heat of the uding today when it was illure to identify high-risk hey had adequate to reduce the risk for a heat with limited access to as in the facility placed all built of the facility placed all fors in an immediate safety uired the activation of their the Plan and the local Office of ment (OEM).	F	600			

Facility ID: NJ60412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER						
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 600	surveyor asked the re- doing, and the resident the surveyor ' resident did not have At 7:52 PM, the surve Aide (CNA #2) walkin stated that she has be since and the facility about the indo stating, "It's b She stated that she w stating that many peo doesn't talk, but she s express his/her needs alerted the CNA #2 re- request for water and resident was unable to need assistance with she would go and give At 7:56 PM, the surve again who was assign surveyor requested the printed copy of the un- stated that she just st week ago and that she the census or the mean resident. The surveyor transferred to the hos out the records such a Administration Record resident, and she stat ask someone else to she had been trained Preparedness at the f	s no ice in the pitcher. The sident how he/she was in stated in a resident to ?" The access to the call bell. eyor saw Certified Nursing g down the hallway, and she een employed at the facility hat she had informed the or room temperatures on een hot for a while-weeks!" vas familiar with Resident #2 ple think that the resident stated that he/she can is at times. The surveyor egarding the resident's she confirmed that the o reach the water and would drinking. She stated that e him/her water. eyor interviewed the LPN #3 ned to reach the facility only a e doesn't know how to print dical records for any or asked if a resident was pital, how she would print as the electronic Medication d (eMAR) to go with the red that she would have to do it. The surveyor asked if on Emergency facility and how to respond, ed that she had not been	F	600			

Facility ID: NJ60412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER 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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	and because she didr documents, she ackn difficult to send reside electronic medical red At 8:07 PM, the ED in a voicemail for the loo facility's indoor heat s At 8:16 PM, the surve Resident #13 who wa The resident stated th facility about a week a conditioner] doesn't k complained that it was that the PTAC unit will but then after a short The resident stated th keep being reset by p corner of the machine there was an issue wit the unit. At 8:18 PM, the surve representative who w The represent on this unit" and that it visiting was sweating providing hygiene to the hot on the unit to do the representative stated receive hygiene care The surveyor noted the	dn't know what what to do n't know how to print owledged it would make it ents elsewhere with their cords. formed the surveyor he left cal OEM regarding the ituation. eyor interviewed unsampled as ambulatory on the unit. nat he/she got a fan from the ago, "because my AC [air eep up." The resident s "hot as hell in here" and Il turn on and start off cool, period of time it shuts off. nat the unit would have to pushing a button in the e. The resident added that it the ice machine also on eyor interviewed a resident as visiting a resident on ative stated that "It's so hot the resident he/she was and that staff don't he resident because it's too he physical work. The that the resident did not that day. the new outdoor temperature degrees Fahrenheit, and nal temperatures on	F	600			

Facility ID: NJ60412

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		D HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		315205	B. WING				/19/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	Room degree At 8:35 PM, two survey of Resident #1 and to which read degree no fan or functioning a The resident stated the not feeling well. At the to get the RN/Supervise brought the machine take a set of vital sign stating he had to look gloves accessible in or room. The RN/Super three minutes to find a taking the resident's we RN/Supervisor applie the resident's finger fi oxygenation status we resident was on The heart ra minute (bpm) for sever machine, and slowly se then bpm, then never accessed a ste heart rate when the h from the pulse oximet Mocument the blood p temperature, and he we to the resident using a	F. es F. es F. es F. es F ees F ees F ees F ees F ees F. The resident still had air conditioner in their room. the hyshe was still hot and hat time, two surveyors went for conductioner in their room. the resident's room to as, but then stepped out for gloves. There were no or around the resident's rvisor took approximately a pair of gloves before rital signs. The d the pulse oximeter onto rst to determine his/her hich read to while the started to decline to be pm bpm. The RN/Supervisor thoscope to get an apical eart rate was showing signs ry device that there may be l/Supervisor did not take or or essure reading or take a went to get the resident a o aid in the started the the started to decline to approximately and the started to approximately approximately a	F	600			

Event ID: 5E8J11

Facility ID: NJ60412

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/22/2023 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>				(X3) DATE COMP	SURVEY LETED
		315205	B. WING			_		C 19/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•••	10/2020
MAJESTIC	CENTER FOR REHAB	SUB-ACUTE CARE		Т	WO COOPER PLAZA			
				С	AMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page respiratory rate prior to The surveyor asked we temperature, and the he wasn't going to tak that he would go try a thermometer that can forehead. At approximately 8:45 surveyors the facility's (EP) Manual stored in surveyors asked about Emergency Plan and The ED stated that it to and he would have to any urgency, he stepp surveyors where to fir it himself, and the sur the EP manual. The se find any information a residents could be tra emergency or evacual Inside the red binder to Preparedness Plannin revised October 2012 Considerations for Uti specified very generic identifying all critical of conditioning systems, communication system and maintenance persi- familiar with all buildin procedures for restori	<ul> <li>32</li> <li>o applying the the second state of the second on th</li></ul>		600				
		ency Procedure for Utility						

Facility ID: NJ60412

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/22/2023 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		315205	B. WING		07/19/2023
	ROVIDER OR SUPPLIER	& SUB-ACUTE CARE	т	TREET ADDRESS, CITY, STATE, ZIP COI WO COOPER PLAZA CAMDEN, NJ 08103	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	IN SHOULD BE COMPLETION E APPROPRIATE DATE
F 600	Outage revised Octol Brown" is announced "determine if the loss incident occurring at leak, fire, or collision, service disruption and 911 if there is an eme management staff rej Command Post for a Activate the Incident management the inci systems (emergency water) are available designated in accord Monitor Residents to check resident-used attached Severe Colo Procedures to prever of cooling functions. and threatens resider Evacuation Procedur contact with local em advise them of the sit informed of potential worsens. The situatic control" after the outa the Incident Comman situation 'safe' " The attached Severe included: When the function hours: 1. Move reside air-conditioned part of Encourage residents hy necessary and record wash cloths as needed	ber 2012 in which a "Code overhead, and staff should of a utility is due to an the facility like a rupture, determine the impact of d projected durationcontact ergency situation. Facility bort to the Incident briefing and instruction. Command System to dentEnsure back-up generatorsemergency e and operating as ance with requirements. ensure they are safe and medical equipmentsee d and Hot Weather nthyperpyrexia during loss If the outage is long term at safety and welfare, initiate esestablish and maintain ergency responders to cuation and keep them needs as the situation on is only deemed "under ages has been restored and der has declared the Hot Weather Procedures facility temperature reaches eit and remains so for four	F 600		

Facility ID: NJ60412

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE COM	E SURVEY PLETED
		315205	B. WING				/19/2023
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			OOPER PLAZA EN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	and notify attending p Notify 911 if a resident be in danger of heat-r residents if necessary thermometers. 9. Not The Emergency Oper the Evacuation Plan r response for a Heat E equipped with air con and individual units in Temperatures in the f Fahrenheit and below start to rise above 79 following procedures Maintenance: 1. Com ensure: a. Window cu offices are drawn to b windows and doors a temperatures at all sta minimum of every fou interior facility temper degrees Fahrenheit o immediately. 3. Turn offices and common a light would cause safe available fans. a. inve of all portable and wa additional ice, quantit Administrator or desig delivery of portable ai directed by the Admin Continue on-going fac every two (2) hours.	beratures of the residents hysicians if necessary. 6. tt/staff member appears to elated stress. 7. Evacuate 7. 8. Monitor environmental tify Medical Director. Tations Plan located within evised 7/10/15 included a Emergency. "The facility is dition in all common areas each patient room. acility must be 81 degrees 7. Should the temperature degrees Fahrenheit the should take place: plete facility rounds to intains in resident rooms and lock direct sun. b. all re closed. 2. log ations initially and at a r (4) hours. a. Report all ature readings of 80 r above to the administrator off lighting in all corridors, areas, except where lack of ety issues. 4. Turn on all entory quantity and location Il mounted fansprocure y as determined by the gnee. 6. Rent and set up r conditioning units as instrator or designee. 7. cility rounds at a minimum of 	F 6	00			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/22/2023 M APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		315205	B. WING				C / <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	10/2020
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 600	utilizing the following weight loss, b. dialysi staff for nutrition, d. R nutrition, e. any reside and/or determined to residents with the corn necessarily at-risk. C factors must be consi residents at greatest measures to stabilize Interventions include, notification of physicia b. COPD [Chronic Ob Disease] -monitor O2 four (4) hours or as co internal temperature of degrees Fahrenheit, or residents a minimum condition warrants cooler areas of facility warrant. 8. Continue of hourly. 9. Complete p residents' conditions of lightweight clothing of continuation hydration PM12. Revise staffi appropriately implement Social Services: 1. Co and family members of Administrator: 1. Impl and revise the facility Notify the Medical Dir Manager and Clinical	assessment of their e residents at greatest risk guidelines: a. significant s, c. total dependence on tesidents requiring enteral ent that is compromised be at high risk. Note: not all ndition(s) listed are other physical and lifestyle dered. 4. Collate listing of risk and implement and/or reduce the risk. but are not limited to: a. an of any condition change. ostructive Pulmonary [oxygen] saturation every ondition warrants. 5. If the of the facility reaches 80 obtain temperatures on all of every four (4) hours or as . 7. Relocate residents to <i>x</i> if possible, as conditions visual rounds a minimum of hysical assessment as warrant. 10. Maintain n all residents 11. Initiate n cart 7:00 AM to 10:00 ng as needed, to ent and maintain action plan.	F	600			

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		LE CONSTRUCTION	(X3) DATE COMF	
		315205	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 600	degrees Fahrenheit o period of four hours o notification of the New Health is required. 5. adequate to maintain procedures and meet the need to evacuate There was an Evacua date of 7/10/2015 but address specific facili transfer of residents. At 9:45 PM, the surve the DON who stated to local facilities they ha transfer residents to it emergency. The ED surveyors to rememb facility for two weeks. speak to evacuation of in the event of an emergency response to the safety, relocation, and temperatures. At 9:54 PM, the surve outdoor temperatures F, there were resident following was observe Room The PTAC	r higher for a continuous r longer the immediate w Jersey Department of Ensure staffing levels are facility emergency resident needs. 6. Assess ." ation Plan with a revised the evacuation plan did not ty agreements for the eyors interviewed the ED and that they were not sure what d an agreement with to n the event of an stated that he wanted the er he had only been at the The DON was unable to destinations for the residents ergency. nation with the local team, the surveyor returned e ED to screen residents for d take additional room eyor observed that even as a had reduced to degrees dents that had room ceeded degrees F, and at rooms had temperatures degrees F. The	F	60	0		

Facility ID: NJ60412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	
		315205	B. WING				_ 19/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	conditioner in the root degrees F. Room There was unit installed in the root degrees F. Room Cherror and the root with cool air, but the F room was degree portable air conditioner Room The PTAC the room. The room Room The PTAC the room. The room Room The PTAC blowing a minimal arm temperature was Co Room The PTAC blowing a minimal arm temperature was Co Room The PTAC the room. The root the room. The root com The root the PTAC the room. The root the room The root the room The root com The root com The root the PTAC unit shuts co button has to be press to blow any cold air. Room The root the PTAC unit shuts co button has to be press to blow any cold air. Room The root Room The root com The root conditioner in the	degrees F. s no fan and no air m. The room was s a portable air conditioner om. The room was C unit was set to run on high PTAC blowing warm air. The es F. (There was no er in the room). C unit was not functioning in was degrees F. C unit was not functioning in was degrees F. C unit was not functioning in now a box fan in the at's room that the resident one hour ago. The room degrees F. C unit was not functioning in now a box fan in the at's room that the resident one hour ago. The room degrees F. no functioning air m. The residents stated that off every hour and the reset sed each time in order for it The room was degrees. s functioning air conditioner m was degrees F. C unit was not functioning o were both to be observed fan. The room temperature s no functioning air m but there were two fans. e was degrees F. C unit was functioning at the	F	600			

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES		(X2) MUL	TIPLE			FORM	D: 11/22/2023 A APPROVED 0. 0938-0391 SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _				LETED
	315205	B. WING					C 19/2023
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE	•••	
MAJESTIC CENTER FOR REHAB 8	SUB-ACUTE CARE			WO COOPER PLAZA AMDEN, NJ 08103			
	TEMENT OF DEFICIENCIES	ID	U		PLAN OF CORRECTION		(XE)
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
The room was in de Room is The reside conditioner unit installe running. The room wa door and is degrees Room is The reside conditioner unit. The reside maintained by the Dol rooms that did not hav including rooms is and is The liss listed on is that further units had zero of them list was started (which according to the DolM) shutdown of the air co on when there issue system and subs observation, there was provided such as a po maintain the room tem F in those resident roo conditioner units in ac regulatory requiremen portable air conditioner also on the list of malf During the course of th temperature checks of approximately 10:45 F staff on the unit makin relocate the residents	a no air conditioner or fan. egrees F. ents had a portable air ed in their room which was as degrees F by the s by the window. ents had a portable air room temperature was ed "P-TAC (Rooms)" list W reflected nine resident ve a working PTAC unit, t reflected that all the rooms had malfunctioning PTAC in fixed or replaced since the a was two weeks ago ), particularly upon the inditioner system on was noted to a sparking sequent fire risk. Upon s no alternative means ortable air conditioner to nperature below degrees borns with malfunctioning air cordance with the tts. In addition there was no er in room dwhich was unctioning P-TAC rooms. the safety and room n form 9:54 PM to PM, there were no facility g a good faith effort to who were unable to make were dependent on staff	F	600				

Facility ID: NJ60412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
CENTERS FOR MEDICARE & ME           STATEMENT OF DEFICIENCIES         (X1           AND PLAN OF CORRECTION         (X1					E CONSTRUCTION		SURVEY LETED		
		315205	B. WING						
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•			
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			WO COOPER PLAZA CAMDEN, NJ 08103				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 600	at approximately 10:2 wheel a resident down and that he would be returned to the <b>Second</b> continued the tour che taking temperatures v At 11:10 PM, a new fa the facility and office of he was "second in co and and that he wante plan to address the m conditioning system. trying to get every por available to the facility able to bring six over and they are hoping to added that they would cooler space if they d conditioner to give the At that time the DON Medical Director. She Director had been cal that she had not hear confirmed there has r building yet. The DO licensed as a Nurse F acknowledged that sh medical services as a DON of the facility. At 11:41 PM, the surv emergency response	om In addition, while s with the ED, the ED stated 0 PM that he had to go in the hallway in a wheelchair right back, but the ED never Unit and the surveyor ecking on the residents and without him. acility representative entered of the LNHA and stated that immand" with the company, ed to discuss the facility's alfunctioning air He stated that they were table air conditioner unit $\gamma$ . He stated that they were now from another building, o deliver 10 more total. He d relocate residents to the id not have a portable air em. provided the name of the e stated that the Medical led earlier this evening, but d back from him yet. She not been a physician in the N stated that she was Practitioner, but he could not perform the NP since she was also the eyors and the local team discussed with facility of approximately 10 PM at rooms affecting	F	600					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA1	E SURVEY IPLETED
		315205	B. WING			0	C 7/19/2023
NAME OF PR	OVIDER 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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	Practitioner (NP) wou 90 minutes in lieu of t assess residents. On 7/16/23 at 12:35 A to the 3-North Unit an in his/her room. The conditioner and a box resident stated that he in his/her room. The conditioner and a box resident stated that he in his/her room. The conditioner and a box resident stated that he in his/her room. The conditioner and a box resident stated that he is that time the survey stated that he worked in the time the survey stated that he worked in the time the survey stated that he worked is stated that he worked is services soor but was not currently that this was the reside because of the prospet the LPN #4 asked the to go to a cooler locat indicated that he/she resident acknowledge warm. The LPN #3 of to the recreation room resident is a state in the could be done with the	s exceeding degrees F TAC units. A stated that the Nurse Id be at the facility in about he Medical Director to AM, the surveyors returned d observed Resident #1 still resident had no air fan in the room. The e/she was still not appeared and factors appeared and factors appeared and factors and that he is familiar with N #4 confirmed that the warm and he was because there was no oner in the room and there hich was in the window. The esident #1 may be going on a due to his/her condition on factors. At that time, eresident if he/she wanted ion, and the resident did not want to go, but the ed that the room was too ffered to bring the resident in with his/her bed, and the that time, the LPN #4 stated he couldn't force the e surveyor asked if anything e room temperature then, hat he would have to look	F	600			

Facility ID: NJ60412

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		ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MU	тірі	PLE CONSTRUCTION	(X3) DATE	D. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:			6		PLETED
			A. BOILD	110			с
		315205	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2020
					TWO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			CAMDEN, NJ 08103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG			IAG	1	DEFICIENCY)		
F 600	Continued From page	e 41	F	60	0		
	resident's condition, h	ne didn't know why there was					
		is/her room, especially if					
	he/she didn't want to	leave the room. The					
	resident had no cool	-					
	methods offered to hi	m/her at the time of the					
	encounter.						
	At approximately 12:5	50 AM, the surveyor					
	observed two new po	rtable air conditioner units					
		ugh the elevator. The staff					
		the unit, but nobody					
	-	air conditioning unit to the					
	room of Resident #1						
		e was hot and sweaty and					
	had known multiple	and					
	c	and					
		·					
	At approximately 1:00	) AM, the second in					
	command regional ac	Iministrator stated that they					
	went back up to chec	k the temperatures of the					
	rooms again on	and found that many of					
		below degrees, and that					
		offered to leave their rooms					
	-	room where it was colder					
	and all but two had re	fused to leave their rooms.					
	The surveyor went to	to verify the report.					
		s #14 and #15 were in their					
	-	l stated that no one from the					
	-	neir rooms and offered them					
		cation. The residents both					
	-	d be fine overnight and don't					
	need to leave their ro	-					
		pled Resident #10 now a					
	portable air condition						
		#16 stated that he/she was					
	-	to leave the room to go to					
	ine cooler room wher	e his/her roommate was, but					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED NO. 0938-0391
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		315205	B. WING				C 7/ <b>19/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
					TWO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 600	Continued From page refused.		F	600			
	had a room temperate no fan or air condition that no one from the f ask if he/she wanted and that the resident consider moving to a	Resident #3 who previously ure of degrees F with hing, and the resident stated facility came to their room to to go to a cooler location, stated that he/she would cooler location because the he resident stated he/she e.					
	with their eyes closed	the residents were in bed I and appeared to be asleep boms felt less humid due to temperatures.					
	easily accessible sup emergency or other h #4 and DON were un initially, desp he signs off the accou- cart. After looking all the surveyors found it At that time, the LPN surveyors and the DO was the have known where it it. At that time, the su- the 11-7 (night shift) D Check List and compa- was actually in the en- surveyor observed the cart were in disarray v located in several of the	sh" cart check on the <b>sec</b> to determine adequate, plies in the event of an eat related event. The LPN able to locate the <b>sec</b> oute the LPN #4 stating that untability sheet for the code over the mobile code cart, t on the top shelf of the cart. #4 walked away from the DN acknowledged that this and that LPN #4 should was because he signs off on urveyors continued to review Daily Nursing Crash Cart ared the checklist with what nergency code cart. The at the items within the code					

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
CENTERS FOR MEDICARE & ME STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SURVE COMPLETED C	
		315205	B. WING				_ 19/2023
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			D COOPER PLAZA MDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 600	difficult to easily ident observed there was s gels, but there was or DON stated that there medication carts, and medication carts, and medication cart to pul surveyors. The surve signing off that there on the surveyors. The surve signing off that there and the DON stated t accessible in the medication wasn't on the code car the code cart should he on the list for easy ac- emergency. The surve there supposed to be the code cart, but the surveyors also observe house-stock doses of medication ass resident's name on it. that a medication ass resident should not be The surveyor observe Nursing Crash Cart C down the " Mursing Crash Cart C down the " Mursing verified such as functioning, and the event a resident r functioning during the	ify supplies. The surveyors upposed to be ally one in the code cart. The evere for the in the the DON went to the I one out to show the eyor asked why nurses were were two present including was only one in the drawer, hat they had them lication carts, even if it art. She acknowledged that be stocked with all the items cess in the event of an veyor also observed that two for the formal of the prescription with a The DON acknowledged igned to an individual e in the code cart. The DON acknowledged igned to an individual e in the code cart. ed that the 11-7 Daily theck List had a box to mark er it did not specify what was a the location of the formal its expiration check. expor checked the functioning at would need to be used in needed The formal turned on and was	F	500			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		315205	B. WING				_ 19/2023	
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE			
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 600	stated that someone into that issue. She is a Nursing Crash Cart C accountability for the and functioning of the unable to provide any accountability reaction of the unable to provide any accountability reaction of the unable to provide any accountability reaction of the unable to the solution of the units, and that she was conditioners worked of she was waiting on m. The surveyor asked if anything different for the units, and the LPN to do anything different for the units, and the LPN to do anything different routs signs, and the LPN #5 have to do that. The frequent assessments LPN #5 stated "no" be trying to correct the p. At that time at approximation of the DON, the NP state was going to start doi residents due to the normality is stated of the the to the the to the to the the to the to the the the to	r a month ago. The DON from the facility would look confirmed that the 11-7 Daily heck List did not have the expiration of the pads machine. The DON was evidence of a separate cord. yor observed LPN #5 in the Unit. The LPN #5 stated at the facility as she . She confirmed she was unit for the night shift. at the unit was on the warm a ware that not all the air on the unit. She stated that aintenance to fix the issue. is she was informed to do the residents in particular stioning air conditioning on N #5 stated she was not told at except offer the residents urveyor asked if she had to nding, monitoring or vital 5 stated that she did not surveyor asked about more is on the residents, and the ecause maintenance was roblem. imately 1:28 AM, the e Nurse Practitioner enter ed over to the nurses ne DON. After meeting with ed to the surveyor that she ng assessments on the	F	600	0			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED		
		315205	B. WING				C / <b>19/2023</b>		
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE	TWO COOPER PLAZA CAMDEN, NJ 08103						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RECTIVE ACTION SHOULD BE CORENCED TO THE APPROPRIATE			
F 600	At that time, the NP s start her assessments surveyor stopped the she prioritized her dea unit when the more serious tempera NP turned around and surveyor's question. on the discussed Resident # would start her asses At 1:31 AM, the surve the hallway in a whee alcove. The resident's also. The surveyor of vital signs using a ma was not utilizing resident's pulse oxyge room air, and the hea oxygenation device w bpm. The resident's I manual blood press manual reading and s She also stated that s resident's apical pulse and he/she was expe normal behavior as he observation earlier in At 1:38 AM, the surve stated that she had w	tated that she was going to s on the <b>second</b> unit. The NP and asked about how cision to start on the unit was known to have the atures by the heat, and the d acknowledged the She stated she would start stead. The surveyor 1 and she stated that she sment with Resident #1 in elchair positioned in an s bed was in the hallway beserved LPN #5 take some inchine on the resident who at the time. The enation status was <b>second</b> on rt rate using the pulse vas reading a pulse of blood pressure read ted that she wanted to take sure reading. The NP took a stated that it was <b>second</b> , riencing a change in their e/she appeared more at she wants to send the ency room for evaluation. ed that this was how the essenting since the first	F	600					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED 3 NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		315205	B. WING				C 07/19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 600	stated that the reside listened to it was was She st just not the NP how she was related to a heat ever mostly she would be cognition or behavior may feel warm too. T asking if there was ar assessing the resider change in staff were supposed to residents over any free temperatures not mai levels, and the NP sta assessed resumed her assessment	<ul> <li>nt's heart rate when she</li> <li>and the blood pressure</li> <li>ated that the resident was</li> <li>The surveyor asked</li> <li>assessing the residents</li> <li>and she stated that</li> <li>booking for a change in</li> <li>She stated that the skin</li> <li>The surveyor pressed the NP</li> <li>bything else she would be</li> <li>and she stated a</li> <li>The surveyor asked if</li> <li>be monitoring the</li> <li>equency due to the room</li> <li>ntaining safe, comfortable</li> <li>ated that residents should be</li> <li>The NP then</li> <li>nents of the other residents</li> </ul>	F	600			
	in command Regiona that the facility had al air conditioning units them in. He stated th families or next of kin the malfunctioning air surveyor asked for ar made related to coolin survey and the survey summary of the HVAC The surveyor was told the HVAC company b surveyor asked about facilities that have an	eyor interviewed the second I Administrator who stated ready delivered five portable and they were still bringing that he wasn't sure if the s had been notified about r conditioning units. The hy invoices for purchases ing the facility prior to the yor requested the visit C company on the sister C company on the sister the sister facilities or other agreement for evacuation to told that there was one					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		315205	B. WING				C / <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
					TWO COOPER PLAZA		
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE	CAMDEN, NJ 08103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	sister facility that had but that was it. The f the EP related to the transfer agreements of Approximately 1:50 A Emergency Managen medical transportation transferred to the Em At 2:00 AM, the surve manual updated in Ja facility agreements fo surveyors had been a that the DON, ED and regional administrator speak to or provide bo of the activation of the the heat. At approximately 2:30 local responders met second in command r regarding the surveyor facility neglect to iden during their heat eme individualized plan to adverse event when t and individual PTAC of down or not working a adequate and sustain reduce the risk for set temperature checks w resident units were ex- residents were visibly of feeling "hot," and a emergency response their air conditioning r	10 vacant beds available, facility still had not provided evacuation plan with the of other facilities. M, the local Office of nent (OEM) officer called for n for Resident #1 to be ergency Room. eyors found an updated EP muary 2023 which had the r evacuation that the usking for and looking for d second in command r were unable to provide or efore and during the course eir Emergency Plan due to 0 AM, the surveyors and with the DON, ED, and regional administrator ors concerns regarding the tify high-risk residents rgency and develop an prevent a heat-related heir air conditioning system units were known to be shut at full capacity, implement ing cooling measures to rious harm, initiate room when air temperature on	F	600			

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	-	ID HUMAN SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
		IDENTIFICATION NUMBER:	A. BUILDI	ING		COMPLETED	
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER 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				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	correct the HVAC main notified of Resident # had to be hospitalized condition that nursing when brought to the at The surveyors informan immediate jeopard written removal plant to situation, including the The facility could not and response to the E implementation of the facility's negligence to did not exceed 81 deg their malfunctioning H failure to implement in residents, assess, more resident room temper units ( survey intervention pl serious avoidable temperature readings degrees Fahrent Symptoms of heat ext nausea, dizziness, irr sweating, thirst, eleval can quickly lead to heat temperature can rise 10-15 minutes of profileading to serious hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes of profileading to serious heat hospitalization and degrees Fahrent for the temperature can rise 10-15 minutes for the temperature can rise 10-	Ifunction. They were 1 had known no air conditioner or fan and e exceeded degrees and d due to a change in staff did not act upon even attention by the surveyors. ed the facility that this was ly situation that required a to address the serious e code cart discrepancies. speak to lack of knowledge Emergency Plan and the a Heat Emergency plan. The to ensure room temperatures grees with knowledge of NAC system or the and heasures to identify at risk ponitor, and maintain the atures on two of their two floors) from until acced all residents at risk for from illness when resident room were recorded as high as heit on the floor. haustion include headache, itability, muscle cramps, ted body temperature which eat stroke when the body to 106 degrees F within onged heat exposure, alth consequences including	F	600			

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/22/2023 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315205	B. WING			_		C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	••••	
				т١	WO COOPER PLAZA			
MAJESTIC	CENTER FOR REHAB &	SUB-ACUTE CARE		С	AMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 600	Continued From page remove the immediac On 7/16/23 at 12:30 F returned to the facility building a rented gene trucks. The surveyor the main entrance on At 12:47 PM, the surve Regional Licensed Nu (R/LNHA) who stated administrator in New A he is not the LNHA or name of the Surve ED did not know that country in R/LNHA could not spe have disclosed that to stated that he wanted what has been done i air conditioning situati contracted with an HV every resident room in their own portable air room and the room te good and "residents a stated that they also in conditioner units for th BTU's, two per floor. rented a high power g	A 49 y. M, the survey team and observed outside the erator and HVAC rental entered the building through the floor. eyor was introduced to the ursing Home Administrator that he was licensed as an Jersey. He stated that while a record, he provided the record and stated that he is and that he wouldn't be be available for an yor asked why the DON and the LNHA was out of the		600			TE	DATE
	items purchased relat fans including fans, ai the HVAC visit from th	equested any invoices of ed to the heat emergency r conditioners, as well as ne invoice datec <b>ed to the set</b> tated that he may not have						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CONSTRUCTION		LETED
		315205	B. WING				C 19/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE					IWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	a copy of the HVAC v tomorrow. From approximately 1 surveyor toured the temperatures and cor checks. The surveyo had the portable air c temperatures were wir requirements. The surveyor reviewe Resident #1 who was at approximat A review of the Admis summary) reflected the admitted to	isit from that invoice until :00 PM to 2:00 PM, the floor and took room inducted resident safety r verified all resident rooms onditioning units and room thin regulatory d the medical records for sent to the hospital on tely 2 AM. sion Record (an admission nat the resident was t also had a diagnosis of ) with an onset Admission Record revealed a status, efforts should be		600	DEFICIENCY)		
	initiated on 3 in due to being a of the goals included	nt's individualized care plan cluded that the resident had n . One that the resident will display daily with an [outdated] Interventions included give					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/2023 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	D.			(X3) DATE		
		245205					C	
	ROVIDER OR SUPPLIER	315205	B. WI		STREET ADDRESS, CITY, STATE, ZIP CODE	<b>07/19/2023</b> =		
					TWO COOPER PLAZA			
MAJESTI	IAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE				CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIC	LL PR	id Efix Ag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 600	In addition, there was that the resid that the resid target date of the will be maintained thr intervention included and social services to resident in the facility The care plan reflected an extensive physical mobility. A review of the active Report for the active Report for the active for a evaluati and a physician order add Summary Report also was on medication for no physician order for addition the electronic Record (eMAR) for	as ordered. y side effects and r for signs and symptom ; ; and to utilize the a care plan initiated on ent has a goal had an outdated hat the resident's comforder ough the review date. A to consult with physician to consult of one staff for physician Order Summer effected a physician order on and treat dated for minister as needed for to reflected that the resident care for minister as needed for to reflected that the resident care for minister as needed for to reflected that the resident care for minister as needed for to reflected that the resident to orders found in the Or	ns of ort An n lired ed ary der ent as In tion he	F 600				

Event ID: 5E8J11

Facility ID: NJ60412

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 11/22/2023 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		LETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE WO COOPER PLAZA		
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE					CAMDEN, NJ 08103		
(X4) ID PREFIX TAG					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	reflected a physician at 23:31 (11:31 PM) the readmitted to the facil and was the resident has the resident has the resident has the resident has the resident has the resident has the nurse from AM which reflected the the hospital via 911 for recorded indicated BF SP02 (pulse oxygena air, temperature indicted that the phys POA was contacted. rate recorded on the p documented evidence when the residence when the residence treatment. The nurse had breaths per m Summary on A review of the ePNs and the vite reflected that the residence signs taken and docu 15:43 PM (3:43 PM) to despite know	brogress note dated intervention of the resident was recently ity following an intervention of the auscultation ausculta	F	600			

Event ID: 5E8J11

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	-	ID HUMAN SERVICES				FORM	APPROVED		
		MEDICAID SERVICES					D. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY		
			A. BUILD	ING _					
		315205	B. WING				C 19/2023		
NAME OF P	ROVIDER OR SUPPLIER	I	1	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
	MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			L I	TWO COOPER PLAZA				
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		0	CAMDEN, NJ 08103				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION					(X5) COMPLETION			
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE					
IAG					CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 600	Continued From page	e 53	F	600					
		lent's individual room as							
	indicated on the facili								
		unctioning P-TAC units.							
		air conditioner or fan in the							
	room on and and exceeded degrees	the room temperature							
		, , , , , , , , , , , , , , , , , , ,							
	On 7/16/23 at 2:00 PI	M, the facility provided the							
		esidents identified by the							
	facility to be at								
		cordance with their written							
		acility indicated that there ut of a total of <b>a total of</b>							
	on their census that w								
		his indicates a total of							
		lation identified to be at high							
		Itcome if not provided							
	adequate room tempe	eratures.							
	The surveyor reviewe	ed the invoice dated							
	-	through an email for an							
		with the HVAC company.							
	The invoice did not sp	pecify what the amount was							
	covering or what serv	vice it provided.							
	At 2.47 PM the Regi	onal LNHA stated that the							
		e HVAC invoice dated							
	was the "purchaser" o								
	At 3:56 PM, the surve	-							
	emergency transporta	ation contracts in the EP							
	ambulance company								
		ne ambulance company.							
		nal copy of an Emergency							
		ract not on an ambulance							
	company letterhead t								
		"to the best of its ability							
	given the emergency	evacuation circumstances							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	CENTER FOR REHAB	& SUB-ACUTE CARE			IWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	to an emergency evaluation of residents designated relocation signature dated in the signature dated information related to at that time, the survey ambulance service contract with a referenced on the manual. At 5:02 PM, the survey of an active contract with as referenced on the manual. At 5:02 PM, the survey of an active contract with as referenced on the manual. At 5:02 PM, the survey of an active contract with as referenced on the manual. At 5:02 PM, the survey of an active contract with as referenced on the manual. At 5:02 PM, the survey of an active contract with as referenced on the manual. At 5:02 PM, the survey of an active contract with as the state of New Jerecord went to the state of the DC LNHA on record was asked them yesterday and that both responder religious for the LNHA state of the the stated that the Medica by whoever identified that he wasn't sure with never came to the fact heat emergency. He stated that on the stated that on the stated that the the state of the the stated that on the stated that on the stated that the the stated that on the stated that on the stated that the the stated the stated that the the stated that the t	least two transport vehicles cuationfor the emergency requiring ambulance to facilities" with a typed but there was no phone of contract, or other the ambulance company. eyor discussed the ontract with the <b>Emergency</b> ator who called the r information, and he r that the facility did not have h the ambulance company contract(s) in the EP eyor interviewed the stated that he was licensed ersey and the LNHA on and believed his last day d not speak to how long he puntry. The surveyor asked DN did not know that the out of the country when y who and where he was,	F	600			

Facility ID: NJ60412

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		D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315205	B. WING				C / <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	CENTER FOR REHAB	& SUB-ACUTE CARE			IWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	He stated that they "p most of it." He stated and monitored it. The provide evidence of p regarding services ren invoice dated they called and they called and that the facility was cu- He stated that on had purchased addition units. The surveyor re- purchases. The surveyor re- purchases. The surveyor re- purchases. The surveyor re- process was for commissues at the facility, s maintenance log, and that he couldn't speak maintenance logs but information and get bases. At 6:06 PM, the surve again in the presence stated that he could s process. He stated the knows has to be fixed ways in which he rece needed action. He stated the PTAC units in the contractors are needed would be responsible stated that he was no professional. He stated the facility to fix some log. The DoM stated ice and some portable second and floor	which was working at 50%. repaid everything and fixed that they ordered the parts Regional LNHA did not ayment to the contractor indered at the time of the He stated that on Friday ind asked for more parts and urrently awaiting the parts. If a 2 PM the facility onal portable air conditioning equested receipts for those eyor asked what the nunicating maintenance such as the use of a the Regional LNHA stated to the process regarding he could find out the ack to the surveyor. Yor interviewed the DoM of the Regional LNHA who peak to the maintenance log nat the logs are what he daily, but there are three eived information about what at the logs are what he daily, but there are three eived information about what at the logs are what he daily, but there are three eived information about what at the logs are what he daily of the receptionist is to be done such as with resident rooms. If ed to do the work than he to call a contractor. He t a licensed HVAC ed that if anyone came to thing he can write it in the	F	600			

Facility ID: NJ60412

If continuation sheet Page 56 of 124

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 600	able to address all the PTAC unit in the room stated that the LNHA, should know how to m conditioning to the Net Health (NJDOH). A review of the Mainte provided at 6:30 PM to Building Operations in resident rooms receiv A.C. [Air Conditioner]] , and . However, on 7/15/23 had observed room that was blowing warn temperature was did not have a portab room. Room was (Rooms)" audit list ind the room was not fund Further the Maintenan indicated that on rooms that got a "New and . He invoices provided that received new air cond (On 7/15/23 at 5:52 P that resident room of degrees F). The Maintenance Dai reflected that room and on room to motor	e individual issues with each hs. The Regional LNHA DON and Assistant DON eport an interruption in air w Jersey Department of enance Daily Work Log by the Regional Director of indicated that on ed a "New Port [portable] " unit including room at 9:54 PM, the surveyor only had a PTAC unit m air and the room degrees F. The resident le air conditioner in his/her s also on undated "P-TAC dicating that the PTAC unit in ctioning at capacity. here Daily Work Log there were five resident v A.C.," rooms bowever, there were no t indicated the resident ditioning in these rooms. M, the surveyor observed had a room temperature by Work Log for had a "Replaced P-TAC," received a "new A.C. in ad valve on A.C." The DoM to change the valve and	F	600			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		315205	B. WING			C 07/19/2023		
NAME OF PI	ROVIDER OR SUPPLIER	L	<b>I</b>	:	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	Continued From page	9 57	F	600	D			
	stated that on the PTAC audit and re and the others were r for a copy of the audit At 7:05 PM, the Regio was no procedure/acc check the function of and no documented p the equipment.	Building Operations who that they started epaired 3 of the PTAC units reset. The surveyor asked t. onal LNHA stated that there						
	copies of facilities pol that all the policies ar does not have access The surveyor asked v access to the policies facility since has access to the pol copy of the policy boo	icies, and the DON stated e electronic and that she s to the electronic policies. why she does not have if she has been at the , and she stated that she icies only through a hard ok and she would have to flip nd the individual policies						
	inform the surveyor the the LNHA on record v country and that he w through He of the administration I	could not speak to why none knew this information.						
	the facility administration brought in himself and Building Operations. brought in and the su	eyors requested to meet with tion, and the Regional LNHA d the Regional Director of The ED and DON were not rveyor asked why. The d that the ED was not						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		315205	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			IWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 600	the DON. At that time DON about Resident resident was hospitali She stated that he was had frequent hospitali resident had a history resident was not alwas the hospital and would time the resident was surveyor asked if the hospital each time, an stating that the reside for re-hospital asked why the reside conditioning if the res when the PTAC syste be nonfunctioning and been shut down to pro- not speak to it. There evidence that the resid declined a portable ai to move to a different DON stated that she of interruption in service didn't know there was She stated that she h report it, and stated that aware of the issue on the NJDOH on informed the facility o outdated on the verified to be replaced on after	the stated that he would get a, the surveyor asked the #1 and she stated that the zed for	F	600			

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Facility ID: NJ60412

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &						FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONST	RUCTION		(X3) DATE	
AND FLAN OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG				C
	315205	B. WING _					19/2023
NAME OF PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE			
MAJESTIC CENTER FOR REHAB	& SUB-ACUTE CARE			OPER PLAZA N, NJ 08103			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	κ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE		(X5) COMPLETION DATE
<ul> <li>PTAC units in the res asked the Regional D Operations how the fat the PTAC units are fur replied that despite the Operations, he could</li> <li>The surveyor reviewer (Rooms)" audit again were three resident resident resident resident resident for PTAC units, rooms</li> <li>At 11:05 AM, the surve Director of Building O "New" PTAC unit in resident stated to the did not work because had to keep pressing clarifying it was some make it work. The resident stated that the conditioning until the delivered into the root resident kept thanking facility provide function rooms. The room tem air conditioning was resident conditioning was resident the surve Director of Building O "New" PTAC unit.</li> </ul>	perations to conduct s and test the room urveyor also observed the ident rooms. The surveyor Director of Building acility tests to determine if unctioning at capacity and he e works in Building not answer this question. ed the undated "P-TAC which indicated that there booms that received "New" , and .	F	500				

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If continuation sheet Page 60 of 124

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	brown substance stai buttons. The plastic of "Hi Cool" was missing There was a portable and the room tempera The surveyor took a p At 11:18 AM, the surv Director of Building O "New" PTAC unit in ro- set on "Hi Cool" but the operating. There was the unit. There was the room and the room degrees F. The surve PTAC unit. At 11:27 AM, the surve rovides maintenance is not employed by a which he works. He se to "clock in" to the face site. and that the face is not sure how lon maintenance employed been working indepen Maintenance Director about the air condition when the DoM called on maintenance director about the air condition when the dom't make	ned along the line of the cover for the button for the g, exposing the metal. air conditioner in the room. ature was degrees F. boto of the PTAC unit. reyor and the Regional perations observed the bom to The PTAC was ne PTAC unit was not a no air being released from a portable air conditioner in m temperature was to yor took a photo of the reyor interviewed the e Director and the Regional e of a second surveyor. The e Director stated that he e support to the building and company but the facilities in stated that he does not need silities when he arrives on ity recently lost one of their es and it has been hard to The Regional Maintenance g ago the facility had lost the es or how long the DoM had ndently. The Regional e stated that he found out ner issue or the support in and that there was a switch wart and he called the	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY LETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			WO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	they could arrive was surveyor asked why t or and none informed the team on plan for the air conditi Regional Maintenance the company wasn't of he was in this facility an issue with an eleva aware of only one uni- whole building was co- they would request the hours especially if the elevated. At that time, the Regions surveyors that if the te degrees F in the room implement measures going above 81 degree not safe." The survey Emergency Plan show stated that couldn't sp would be implemente they would try to exha accessing contractors portable air conditioned residents within an ho the local the st the air conditioning sy manufic the confirm systems were not work	Ing rentals, and the earliest The he DoM never disclosed this e of the administrative staff about the ioning rentals, and the e Director stated because called until after the mathematical state because atom functioning but if the promovised, he stated that e HVAC to be here within six e outdoor temperatures are onal LNHA stated to the emperature climbs over 78 h, it would be important to for cooling to prevent it from sees F, as degrees F "is yor asked when the uld be implemented, and he beak specifically when it d. He stated however that aust all options first like s and if they could not get er units or move the bur, then they will contact ated that he found out about ystem not functioning on hey knew it was going to be " The Regional LNHA be very hot "outside" on hed that the air conditioning	F	600			

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Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/22/20 FORM APPROVE OMB NO. 0938-03		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED		
		315205	B. WING		C 07/19/2023		
	ROVIDER OR SUPPLIER	& SUB-ACUTE CARE	тw	REET ADDRESS, CITY, STATE, ZIP CO O COOPER PLAZA MDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE		
F 600	capacity or not, and t Director stated that it temperatures could b air conditioning is fun return and test the re- difference. At 12:10 PM, the surver reported that they have PTAC units, and why of Building Operation out the functioning of the rooms, the reset H of reach of the unit, h on, and the Regional that the Certified Nur- residents, or other star reset button has to be that the PTAC units s sometimes so it does compressor, which is button has to be pres- stated that residents keep pressing the rese and acknowledged no physical or cognitive so. He stated that the overload switches. The surveyor reviewer corresponded with the the HVAC company. 8:07 AM from the HVA indicated that once the stroubleshoot the issue	system was working at full he Regional Maintenance could be felt in the air, room e taken to determine if the ctioning, he could check the turn and compare the veyor asked why residents ve to keep resetting the when the Regional Director s and the surveyor tested the PTAC units in many of outton, which was often out ad to be pressed to turn it Maintenance Director stated sing Aides might turn it off, aff turn the dial to off and the e pressed again. He stated hut down on their own not burn out the why, in turn, the reset sed. The Regional LNHA and staff should not have to set button on the PTAC units, of all residents have the ability to independently do e facility ordered new ed the emails that e invoice dated from An email dated from at AC service coordinator rey receive the payment of chedule a technician to es with the three air handler ioned, and if they were not	F 600				

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	employee will send a parts and repairs nec Coordinator asked wi issues are with the air The facility's purchase email on at 8:2 they needed a tech of possible as this facilit the temps outside are An email written on 7, theHVAC company re to inspect two of the w and that they would b overload switch for or recommended a leak heat pump that was " indicated that an addi sent for the two repair The facility's purchase 3:51 PM asking if the unit because it had be The HVAC company if waiting on pricing and supplier before sendin A review of the HVAC dated provide at 12:30 PM, included three air handler units degrees and te also reflected that the water source heat pur unit has a faulty overl compressor." The S	proposal for the required essary. The Service nat any insight for what the r handler units. er submitted a follow up 27 AM which indicated that ut there today or as soon as y was "a nursing home and e hitting "" /12/23 at 12:08 PM from effected that they were able water source heat pumps e sending a proposal for an ne of the units, and search on the water source downstairs." The email tional proposals would be rs. er responded on at re was a quote to repair the een almost a week already. responded that they were d availability from the ng the proposal. c contractor's Service Report ed by the facility on the re ware not cooling below mps were set around the "last oad protector for the	F	600			

Facility ID: NJ60412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 11/22/2023 APPROVED ). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315205	B. WING	_		07/	C 19/2023
NAME OF PI	ROVIDER 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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	9 64	F	600			
	indicated "Met air handler, other unit relays." There was no contractor's Service F were repaired and the contractor only inspec pumps. There were no addition receipts provided to th prior to the survey stat an effort to fix or rectif issue. There were no air conditioners purch team dated prior to th On 7/19/23 at approxi-	Report that the air handlers e emails indicated that the cted the water source heat anal invoice documents or the surveyor that were dated art date of to indicate fy the malfunctioning HVAC o receipts of fans or portable ased provided to the survey e survey. imately 1:00 PM, the facility otified that the immediacy					
	interview, and review A review of an in-serv In-Service Education Administrator to Nursi Director of Nursing an white neglect "the failure of service providers to p to a resident that are harm, pain, mental an distress." A review of the facility Abuse & Neglect date types of abuse, "Negl	rice record revealed Provided by the Regional ing Home Administrator and and all departments on ch included the definition of the facility, its employees or rovide goods and services necessary to avoid physical aguish or emotional r's Prohibition of Resident ed formation included under ect: The failure to provide ecessary to avoid physical					

Facility ID: NJ60412

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OLIVILI		MEDICAID SERVICES			OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315205	B. WING		C 07/19/2023	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAD	3 & SUB-ACUTE CARE		WO COOPER PLAZA AMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 600	Continued From page	ge 65	F 600			
	intervene in situatio mistreatment, and m property are more li an analysis of: a. fe environment that ma mistreatmentmore staffing on each shir residents; c. The tra staff regarding resdi be trained to immed observed/suspected A review of the Eme 11/22/22 included, " be checked each 11 ensure the lock is in place The magnetic statements of the statement of the trained to the trained place The trained to the trained to the trained to the trained to magnetic statement of the trained to the trained to method to the trained to the trained to the trained to the trained to the trained to the trained to the trained to the trained to result the trained to	d incident." ergency Cart policy effective The Emergency Cart lock will -7 shift by the nurse to tact and supplies are in present and battery intact and em misisng will be replaced				
F 658 SS=J		leet Professional Standards	F 658		7/21/23	
	The services provid as outlined by the c must- (i) Meet professiona This REQUIREMEN	orehensive Care Plans ed or arranged by the facility, omprehensive care plan, Il standards of quality. IT is not met as evidenced				
		731 on, interview, record review, ent facility documents, it was		F658 Element One-Corrective Actions "Resident #1 was assessed by Nu Practitioner on and was	rse	

Event ID: 5E8J11

Facility ID: NJ60412

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	-	ID HUMAN SERVICES				FORM	1 APPROVED	
		MEDICAID SERVICES	-			<u> </u>	0.0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURV COMPLETED		
			A. BUILDI	ING _		с		
		315205	B. WING				_ 19/2023	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
				т	WO COOPER PLAZA			
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		c	CAMDEN, NJ 08103			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE	
TAG	REGULATORT OR I	SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)			
			1					
F 658	Continued From page	9 66	F	658				
		sident #1) who was			subsequently admitted with a diagnosis			
	complaining of	and			. Resident #1 had beer	1		
	•	manner that adheres to			placed on services on			
		ls of nursing practice to						
		ond, and call the physician			" Roommate of Resident #1 was			
		resident was verbalizing a aused from environmental			assessed, offered a room change, or			
	heat. There was no a				temporary placement in a temperate environment but the resident declined	-		
		in, and the resident's room			room change and was provided with a	a		
		d degrees Fahrenheit.			portable air conditioner unit on			
						•		
	Two LPN's and one F	N who each saw Resident			" All Residents were assessed by th	e		
	#1 stated that this wa	s the resident's baseline. A			medical director for signs or symptoms			
	· ·	that the resident might be				ח no		
		ut was not on			issues found.			
	service.				" Additional rounds and vital signs			
	The Nurse Practitions	er arrived at 1:30 AM and			monitoring were implemented on to evaluate residents for signs or			
		t and stated that this was			symptoms of			
	not the resident's				" Additional Hydration carts were			
	and the resident had	and			purchased on July 14, 2023 and hydra	tion		
					stations were placed on each unit.			
					" Residents were provided with extr			
		t to the hospital during the			ice throughout the day as needed start	ing		
	early morning hours of	Dt			on July 14, 2023.			
	Intonyiow with the sid	ht shift agency LPN stated			" Residents were notified of the hea			
	•	f the heat situation in the			emergency and to notify staff if they ne assistance or if their room temperature			
		dn't need to do anything			not to their liking. Resident rooms with			
	different for the reside				nonfunctioning PTAC units were provid			
		nal vital signs. She stated			with portable air conditioner units and			
	-	anything extra that she			residents instructed in use. Staff moni	tor		
	needed to do.	· –			resident rooms during hourly rounds ar	nd		
					adjust the portable air conditioner unit			
		haustion include headache,			temperatures for residents unable to de	כ ו		
		itability, muscle cramps,			so to assure their comfort.			
	-	ted body temperature which			" Both physicians and Responsible			
		eat stroke when the body			Party Representatives were notified of			
	temperature can rise	to 106 degrees F within			heat emergency and that they would be	e		

Facility ID: NJ60412

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		D HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:					CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315205	B. WING			C 07/19/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				Т	WO COOPER PLAZA			
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE		с	AMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 658	10-15 minutes of prol causing serious adve hospitalization and de This resulted in an im for Resident #1 who w have known had no fan and no air room temperature rea degrees. The Residen surveyor, " " Resident was from the The facility's failure to did not exceed de HVAC system not fun to implement measure the resident's room te follow professional sta the resident complain and worsening of the conditioner intervening to address room or offering to tra another area of the bu The immediate jeopan facility was notified of Manacceptate was received on the Removal Plan on was lifted on	onged heat exposure, rse health consequences, eath. mediate jeopardy situation vas known by the nurse to The resident conditioner in the room and adings were in excess of the complained to the and wiped the ensure room temperatures grees with knowledge of the ctioning on but failed es to assess and maintain emperature and failed to andards of practice when ed of section by calling physician, is the lack of cooling in the insporting the resident to uilding until surveyor inquiry. rdy began on the immediate situation on one written Removal Plan . The surveyors verified . The immediacy	F	658	notified of any resident changes in condition. " All resident rooms, and common areas were immediately re-evaluated fe elevated temperatures and portable air conditioning units placed throughout th facility as appropriate on "" Temperature logs are being utilize monitor and track room temperatures. " Items missing or expired in the cor- carts were immediately replaced and se educated on code cart audit process. New code carts were purchased and restocked to ensure adequate supplies are in the cart. A daily code cart check was implemented, and nursing staff re-educated about proper completion. " The were replaced, and the units checked to ensure proper function Checking the and functionin was added to the code cart checklist. " Nursing staff were re-educated on monitoring of code cart and """" and functioning process/policy. " The Heat Emergency Response P was activated """. The facility Emergency Preparedness Plan was reviewed and revised by the new facilit Licensed Nursing Home Administrator (LNHA) with assistance of the Licensed Nursing Home Administrator and Direct of Nursing consultants and staff receiver re-education. New binders were place on resident care units and throughout to facility where appropriate for easy acce Element Two-Identification of at Risk Residents	e d to de taff slist n. g lan y d tor ed d he		

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		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			PRINTED: 11/22/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		315205	B. WING		07/19/2023
NAME OF P	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE		WO COOPER PLAZA CAMDEN, NJ 08103	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 658	Continued From page	e 68	F 658		
	45. Chapter 11. Nursi Practice Act for the S "The practice of nursi professional nurse is treating human respo physical and emotion such services as cas health counseling, an supportive to or resto	ey Statutes Annotated, Title ing Board. The Nurse tate of New Jersey states: ing as a registered defined as diagnosing and onses to actual and potential al health problems, through e-finding, health teaching, id provision of care rative of life and wellbeing,		<ul> <li>All residents without adequate temperature control have the potentiable affected by these practices.</li> <li>Element Three-Systemic Change</li> <li>The Director of Nursing (DON) a Nurse Practitioner (NP) identified residents with</li> <li>illness. The high risk acuity literation</li> </ul>	ind
	a licensed or otherwis physician or dentist." Reference: New Jers 45, Chapter 11. Nurs Practice Act for the S	ey Statutes Annotated, Title ing Board. The Nurse tate of New Jersey states:		was revised and updated by the interdisciplinary team with the assista of the Director of Nursing consultant Unit Managers and placed on each u for easy access by staff in case of ar emergency. The list is updated base resident changes in condition and wi	and เnit เ d on
	nurse is defined as p responsibilities within finding; reinforcing th program through hea counseling, and provi restorative care, unde registered nurse or lic authorized physician	the framework of case e patient and family teaching lth teaching, health ision of supportive and er the direction of a censed or otherwise legally or dentist."		new admissions. The Medical Director assessed to remaining residents on July 17, 2023 no additional changes in condition not for any resident. All residents were assessed for signs and symptoms of related illness and a list of diagnoses determined to identify at risk resident The high risk acuity list was revie by the Assistant Director of Nursing	with oted heat was ts. ewed and
	the facility for an una the issue regarding th conditioning system a noted that the local o time was degrees surveyor entered thro noted a heavy duty flucture the floor with a long e	at the facility. The surveyor utdoor temperature at that Fahrenheit and humid. The ough the main lobby and oor fan blowing air across		DON consultant and Unit Managers a updated based on Resident acuity ar posted at each nursing unit for easy reference and nursing staff re-educa about use. The list is updated with a changes in resident conditions and w there is a new admission. " The Licensed Nursing Home Administrator (LNHA) was educated heat related emergencies, identifying	nd ted ny rhen on

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ND DI AN OE	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE	CONSTRUCTION			
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			COMPLETED		
		315205	B. WING _			C 07/19/2023		
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 01	10/2020	
				т	NO COOPER PLAZA			
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			AMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE	(X5) COMPLETION DATE	
					DEFICIENCY)			
F 658	Continued From page	e 69	Fe	558				
		e surveyor asked the SG #2			rick residents, maintaining appropriate			
		floor and he stated that he			risk residents, maintaining appropriate			
					temperatures in facility, reporting			
		s there. He acknowledged			interruption of services to the Departm			
		or a housekeeping reason.			of Health, and activation of Emergency	/		
	-	f the facility had any issue			Response Plan.			
		emperatures in the building,			" An experienced permanent New			
		I that he didn't know anything			Jersey Licensed Nursing Home			
	-	shift and was filling in for			Administrator replaced the temporary			
	someone else.				LNHA and executive director effective			
	At 5:07 PM, the surve				Both a DON and a Licensed Nurs	ing		
	-	pervisor (RN/S) who stated			Home Administrator consultant were			
		ift at 3 PM and that he took			retained as per the Directed Plan of			
		e supervisor. At that time,			Correction providing 40 hours onsite			
	the RN/S didn't want	-			consulting.			
	surveyor's questions	and called the Director of			" The maintenance director was			
	Nursing (DON).				re-educated and instructed to maintain	1 I		
					temperature logs of facility temperature	es		
	At 5:09 PM, the surve	eyor conducted a phone			as required per the Directed Plan of			
	interview with the DC	N. The DON stated that the			Correction and then after substantial			
	air conditioning in the	e building was not functioning			compliance.			
	-	sue, and it had to be shut			" Nursing Staff were re-educated or	n		
		cility had implemented			recognizing and assessing for signs ar			
		d ice in response. She			symptoms of heat related illness and			
	-	ot know the mechanics of			reporting to supervisor/designee any a	ir		
		jional Maintenance was			temperature abnormalities and			
	-	e issue." She stated that he			transferring residents to appropriate			
	-	f right now looking at the			temperate areas.			
		ey had been working on			" Families were updated as were fa	cility		
	resolving it since yes				physicians. All residents affected by	2		
		o air conditioning in the			increased temperatures were offered			
		that the air conditioning only			room changes or temporary placemen	t in		
	affected the kitchen y				cool common areas.			
		stated because they knew			" All rooms had portable, or wall air			
		ng to be hot today, they			conditioners placed, and temperatures			
	purchased fans and				continue to be monitored with no			
	•	a precaution. The DON			abnormal readings as of July 16, 2023			
	-	rse called her today to inform			<ul> <li>Repairs to the main cooling system</li> </ul>			
1	UIG C TOOT DONNE OPIC	rea called her today to inform			" Renaire to the main cooling evetor	m		

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/22/20 M APPROVE <u>D. 0938-03</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED		
		315205	B. WING		07/19/2023		
NAME OF P	ROVIDER OR SUPPLIER	I	s	TREET ADDRESS, CITY, STATE, ZIP CODE	• • •		
	C CENTER FOR REHAB	& SUB-ACUTE CARE	т	WO COOPER PLAZA			
	o dentent on nenad		C	AMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 658	Continued From page	<del>9</del> 70	F 658				
	The surveyor asked to issue occurred that re- system, and the DON date. She could not so issues within the resid- residents told her it w complained" to her. So purchased fans yester why they purchased for not hot indoors and if functioning on the un- it was because they a hot outside today and an added "precaution she had been on the difference in air temp replied that "I'm tropic like the rest." The DC been a bit warm, but her that it was hot in to been too hot. She could Director of Maintenar returned to the facility about the status of the The surveyor asked w and the DON stated to far hallway that was a they put all the fans. were any fans brough the DON replied that floor." The so any temperature chear resident units and the know about any room done.	he DON when the sparking equired the shut down of the l could not speak to an exact speak to air conditioning dent units adding no vas hot and "no one She stated that they erday. The surveyor asked fans for the residents if it was the air conditioning was its, and the DON stated that anticipated the weather to be a reiterated that it was just for the surveyor asked if resident units and felt a erature, and the DON cal, so heat doesn't hit me ON stated that it may have since no one complained to the building, it couldn't have ntinued to state that the nee purchased the fans and v today to find out more e air conditioning system. what floors were affected, hat it was only the floor affected, which was where The surveyor asked if there		units continue to be replaced as delivered with portable air condi units in every room in the interin residents to control their room temperature. Element 4-Quality Assurance " The Maintenance Director/d will monitor room and common temperatures every two hours x then every shift x 14 days and of thereafter with no stop date. Re- reported to the administrator an daily to the department health u substantial compliance is achieve Results are also shared at the v Quality Assurance Performance Improvement (QAPI) meeting for as appropriate. " The Administrator/designeer random daily rounds with the m staff to confirm room air temper- assure the comfort of residents. are discussed with the Director daily and in aggregate at the we Quality Assurance Performance Improvement (QAPI) meeting for action as appropriate. " The Director of Nursing/des audit 5 random at-risk residents records for signs and symptoms related illness daily x 7 days, we and monthly x 2. Findings are of at clinical meetings and acted u appropriate. Results are shared aggregate at the weekly Quality Assurance Performance Improv (QAPI) meeting for further action needed.	tioner in allowing designee area 48 hours, laily esults are d emailed ntil ved. veekly or action e makes aintenance atures and Results of Nursing eekly or further signee will medical s of heat eekly x 4 discussed pon as d in		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 11/22/2023 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315205	B. WING _			07/*	C 19/2023
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY,	STATE, ZIP CODE		
				TWO COOPER PLAZA			
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE		CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	following: Monitor Resafe and check reside equipmentsee attact Weather Procedures If the outage is long to safety and welfare, in Proceduresestablis local emergency resp the situation and keep needs as the situation only deemed "under of has been restored an has declared the situat The attached Severe included: When the f degrees Fahrenhe hours: 1. Move reside air-conditioned part of Encourage residents keep the residents hy necessary and record wash cloths as neede cooler outside air in a 5. Monitor body temp and notify attending p Notify 911 if a resider be in danger of heat- residents if necessary thermometers. 9. No The Emergency Open the Evacuation Plan r response for a Heat E equipped with air con and individual units in Temperatures in the f	esidents to ensure they are ent-used medical ched Severe Cold and Hot to prevent functions. erm and threatens resident itiate Evacuation sh and maintain contact with onders to advise them of p them informed of potential n worsens. The situation is control" after the outages d the Incident Commander ation "safe" Hot Weather Procedures facility temperature reaches eit and remains so for four ents to another f the facility, if available. 2. to take in more fluids and vdrated. Force fluids if d fluid intake. 3. Provide cold ed. 4. Open windows to let and utilize fans to move air. peratures of the residents ohysicians if necessary. 6. nt/staff member appears to related stress. 7. Evacuate y. 8. Monitor environmental tify Medical Director. rations Plan located within revised 7/10/15 included Emergency. "The facility is dition in all common areas n each patient room. facility must be 81 degrees	F 6	Nursing/designee carts to ensure th stocked, and Aut Defibrillator pads days, weekly x 4 thereafter. Resu	e will monitor all code ney are adequately omatic External are not expired daily x weeks and monthly Its will be provided to th ng and shared at the		
	following: Monitor Res safe and check reside equipmentsee attact Weather Procedures If the outage is long to safety and welfare, in Proceduresestablis local emergency resp the situation and keep needs as the situation only deemed "under of has been restored an has declared the situat The attached Severe included: When the f degrees Fahrenhe hours: 1. Move reside air-conditioned part o Encourage residents keep the residents hy necessary and record wash cloths as neede cooler outside air in a 5. Monitor body temp and notify attending p Notify 911 if a resider be in danger of heat- residents if necessary thermometers. 9. No The Emergency Open the Evacuation Plan r response for a Heat E equipped with air con and individual units in Temperatures in the f	esidents to ensure they are ent-used medical ched Severe Cold and Hot to prevent functions. erm and threatens resident itiate Evacuation sh and maintain contact with onders to advise them of p them informed of potential n worsens. The situation is control" after the outages d the Incident Commander ation "safe" Hot Weather Procedures facility temperature reaches eit and remains so for four ents to another f the facility, if available. 2. to take in more fluids and rdrated. Force fluids if d fluid intake. 3. Provide cold ed. 4. Open windows to let and utilize fans to move air. beratures of the residents ohysicians if necessary. 6. nt/staff member appears to related stress. 7. Evacuate y. 8. Monitor environmental tify Medical Director. rations Plan located within revised 7/10/15 included Emergency. "The facility is dition in all common areas n each patient room.		Nursing/designee carts to ensure th stocked, and Auto Defibrillator pads days, weekly x 4 thereafter. Resu Director of Nursir	ney are adequately omatic External are not expired daily x weeks and monthly Its will be provided to th ng and shared at the		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 11/22/2023 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315205	B. WING				C / <b>19/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				ти	VO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		C	AMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From page	e 72	É F	658			
		degrees Fahrenheit the					
	their conditions. Deternisk utilizing the follow weight loss, b. dialysi staff for nutrition, d. F nutrition, e. any reside and/or determined to residents with the corn necessarily at-risk. C factors must be consi residents at greatest measures to stabilize Interventions include notification of physicia b. COPD [Chronic Ot Disease] -monitor O2 four (4) hours or as con internal temperature of degrees Fahrenheit, or residents a minimum condition warrants cooler areas of facility warrant. 8. Continue hourly. 9. Complete p residents' conditions of lightweight clothing of continuation hydration PM12. Revise staffi appropriately implement At 5:50 PM, the Exect been working at the fa- told the surveyor that	visual survey of all a baseline assessment of ermine residents at greatest ving guidelines: a. significant s, c. total dependence on Residents requiring enteral ent that is compromised be at high risk. Note: not all ndition(s) listed are Other physical and lifestyle idered. 4. Collate listing of risk and implement and/or reduce the risk. but are not limited to: a. an of any condition change. ostructive Pulmonary cloxygen] saturation every ondition warrants. 5. If the of the facility reaches 80 obtain temperatures on all of every four (4) hours or as 7. Relocate residents to y, if possible, as conditions visual rounds a minimum of ohysical assessment as warrant. 10. Maintain n all residents 11. Initiate in cart 7:00 AM to 10:00					

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	-	ID HUMAN SERVICES				FORM	M APPROVED	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY	
AND PLAN OF	IND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ING	i	COMPLETED		
		315205	B. WING			C 07/19/2023		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	19/2023	
					TWO COOPER PLAZA			
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			CAMDEN, NJ 08103			
(X4) ID	-				PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	· · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
IAG					DEFICIENCY)			
F 658	Continued From page	e 73	F	658	8			
	according to the regu	lation.						
		eyor was introduced to the ice (DoM) who stated that						
		ployed by the facility for						
	approximately m							
		the "last few days it's been						
		that there had been issues						
	the facility had severa	ng systems. He stated that						
		, since there was a leak in						
		He added that there was						
	also an "air handler w	ith a bad condenser for the						
		tinued, that in addition to the						
		floor had an issue with the n causing "sparking" which						
	-	conditioning system on						
	•	"or there would be a fire."						
		they received a bid on						
		oblem, but it was not						
	processed until yeste							
		to diagnose the problem. ed documented evidence of						
		om the company and the						
		nat he didn't have a copy of						
	it, but that he would lo	ook into finding out if anyone						
	did.							
	At that time the curv	eyor observed that the DoM						
		and loose leaf paper with						
		ng "P-TAC (Rooms)" and a						
		written under it. It was not						
	-	asked the DoM about the						
		t he has not HVAC licensed,						
		working on changing the						
	-	units in the resident rooms He stated that he started						
		eks ago when he began						
		he list indicated that there						

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CENTER	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE			FORM	D: 11/22/2023 A APPROVED 0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _			COMP	LETED
		315205	B. WING			_		C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MAJESTI	C CENTER FOR REHAB &	& SUB-ACUTE CARE			WO COOPER PLAZA CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	rooms and that those rooms he h with new ones and that PTAC units that "did r process of replacing t because he was "only asked what has been resident rooms when due to the heat, and t purchased ten portab put some of them in re the purchase of 30 far a receipt of the purchas other than purchasing air conditioner units, w regarding the malfunct he added that he purchas other than purchasing air conditioner units, w regarding the malfunct he added that he purchas only been processed he should be checking indicated he did check it read degrees F i surveyor asked where and he could not spea if he kept any logs of the air conditioning sy malfunctioning or not the DoM stated that th temperature logs. He kept a room temperature no room temperature	thad "new" PTAC units, The DoM confirmed had replaced the PTAC units at the other rooms had not work." He stated that the hem had been going slow one person." The surveyor done for these other the PTAC units do not work he DoM stated that they le air conditioner units and esident rooms, in addition to ns. The surveyor requested ases. The surveyor asked 30 fans and ten portable what had been doing ctioned air conditioning and chased four to five jugs of yesterday and 12 bags of the had not been doing by stated that the air ed for a few days but that e date because the bid had yesterday. He stated that g room temperatures, and k a temperature earlier and n a resident area. The e and when that was taken, ak to it. The surveyor asked temperature readings while restem had been working at full capacity and	F	658				

Facility ID: NJ60412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315205	B. WING				C / <b>19/2023</b>	
NAME OF PI	ROVIDER 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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658	with temperatures if the over a given period of The DoM stated that if generally cooler than was unable to provide of that being the case At 6:07 PM, the surve the DoM who stated to check room temperate thermostats on each if temperatures needed and that he looks at the everyday." He stated above degrees F, temperatures of the re At 6:18 PM, the surve the fill Floor throug exiting the elevator, the be very warm in the ho observed with the Do the ice cooler. The su observed with the Do the ice cooler. The su observed the thermose of the surve of the rest thermostat read it was At 6:25 PM, the DoM unit. At that the the thermostat for this because the system is sparking. He stated to heavy duty relay were sparking and they shu	they were not checking them if time and recording them. the resident rooms were the hallways, but the DoM any documented evidence any documented any that the thermostats read the would go and take esident rooms. Any or and the DoM entered the the elevators. Upon the surveyor felt the floor to allways. The surveyor M that there was no ice in urveyor and the DoM estat reading for the front end ated a reading of ack end ack end end ack end ack end ack end ack end ack end ack	F	658	3			

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/2023 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			LETED
		315205	B. WING				C 19/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				٦	TWO COOPER PLAZA		
WAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		0	CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	e 76	F	658	3		
	A roviou of the weeth	or history roport for					
	A review of the weath	reflected the following					
	outdoor temperatures	0					
	7/6/23: 91 degrees F,						
	7/7/23: 91 degrees F,						
	7/8/23: 90 degrees F,						
	7/9/23: 85 degrees F,						
	7/10/23: 86 degrees F 7/11/23: 89 degrees F						
	7/12/23: 91 degrees F						
	7/13/23: 93 degrees F						
	7/14/23: 89 degrees F						
	7/15/23: 92 degrees F	Ξ.					
	At 6:29 PM, upon ent	ering the wing the					
		air on the unit was very hot					
		e surveyor to feel sweaty					
		reyor and DoM toured the veyor noted beads of sweat					
		A's forehead. The DoM					
	acknowledged that it						
	uncomfortable on this	-					
		loor temperature of the n read degrees F.					
	The DoM with the sur	veyor began taking room				ľ	
	temperatures on the	Unit which included				l	
	the following tempera					l	
		ees F.				ľ	
		ees F. There was no fan or				l	
		he residents' room and both . The DoM stated that the				ľ	
		t turned on and he turned				I	
		ner on. The surveyor				ľ	
		v the residents in that room				I	
	but the residents who	were both awake did not					

Facility ID: NJ60412

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	-	D HUMAN SERVICES				FORM	APPROVED	
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	E CONSTRUCTION	(X3) DATE	0. 0938-0391	
	CORRECTION	IDENTIFICATION NUMBER:					LETED	
						С		
		315205	B. WING			07/	19/2023	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA			
MAJESTIC	ESTIC CENTER FOR REHAB & SUB-ACUTE CARE				CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 658	were visibly perspiring At 6:33 PM, the surve Practical Nurse (LPN the hallway passing of The LPN #3 stated th floor were ' <b>Second</b> the temperatures and different in response a unit, and she stated th residents this shift an out medications, do residents and perform stated that we can en vital signs and skin tu confused, but otherwid different that she had if any residents had to stated that there were At 6:35 PM, the DoM of Unsampled Reside degrees F. The resid bed in the room by the conditioner. The roor orange fan on the floor bed and the window. produced by the fan v bed and not reaching #10. The window was surveyor attempted to the resident appeared interviewed.	e surveyor. Both residents g. eyor observed the Licensed #3) assigned to in ut medications to residents. at the temperatures on this " The surveyor asked about if she had to do anything to the heat situation on the hat she was assigned d that she just had to pass of h basic resident care. She courage hydration and take rgor if a resident becomes se there was nothing to do. The surveyor asked be hospitalized and she e none. took the room temperature int #10 which read in e door had no fan and no air n by the window had an or positioned between the Any airflow that was being was getting blocked by the the unsampled Resident s slightly open. The o interview the resident, but	F	658				
	room and took a set o	#3 entered the resident's of vital signs. The resident's s F, the heart rate was the blood pressure was						

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X3) DATE COMP	SURVEY LETED			
		315205	B. WING			C 07/19/2023		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	E ATE	(X5) COMPLETION DATE		
F 658	and the pulse on room air. The LPN #3 stop and cour exited the room with the Upon exiting the room there was a resident (known) resided a few doors of At approximately 6:38 to interview residents observed unsampled At approximately 6:38 to interview residents observed unsampled . The "The resident adding that he/s the air conditioner in the resident continued to asthma and because utilize their "The resident they were provided ic ice to give out yester of he/she didn't think the added that the LPN #3 to requess the resident's cup to g and stated that "We d will have to go and ge little bit." The LPN #3 on their side table left resident stated to the	oxygenation status was e surveyor did not see the nt a respiratory rate and she he vital sign machine. n, the LPN #3 stated that (Resident #1) who had and utilized for and own the hall. PM, the surveyor continued on The surveyor Resident #11, who was e resident stated that ' continued to state, she has two fans and that their room is broken. The state that he/she had of the heat, he/she had to with an ent stated that sometimes e, but the facility didn't have day. The resident stated that ey had ice today either, and  time, the resident called for t for ice. The LPN #3 took get ice, and she returned lon't have anymore iceI et more somewhere else in a s put the resident's cup back t the resident's room. The surveyor, ' hat they may get ice in the	F	658	8			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	O. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		315205	B. WING			C 07/19/2023		
	ROVIDER OR SUPPLIER	& SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 658	At approximately 6:40 Resident #1 in bed neresident was hot. The resident had conditioning in the root interviewed the resider resident stated, " resident began to wip forehead. At that time d" and indicate d" and indicate from the not wearing the resident if he/she utilit responded that he/sh wear it. The surveyout place the take some resident confirmed the conditioning in their root that he/she would get	<ul> <li>PM, the surveyor observed ext to the window. The and the room felt d no fan and no air om. The surveyor ent at that time, and the "and the surveyor observed" and the resident stated, for a the surveyor observed frunning at wall, but the resident was and the resident e would put it back on and robserved the resident</li> <li>back onto their for and the resident stated the nurse.</li> </ul>	F	658	8			
	room temperature of a floor which felt cool. ambulatory residents stated that the "air co The temperature reac time, the ED stated th person" and that resid this heat and not wan stated that as long as okay, they have a righ if their health deterior they would remove th the ED why they wou health deteriorated be	in there but no staff. The ED nditioner works in here."						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391			
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		315205	B. WING				C 19/2023			
NAME OF P	ROVIDER OR SUPPLIER	I		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)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE			
F 658	temperatures, and the to be proactive and m want to move, they de inquired how the facil residents' rooms at an for those that may no cannot verbalize it, an provide ice, or the sta for their face to cool the provide fans, and som portable air condition that not all residents h units despite their may their room and the ce within the unit. He ac conducting tour, no re them. At 6:59 PM, the surve the room of unsample bed. There was still r airflow of a floor fan w roommates bed. The read degrees F. At 7:00 PM, the surve surveyor asked about prioritize the use of fa conditioner units whe malfunctioned in the f acknowledged that any residents and that the recreation room. know if doctors were check or should chec situation. He stated t	e ED stated that they need of wait, but if residents don't on't have to. The surveyor ity was keeping the in acceptable temperature t want to move or those that ad the ED stated that they off can provide a cool cloth he body down, offer and ne residents received ing units. He acknowledged have fans or air conditioner lifunctioning PTAC units in intral air conditioning system exhowledged that when esidents had a cool cloth on expor and the ED returned to ed Resident #10 who was in no air conditioning and the was being blocked by the e room temperature reading expor interviewed the ED. The t how the facility chose to uns and portable air in the air conditioning had	F	658	8					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/2023 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315205	B. WING		_		C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				TWO COOPER PLAZA			
MAJESTI	C CENTER FOR REHAB	SUB-ACUTE CARE		CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	\$81	F 65	8			
	about if he found out if Home Administrator ( since the ED was not the ED stated that he but the reason the LN today was because it if if the DON's office with her office which was a The DON provided the LNHA on record and a where he is, and that didn't answer the pho and his is the only started work if the DON continued the LNHA on record in the DON continued the DON informed her on conditioner issue and She stated that there temperatures and the needed replacement if its been replaced." was aware of a therm F and a room that wa fans and hydration stay yesterday because the outside the next day. acknowledged that the temperature logs and anyone to take log temperature logs and	5 PM, the surveyor entered the ED. The DON was in adequately air conditioned. e surveyor the name of the stated that she doesn't know she tried calling him but he ne because it was <b>Sector</b> . . The DON stated that ing at the facility again in he Regional LNHA was the . She stated that the or around <b>Sector</b> . o explain again that the ly yesterday about the air the room temperatures. was a previous issue with a air conditioner system that and explained, "I don't know The DON added that she nostat reading of degrees s degrees F, but that ations were purchased rey knew it would be very hot The DON and ED ere were no room that they never instructed					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		315205	B. WING				/19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658	knowledge of and act especially when outdo degrees F. Temperatu floors were discussed the residents complai and that they were sw stating that the reside "not in distress" and c rooms. She stated th to her about the heat. DON if she would wai distress before respon adequate temperature the DON could not sp resident's were comfo acknowledged that th conditioning service w NJDOH until today af out to her. The DON stated that temperature requirem degrees F. She state aware that the air com down on <b>Section</b> At 7:23 PM, the surve Department of Health who conferenced in te DON and the ED that maintain adequate ro- accordance with regu implement a system t temperatures when th were known to not be functioning at full cap- summer months, inclu	d, how can the facility have upon the temperatures, por temperatures were 89 ures of the second and third with the DON and ED and ning of it being hot, humid veating. The DON began ents were "comfortable" and didn't want to leave their at no residents complained The surveyor asked the it until the residents were in nding to the lack of e control in their facility, and beak to it, insisting that the portable. The DON e interruption in air vasn't reported to the ter the NJDOH had reached she believed the room eent was not to exceed ad that she she was not aditioner system was shut evor and the New Jersey (NJDOH) management elephonically, informed the the facility's failure to om temperatures in latory requirements, o monitor room ne air conditioning systems	F	658	8		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C		
		315205	B. WING				/19/2023	
	ROVIDER OR SUPPLIER	& SUB-ACUTE CARE	1	-	STREET ADDRESS, CITY, STATE, ZIP CODE			
(X4) ID PREFIX TAG				x	CAMDEN, NJ 08103 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658	residents to ensure the temperature control to related emergency, we sufficient cooling areas residents on both floor risk situation that requeres Emergency Response Emergency Response Emergency Managen The ED stated he work the local OEM and no At 7:46 PM, the surver unit and interviewed to who stated, for the local Color of the surver unit and interviewed to who stated, for the surver unsampled Resident a also sweating and that cool cloths for comfor sees staff "every few reported that no one for today. At 7:52 PM, the surver Aide (CNA #2) walking stated that she has be since for a whether and the the indoor room temp "It's been hot for a whether At 7:56 PM, the surver again who was assign surveyor requested the printed copy of the un- stated that she just st week ago and that she the census or the mether resident. The survery	ey had adequate or reduce the risk for a heat rith limited access to as in the facility placed all ors in an immediate safety uired the activation of their e Plan and the local Office of nent (OEM). uld find the phone number of otify them. eyor returned to the <b>second</b> he unsampled Resident #12 sident's roommate, #11 stated that he/she was at no one has offered them t or ice and that he/she only hours." Both residents has checked their vital signs eyor saw Certified Nursing g down the hallway, and she een employed at the facility nformed the facility about eratures on <b>stating</b> , ille-weeks!" eyor interviewed the LPN #3 hed to <b>second</b> . The he LPN #3 to provide a bit census, and the LPN #3 arted at the facility only a e doesn't know how to print	F	658	8			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP		
		315205	B. WING			07/19/2023		
		SUB-ACUTE CARE		т١	TREET ADDRESS, CITY, STATE, ZIP CODE WO COOPER PLAZA	<u> </u>		
	1			C	AMDEN, NJ 08103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658	out the records such a Administration Record resident, and she stat ask someone else to she had been trained Preparedness at the f and the LPN #3 replie trained. She stated th emergency, she woul and because she didr documents, she ackn difficult to send reside electronic medical record At 8:07 PM, the ED in a voicemail for the loc facility's indoor heat s At 8:18 PM, the surve temperature to be began to take addition which revealed the fo Hallway: degrees the Room degree Room degr	as the Medication d (MAR) to go with the red that she would have to do it. The surveyor asked if on Emergency facility and how to respond, ed that she had not been nat if there was an dn't know what what to do n't know how to print owledged it would make it ents elsewhere with their cords. formed the surveyor he left cal OEM regarding the ituation. eyor noted the new outdoor degrees Fahrenheit, and hal temperatures on the surveyor, and the survey of surveyor, and the surveyor,	F	658				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED		
		315205	B. WING			C 07/19/2023			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 011			
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103				
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 658	stating he had to look gloves accessible in o room. The RN/Super three minutes to find a taking the resident's w RN/Supervisor applie the resident's finger fi oxygenation status w resident was on . The heart ra minute (bpm) for seve machine, and slowly a ther bpm, ther never accessed a ste heart rate when the h from the pulse oxime the seven accessed a ste heart rate when the h from the pulse oxime the seven accessed a ste heart rate when the h from the pulse oxime to Upon the RN/Supervi nebulizer to the reside take an oral temperation count a respiratory ra r. The survey going to take a tempe RN/Supervisor stated an oral temperature b find a scanned on the foreh At 9:47 PM, the survey with the ED to screen relocation and take account At 9:54 PM, the survey	for gloves. There were no or around the resident's rvisor took approximately a pair of gloves before vital signs. The d the pulse oximeter onto rst to determine his/her hich read while the ate began at beats per eral seconds on the started to decline to bpm bpm. The RN/Supervisor thoscope to get an apical eart rate was showing signs try device that there may be d/Supervisor did not take or pressure reading or take a went to get the resident a beat using a mask, but did not ure and did not stop to te prior to applying the yor asked when was he erature, and the that he wasn't going to take perature, and the that he would go try and that can be ead. eyor returned to the peratures.	F	658	8				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		315205	B. WING				_ 19/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			WO COOPER PLAZA CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 658	temperatures that exc surveyor took room te included the room of was not functioning in a box fan in the windo screen. Resident #1 s hour ago. The room degrees F. The resid During the course of t temperature checks of approximately 10:45 I staff on the unit makin relocate the residents their own decisions of for activities of daily li conditioning in the roo conducting the round- at approximately 10:2 wheel a resident dow and that he would be returned to the continued the tour ch- taking temperatures w At 11:10 PM, a new fa the facility and office of he was "Second in co and that he wanted to address the malfuncti system. He stated the over now from anothe hoping to deliver ten they would relocate re	ceeded degrees F. The emperatures again that Resident #1. The PTAC unit in the room. There was now ow and a broken window stated it was put there one temperature was dent stated that the rovided some relief. The safety and room on from 9:54 PM to PM, there were no facility ing a good faith effort to who were unable to make r were dependent on staff ving and had no air om. In addition while s with the ED, the ED stated to PM, that he had to go in the hallway in a wheelchair right back, but the ED never Unit and the surveyor ecking on the residents and without him. acility representative entered of the LNHA and stated that ommand" with the company, o discuss the facility's plan to	F	658				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
			A. BUILDI	NG .		с		
		315205	B. WING			07/19/2023		
NAME OF PI	ROVIDER 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)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 658	B Continued From page 87		F	658	8			
	Medical Director. She Director had been cal that she had not hear confirmed there has r building. The DON st as a Nurse Practitione she could not perform NP since she was als At 11:41 PM, the surv administration that, as there were residen residents who resided that had temperatures with malfunctioning P At 11:50 PM, the DON Practitioner (NP) wou	t in those rooms on the second s						
	to the Unit and in his/her room. The conditioner and a box resident stated that he The resident app that time the surveyout that he worked Resident #1. The LP room temperature felt acknowledged that it functioning air conditi- box fan which was in stated that Resident #	fan in the room. The e/she was beared to the LPN #4 who stated and that he is familiar with N #4 confirmed that the twarm, and he was because there was no oner in the room and only a the window. The LPN #4						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		315205	B. WING			C 07/19/2023			
NAME OF P	ROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE					
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103				
(X4) ID PREFIX TAG				IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 658	not currently on was the resident's not the prospect of asked the resident if h cooler location, and th he/she did not want to acknowledged that th LPN #3 offered to brin recreation room with h declined. At that time surveyors that he cou- leave. The surveyor a done with the room te LPN stated that he wo He acknowledged that condition, he didn't kn conditioner in his/her didn't want to leave th no cool cloth or other him/her at the time of At approximately 12:5 observed two new po being brought up thro were walking it down delivered a portable a room of Resident #1 of expressing that he/sh had known	He confirmed that this rmal condition because of At that time, the LPN #4 he/she wanted to go to a he resident indicated that o go, but the resident e room was too warm. The hg the resident to the his/her bed, and the resident e, the LPN #4 stated to the hidn't force the resident to asked if anything could be emperature then, and the build have to look into that. At due to the resident's now why there was no air room, especially if he/she he room. The resident had cooling methods offered to the encounter. 50 AM, the surveyor rtable air conditioner units ugh the elevator. The staff the mean who was e was hot and sweaty and and	F	65					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SU COMPLE         A       BUILDING       C	ETED
315205 B. WING 07/19	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TWO COOPER PLAZA	
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE CAMDEN, NJ 08103	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658       Continued From page 89       F 658         off the accountability sheet for the code cart.       After looking all over the mobile code cart, the surveyors found it on the top shelf of the cart. At that time, the LPM ## walked away from the surveyors continued to review the 11-7 Daily         Nursing Crash Cart Check List and compared the checklist with what was acclually in the emergency code cart. The surveyor observed that the items within the code cart what was acclually in the emergency code cart. The surveyor observed that the items within the code cart of the drawers with other products stored on top of each other making it difficult to easily identify supplies. The surveyors observed there was supposed to be been been been been been been been	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
			A. BUILD	ING	3		с
		315205	B. WING				19/2023
NAME OF PI	ROVIDER 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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Daily Nursing Crash ( had a box to mark do what was being verific the AED, its functionin check. The nurse has the code cart check w items listed on the sh and present and available At that time, the surve of the device that the event a resident r functioning during the were noted to has which was over stated that someone f into that issue. She con Nursing Crash Cart (Ca accountability for the and functioning of the unable to provide any accountability re that the nurse signed the 'mail'." At 1:24 AM, the surve hallway of the she acknowledged the side and that she was conditioners worked of she was waiting on mail The surveyor asked if	Cart Check List for the second of the second	F	65			
		f she was informed to do the residents in particular					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315205	B. WING				C / <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	related to the malfund the units, and the LPN to do anything different water and ice. The st do more frequent rour signs, and the LPN #3 The surveyor asked a assessments on the r stated "no" because r correct the problem. At that time at approx surveyor observed the the station to meet with the the DON, the NP stat was going to start doi residents due to the r conditioning system a At that time, the NP s start her assessments surveyor stopped the she prioritized her dee unit when the most affected by the P around and acknowle question. She stated Marcine assessment with At 1:31 AM, the surve the hallway in a whee alcove. The resident" resident's pulse oxyge	tioning air conditioning on N #5 stated she was not told in except offer the residents urveyor asked if she had to inding, monitoring or vital 5 stated that she did not. bout more frequent esidents, and the LPN #5 maintenance was trying to imately 1:28 AM, the e Nurse Practitioner enter ted over to the nurses he DON. After meeting with ed to the surveyor that she ing assessments on the nalfunctioning air and the heat in the building. tated that she was going to is on the <b>surveyor</b> in the the NP and asked about how cision to start on the 3 West unit was known to be the heat, and the NP turned dged the surveyor's she would start on the surveyor discussed stated that she would start Resident #1.	F	658			

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		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі	LE CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	, í				PLETED
			A. DOILD				С
		315205	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	011	10/2020
				-	TWO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			CAMDEN, NJ 08103		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG					DEFICIENCY)		
F 658	Continued From page	92	F	658	3		
	oxygenation device w	as reading a pulse of					
	bpm. The resident's l						
	. The NP sta	ted that she wanted to take					
		sure reading. The NP took a					
	manual reading and s						
		she had listened to the					
		e and it was very irregular,					
	normal behavior as h	riencing a change in their					
		was usually					
		at she wants to send the					
		ency room for evaluation.					
	-	ed that this was how the					
	resident had been pre	esenting since the first					
	obervation earlier in t	he day.					
	At 1:38 AM the surve	eyor interviewed the NP who					
		orked at the facility for three					
		ar with Resident #1. She					
	stated that the reside	nt's heart rate when she					
	listened to it was						
		ated that the resident was					
	,	elves. The surveyor asked					
		assessing in the residents					
		nt, and she stated that looking for a change in					
	mostly sile would be	She stated that the skin					
	may feel warm too. T	The surveyor pressed the NP					
		nything else she would be					
		nt's for, and she stated a					
		skin turgor that was not					
		st sensations, dry skin, and					
		nere may be paleness. The					
		f were supposed to be					
		nts over any frequency due					
	comfortable levels, ar	ures not maintaining safe, ad the NP stated that					
		hecked every four to six					
		resumed her assessments					

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MENT OF HEALTH AN	D HUMAN SERVICES					M APPROVED
S FOR MEDICARE & I	MEDICAID SERVICES				OMB N	<u> </u>
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
		A. BUILDII	IG			с
	315205	B. WING				/19/2023
ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE		
C CENTER FOR REHAB &	& SUB-ACUTE CARE					
1						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	(EACH	I CORRECTIVE ACTION SHOU	_D BE	(X5) COMPLETION DATE
1 5		F6	58			
of the other residents	on .					
Resident #1 who was	sent to the hospital on					
summary) reflected th	at the resident was					
date of . The that the resident was indicating that performed in the ever emergency.	a status, efforts should be at of a					
initiated on in in due to being a of the goals included target date of Monitor/document any effectiveness; Monitor	cluded that the resident had n . One that the resident will display with an [outdated] Interventions included give as ordered. y side effects and r for signs and symptoms of					
	RS FOR MEDICARE & I         OF DEFICIENCIES         F CORRECTION         PROVIDER OR SUPPLIER         C CENTER FOR REHAB &         SUMMARY STA (EACH DEFICIENCY REGULATORY OR L         Continued From page of the other residents         The surveyor reviewe Resident #1 who was         around 2 AM.         A review of the Admis summary) reflected th admitted to the facility included         date of       The that the resident was indicating that performed in the ever emergency.         A review of the reside initiated on       in         Gue to being a of the goals included       in         Monitor/document any effectiveness; Monitor       in	F CORRECTION       IDENTIFICATION NUMBER:         315205         PROVIDER OR SUPPLIER         C CENTER FOR REHAB & SUB-ACUTE CARE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 93 of the other residents on         The surveyor reviewed the medical records for Resident #1 who was sent to the hospital on around 2 AM.         A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included         Multi an onset         date of	RS FOR MEDICARE & MEDICAID SERVICES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULT         OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULT         B. WING_       315205       B. WING_         PROVIDER OR SUPPLIER       CENTER FOR REHAB & SUB-ACUTE CARE       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         Continued From page 93       of the other residents on       .         The surveyor reviewed the medical records for Resident #1 who was sent to the hospital on       .         around 2 AM.       A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included       .         Matter of the facility with diagnoses that included       .       .         Matter of the resident's individualized care plan initiated on included that the resident had included that the resident will display       .         A review of the resident's individualized care plan initiated on included that the resident will display       .       One of the goals included that the resident will display         Monitor/document any side effects and effectiveness; Monitor for signs and symptoms of acute respiratory insufficiency;       .       .	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         STOUTDER OR SUPPLIER       315205       STREET ADDRESS, TWO COOPER PL         CENTER FOR REHAB & SUB-ACUTE CARE       STREET ADDRESS, TWO COOPER PL/ CAMDEN, NJ 02         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 93 of the other residents on manual 2 AM.       F 658         A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included       F 658         date of the resident's individualized care plan initiated on minitiated on minited the facility with minitiated on minitiated on minitiated on mi	SS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDERSUPPLIENCLIA. IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         316205       IS WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE TWO COOPER PLAZA CAMDEN, NJ 08103         C CENTER FOR REHAB & SUB-ACUTE CARE       INING         (EACH DEFICIENCY MUSTER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       ID CROSS-REFERENCED TO THE APPRO DEFICIENCY)         Continued From page 93 of the other residents on anound 2 AM.       F 658         A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included       F 658         Indicating that       efforts should be performed in the event of a emergency.       One of the goals included that the resident had indicating that       One of the goals included that the resident had indicating that         A review of the resident's individualized care plan initiated on included that the resident had indicating that       One of the goals included that the resident had indicating that         A review of the resident any side effects and effectiveness; Monitor for signs and symptoms of acute respiratory insufficiency;       One of the goals included that the resident and isordered.	SS FOR MEDICARE & MEDICAID SERVICES     OMB NU       OF DERIGENCIES     (N) PROVIDERUPULENCULA LIDENTIFICATION NUMBER:     (N2) MULTIPLE CONSTRUCTION A BUILDING     (N2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING COME AND A BUILDING A BUILDING (CONSTRUCTION AND BUILDING A BUILDING (CONSTRUCTION AND BUILDING A BUILDING (CONSTRUCTION AND BUILDING A BUILDING (CONSTRUCTION A BUILD

Event ID: 5E8J11

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					<i>I</i> APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDI	NG _			C
		315205	B. WING _				_ 19/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2020
	CENTER FOR REHAB			т١	WO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAD	& SUB-ACUTE CARE		С	AMDEN, NJ 08103		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	~	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	^	CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
F 658	Continued From none	- 04					
F 000	Continued From page	94	F 6	558			
	In addition, there was	a care plan initiated on					
	that the resid	ent has a					
		e goal had an outdated that the resident's comfort					
		ough the review date. An					
		to consult with physician					
	and social services to						
	resident in the facility						
	The care plan reflecte	ed that the resident required					
		assist of one staff for bed					
	mobility.						
	A review of the active	physician Order Summary					
	Report for	reflected a physician order					
	for a evaluati and a physician order	on and treat dated					
		minister					
		hours as needed for					
	Summary Papart also	. The Order oreflected that the resident					
	was on medication fo						
	no physician order for	. In					
		c Medication Administration					
	Record (eMAR) for same active physician	did not reflect the n orders found in the Order					
	Summary Report for						
	A review of the Progre reflected a physician						
		hat the resident was recently					
	readmitted to the facil						
	hospitalization after p	resenting with					
	and was	s treated with					
	and improve	d. It further reflected that					
		tiple admissions tohospital					
	for [his/her]						

Event ID: 5E8J11

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DAT	E SURVEY IPLETED
		315205	B. WING			07	C 7/ <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	including recurrent	requiring onic Progress Notes (ePN)	F	658	8		
	AM which reflected the the hospital via 911 for recorded indicated BF SP02 (pulse oxygena air, temperature indicted that the phys POA was contacted. rate recorded on the documented evidence sounds when the resi and rece . The nurse had	at the resident was sent to or The vital signs The vital signs Part of HR of BPM, tion status) for on room degrees F. The note ician was notified and the There was no respiratory progress note or e of the auscultation of lung dent had complained of					
	reflected that the resising staken and docu 15:43 PM (3:43 PM) of , despite know , reconditioner being mail and in the resid indicated on the facili (Rooms)" list for malfi (Resident #1 had no a room on and and exceeded degrees A review of the undat	al signs summary report dent had not had any vital mented since at until surveyor intervention on vledge of the resident's cent hospitalizations, and air functioning on the unit lent's individual room as ty's undated "P-TAC unctioning P-TAC units. air conditioner or fan in the the room temperature					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 11/22/2023 MAPPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION		LETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER 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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 658	rooms that did not have including the room be list reflected that all the that had malfunctioning them fixed or replaced (which was two weeks DoM), particularly upon conditioner system of there was noted to a sisubsequent fire risk. Upon observation, the means provided such conditioner to maintai below degrees F in who had a malfunction for adverse events from emergency, in accord standards of practice On 7/16/23 at 2:00 PM surveyors the list of re- facility to be at high-ri- related to heat. The fivere residents of on their census that we adverse outcome. The of their resident popul risk for an adverse out adequate room tempe Approximately 1:50 A Emergency Managerri medical transportation transferred to the Emo-	ve a working PTAC unit, longing to Resident #1. The periorms listed on the second distributed with a started since the list was started since the list was started since the shutdown of the air on the room temperature in the room for Resident #1 ning PTAC unit and a known that put him/her at high risk of a total of the sident sidentified by the sk for adverse outcome acility indicated that there at of a total of the residents vere at the shutdown and the sidents is indicates a total of the sidents to avoid harm. M, the facilitied to be at high toome if not provided eratures. M, the local Office of hent (OEM) officer called for on for Resident #1 to be	F	65	8		

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		ID HUMAN SERVICES				FORI	M APPROVED
		MEDICAID SERVICES	(X2) MUI	TIPI	PLE CONSTRUCTION		D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			B		PLETED
							с
		315205	B. WING			07	/19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	C CENTER FOR REHAB				TWO COOPER PLAZA		
WAJESTI	CENTER FOR REHAD	& SUB-ACUTE CARE			CAMDEN, NJ 08103		
(X4) ID		ATEMENT OF DEFICIENCIES	IENT OF DEFICIENCIES ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
170		,		•	DEFICIENCY)		
F 658	Continued From page	e 97	F	65	58		
	second in command i	regional administrator					
		ors concerns to develop an					
		prevent a heat-related					
	adverse event when t	their air conditioning system					
		units were known to be shut					
	-	at full capacity, implement					
		ning cooling measures to					
		rious harm, initiate room vhen air temperature on					
	· ·	xcessively humid and					
		perspiring and complaining					
		ppropriately activate their					
	-	plan upon identification of					
		malfunction in degree					
	-	s with no immediate plan to					
	correct the HVAC ma						
	notified of Resident #						
		and for no air conditioner or fan and					
		e exceeded 86 degrees and					
	had to be hospitalized	-					
		staff did not act upon even					
		attention by the surveyors.					
		eyors requested to meet with					
		tion, and the Regional LNHA					
		d the Regional Director of					
	• •	The ED and DON were not urveyor asked why. The					
		d that the ED was not					
		he stated that he would get					
		e, the surveyor asked the					
		#1 and she stated that the					
	resident was hospital						
	She stated that he wa						
		izations. She stated that the					
	resident had a	, ,					
	resident was not alway	. She stated that the ays compliant with the use of					
	I CONCERT WAS HUL AIWS	aya compliant with the use of					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 658	supplementa the hospital and woul time the resident was surveyor asked if the hospital each time, an stating that the reside surveyor asked why t provided air condition was when the was known to be non HVAC system had be fire. The DON could no documented evide offered and declined a unit or asked to move declined. The survey facility of the floor on replaced with new, no after surveyo discussed the discrep off in the 11-7 Daily N List on emergency, particular emergency. The facil failure to identify their #1) who was complain adheres to profession practice to assess, ide physician at the time verbalizing a change there was no air cond room, no fan, and the temperature exceede Two LPN's and one Face	and was frequently sent to d come of the hospital. The resident was admitted to the nd the DON replied yes, ent was the resident was not ing if the resident's health PTAC system in the room functioning and the unit en shut down to prevent a not speak to it. There was ence that the resident was a portable air conditioner to a different room and for further informed the being outdated on the but were verified to be on-expired for the surveyor also pancies in what was signed fursing Crash Cart Check hat was available in the that day in the event of an rly during their heat lity was notified that their thigh-risk resident (Resident ning of for the surveyor also pancies in a manner that hal standards of nursing entify, respond, and call the when the resident was in condition during a time litioning in the resident's	F	658	8		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/2023 MAPPROVED D: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		LETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 658	night shift LPN stated admitted to be service. The Nurse Pr 1:30 AM on an a and stated that this we behavior or baseline a were no vital signs tal #1 on and an and intervention. The resident was sen early morning hours of Interview with the night that she was aware of facility but that she did different for the reside Emergency Plan reque This resulted in an im for Resident #1 who we have known for to implement measure the resident's room te follow professional stat the resident complain manner to prevent wo promptly calling physit the lack cooling in the transporting the reside building until surveyor information was provid The facility administra an immediate jeopard	that the resident might be ut was not on hospice ractitioner arrived around nd assessed the resident as not the resident's normal and he/she had an There even or recorded for Resident until surveyor to the hospital during the of the heat situation in the dn't need to do anything ents despite the Heat iring otherwise. mediate jeopardy situation vas known by the nurses to and failed to assess and maintain mperature and failed to andards of practice when ed of and failed to act in an orsening of the condition by cian, intervening to ent to another area of the r inquiry. No additional	F	658			

Facility ID: NJ60412

If continuation sheet Page 100 of 124

UMAN SERVICES				FORM	APPROVED
PROVIDER/SUPPLIER/CLIA				(X3) DATE	
	A. BUILDI	NG.			c
315205	B. WING				19/2023
IB-ACUTE CARE					
ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE
b he facility provided an al plan. to 3:08 PM, the ions, interviews, cords and pertinent urvey team was able to of the written Removal was confirmed as lifted I documentation was inquiry that indicated en notified regarading resident's ng well when the room degrees F, and ring the heat emergency d no air contitioning in with professional Emergency s. bb description for a included "Receives full he outgoing nurses to ation and necessary est's careRecognizes y to changes in locuments nd partners with all ams, internal and uum of careMaintains sidents/guests and or resolutionNotifies ges in patient's iption did not include job war programmers and	F	658			
	DICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315205 B-ACUTE CARE ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) D and facility provided an al plan. to 3:08 PM, the ions, interviews, cords and pertinent urvey team was able to of the written Removal was confirmed as lifted I documentation was inquiry that indicated en notified regarading resident's ng well when the room degrees F, and ring the heat emergency d no air contitioning in with professional Emergency S. b description for a included "Receives full he outgoing nurses to ation and necessary est's careRecognizes y to changes in ocuments nd partners with all ams, internal and uum of careMaintains sidents/guests and or resolutionNotifies ges in patient's	DICAID SERVICES         PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILDI         315205       B. WING         B-ACUTE CARE       ID         ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)       PREFI TAG         D       F         to 3:08 PM, the ions, interviews, sords and pertinent urvey team was able to of the written Removal was confirmed as lifted Id documentation was inquiry that indicated en notified regarading resident's ng well when the room degrees F, and ring the heat emergency d no air contitioning in with professional Emergency S.         bb description for a included "Receives full he outgoing nurses to ation and necessary est's careRecognizes y to changes in ocuments nd partners with all ams, internal and uum of careMaintains sidents/guests and or resolutionNotifies ges in patient's iption did not include job	DICAID SERVICES         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         315205         B-ACUTE CARE         ENT OF DEFICIENCIES         ST BE PRECEDED BY FULL         DENTIFYING INFORMATION)         F 658         De facility provided an al plan.         to 3:08 PM, the ions, interviews, sords and pertinent urvey team was able to of the written Removal was confirmed as lifted         I documentation was inquiry that indicated en notified regarading resident's ng well when the room degrees F, and ring the heat emergency d no air contitioning in with professional Emergency s.         bb description for a included "Receives full he outgoing nurses to aation and necessary set's careRecognizes y to changes in ocuments nd partners with all ams, internal and uum of careMaintains sidents/guests and or resolutionNotifies ges in patient's iption did not include job	PROVIDERSUPPLIERCIAN       (X2) MULTIPLE CONSTRUCTION         IDENTIFICATION NUMBER:       A. BUILDING         315205       B. WING         B-ACUTE CARE       STREET ADDRESS, CITY, STATE, ZIP CODE         TWO COOPER PLAZA CAMDEN, JU 08103       TWO COOPER PLAZA CAMDEN, JU 08103         ENT OF DEFICIENCIES STBE PRECEDED BY FULL DEPTICENCED TO FULL TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD B CROSS-REFERENCED TO THE APPROPRIN DEFICIENCY)         D       F 658         e facility provided an al plan.       F 658         to 3:08 PM, the fors, interviews, cords and pertinent urvey team was able to of the written Removal was confirmed as lifted I documentation was inquiry that indicated an notified regarading resident's gwell when the room (degrees F, and ing the heat emergency J to air contitioning in with professional Emergency S.         b description for a included "Receives full he outgoing nurses to ation and necessary sts's careRecognizes y to changes in ocuments nd partners with all ams, internal and uum of careMaintains sident's ges in patient's ges in patient's patient include job	UMAN SERVICES FOR DICAID SERVICES OMB NC DICAID SERVICES OMB NC DICAID SERVICES OMB NC DICAID SERVICES OMB NC PROVIDERSUPPLIENCLIA A BUILDING

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/22/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	(X3) DATE SURVEY COMPLETED C	
		315205	B. WING		07/19/2023
NAME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		) COOPER PLAZA IDEN, NJ 08103	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 658	Continued From page	9 101	F 658		
F 761 SS=F	Registered Nurse incl detailed report from the ensure proper commu- follow-up of resident's and responds competer resident's condition and appropriatelyInteract multidisiplinary service external, to assure co- a safe environment for reports unsafe situation responsible party of co- condition Refers to Nursing/Administration Management Policy and Folders, Hard Copy mo of careaccurate and Nursing Assessment and admission A review of the facility Director of Nursing did to Emergency Prepart NJAC 8:39-11.2(b) Label/Store Drugs and CFR(s): 483.45(g) Labeling co Drugs and biologicals	unication and necessary s guest's careRecognizes tently to changes in nd documents ets and partners with all e teams, internal and ontinuum of careMaintains or residents/guests and on for resolutionNotifies thanges in patient's n/IV/Emergency and Procedures (Public nanual) to assure standard d timely completion of and data collection upon 's job description for the d not include duties related edness and response. d Biologicals (1)(2) of Drugs and Biologicals s used in the facility must be e with currently accepted s, and include the y and cautionary	F 761		7/21/23

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MA.IESTI	C CENTER FOR REHAB	SUB-ACUTE CARE		-	TWO COOPER PLAZA		
					CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	§483.45(h) Storage o §483.45(h)(1) In acco Federal laws, the faci biologicals in locked o temperature controls, personnel to have acco §483.45(h)(2) The face locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when the package drug distribut quantity stored is mini- be readily detected. This REQUIREMENT by: COMPLAINT # 1657 Based on observation pertinent facility failed the temperature controls room located on the the facility experience Heating Ventilation Ai Con 7/16/2023 at 3:13 facility, the surveyor of medication storage for noticeably warm upor	f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. sility must provide separately affixed compartments for drugs listed in Schedule II of orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced 31 n, interview, and review of ments, it was determined to implement proper for a medication storage floor of the facility while ad a malfunction in the r Conditioning unit since PM during a tour of the observed the floor for metering it. At this time, the e Director used an Infrared ure the ambient room	F	761	F 761 Element One Corrective Actions " All drugs and biologicals were immediately removed from the third flo medication room to a locked storage a with an acceptable air temperature on . All medications and were discarded as per the pharmacy direction and reordered. " Repair of the exhaust vent in the medication storage room is being completed once the ordered part is received. In the interim all drugs and biologicals are now in the floor medication room that maintains a prop temperature range per recommendatio of the Pharmacist and manufacturer. Element Two - Identification of at risk Residents	rea er	

Event ID: 5E8J11

Facility ID: NJ60412

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· /				PLETED
		315205	B. WING			07	C / <b>19/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE	1 07	/19/2023
				т	NO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		С	AMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 704		400	_				
F 761	Continued From page		F	761			
		d time inside the medication			" All Residents on the	/e	
	room, the surveyor o				the potential to be affected by this		
		e warm to the touch. The			practice.		
	surveyor counted	tions			Element Three  Systemic Change The Director of Nursing and Direct	or	
	medications (medica	in the resident). The			of Maintenance checked all medication		
	labels on the antibiot	ic intravenous meditations			storage areas to ensure drugs and	I	
		dications must be stored at			biologicals were properly stored in		
		pecifically between and			locations that complied with the		
	degrees Fahrenhe				pharmacist and manufacturer room air		
					temperature recommendations.		
	The surveyor also ob	oserved two boxes of an			Licensed nursing staff received		
					re-education regarding monitoring and		
	milligrams/	, assigned to			reporting air temperatures outside the		
		Written on each box were			desired range in medication rooms to		
		e at [degrees] to			ensure all drugs and biologicals are		
	[degrees] F."				properly stored.		
					Element Four  Quality Assurance		
	At 3:05 PM, the surve				" Daily air temperatures are recorde	ed in	
		urse (LPN) who confirmed			all medication rooms as assigned and		
	that the we	ere for residents that had			reported to the New Jersey Departmen		
	Sho ooko	owledged the room			Health per the directed plan of correction All have been within acceptable range	011.	
		ed that she would call the			since July 16, 2023.		
	pharmacy to get repla				The Maintenance Director/designe	e	
	,,				will monitor common area temperature		
	At approximately 3:1	5 PM, the surveyor			including medication storage rooms, ev		
		who acknowledged that the			two hours x 48 hours, then every shift :		
	medication room was	s not considered room			days and daily thereafter with no stop		
		reading degrees F. She			date. Results are reported to the		
		k to what room temperature			administrator and emailed daily to the		
		uld have the medications			department health until substantial		
	removed and stored	in a cooler location.			compliance is achieved. Results are a		
					shared at the weekly Quality Assurance	е	
		3:54 PM during a telephonic			Performance Improvement (QAPI)		
		veyor, a Pharmacist for the			meeting for action as appropriate.	_	
	facility's pharmacy th	at provided the <b>second</b> ons recommended that if the			"The Administrator/designee makes random daily rounds with the maintena		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/22/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315205	B. WING		C 07/19/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		WO COOPER PLAZA AMDEN, NJ 08103	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	DATE
F 761	Continued From page	e 104	F 761		
	not to use them. The malfunction was iden	for approximately ten days, facility's air conditioning tified on <b>the storage</b> . y's undated Storage of		acceptable where drugs and biological are stored. Results are discussed with the Director of Nursing daily and in aggregate at the weekly Quality Assurance Performance Improvement	1
	Medications policy in shall be responsible f storage AND prepara and sanitary manner.	cluded that nursing staff for maintaining medication tion areas in a clean, safe, The policy was nonspecific aperatures for medication		(QAPI) meeting for further action as appropriate.	
F 835 SS=L			F 835		7/21/23
	enables it to use its re efficiently to attain or practicable physical, well-being of each re This REQUIREMENT	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial			
	by: Refer to F600 and F	658		F-835	
	COMPLAINT#:NJ001	165731		Element One – Corrective Actions	
	and review of other p	n, interview, record review ertinent facility 15/2023, 7/16/2023 and		The facility Heat Emergency Response Plan was activated on      The air conditioning main system unit	
	7/19/2023, it was dete Administration failed	ermined that the facility's to initiate their Emergency ctively and efficiently to		was repaired as of <b>common</b> with a common areas and resident rooms hav acceptable temperatures.	all
	services needed to m	tures exceeded degrees		<ul> <li>The secondary PTAC units are being replaced as they are received, and</li> </ul>	

Event ID: 5E8J11

Facility ID: NJ60412

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	(EACH DEFICIENC' REGULATORY OR L Continued From page Fahrenheit (F). The a of 2 resident floors we as no longer functioni through ensure that the maint plan to monitor and de	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 105 ir conditioning systems on 2 ere identified by facility staff ing at full capacity on	B. WING ID PREFIX TAG F 83	STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) 35 portable air conditioner units and	CTION DULD BE ROPRIATE	C 7/19/2023 (X5) COMPLETION DATE
(X4) ID PREFIX TAG	CENTER FOR REHAB	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 105 ir conditioning systems on 2 ere identified by facility staff ing at full capacity on	PREFIX TAG	TWO COOPER PLAZA CAMDEN, NJ 08103 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPP DEFICIENCY)	CTION DULD BE ROPRIATE	(X5) COMPLETIO
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC' REGULATORY OR L Continued From page Fahrenheit (F). The a of 2 resident floors we as no longer functioni through ensure that the maint plan to monitor and do	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 105 ir conditioning systems on 2 ere identified by facility staff ing at full capacity on	PREFIX TAG	CAMDEN, NJ 08103 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) 35	OULD BE ROPRIATE	COMPLETIO
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC' REGULATORY OR L Continued From page Fahrenheit (F). The a of 2 resident floors we as no longer functioni through ensure that the maint plan to monitor and do	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 105 ir conditioning systems on 2 ere identified by facility staff ing at full capacity on	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE ROPRIATE	COMPLETION
PRÉFIX TAG	(EACH DEFICIENC' REGULATORY OR L Continued From page Fahrenheit (F). The a of 2 resident floors we as no longer functioni through ensure that the maint plan to monitor and de	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 105 ir conditioning systems on 2 ere identified by facility staff ing at full capacity on	PREFIX TAG	(EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APP! DEFICIENCY)	OULD BE ROPRIATE	COMPLETION
F 835	Fahrenheit (F). The a of 2 resident floors we as no longer functioni through ensure that the maint plan to monitor and do	ir conditioning systems on 2 ere identified by facility staff ing at full capacity on	F 83		f	
	Fahrenheit (F). The a of 2 resident floors we as no longer functioni through ensure that the maint plan to monitor and do	ir conditioning systems on 2 ere identified by facility staff ing at full capacity on			<b>6</b>	
	There was no evidence the New Jersey Depart of the disruption of set systems until <b>Sector</b> that the facility identifing medical conditions that develop heat related as prolonged exposure to temperatures. The Ex- covering for the Licent Administrator (LNHA) Maintenance Director demostrate knowledg responsibilities and co according to their faci Preparedness Plan for locate it for review. A Administration failed to description that define Administrator within the	t elevation during the on the 2 residential floors. ce that the facility notified artment of Health (NJDOH) ervice of the air conditioning . There was no evidence ied high risk residents with at have the likelihood to symptoms due to the o elevated indoor heat xecutive Director (ED) nsed Nursing Home b, Director of Nursing (DON), and facility staff failed to ge of what their roles and ourse of actions to perform ility's Emergency or heat and the failure to additionally, the to ensure that the job es the duties of the he facility was being rrent Administrator of record		<ul> <li>remain in any rooms where PTAC order have not been received. All temperatures have been acceptal difference in the second seco</li></ul>	c units on room air ble since d uch unit ailable urse and gnosis of eat on onger reported uly 15, educated htifying ropriate partment gency	
	to the building since the air conditioning wa	evidence of the HVAC		<ul> <li>The maintenance director was re-educated on maintaining temper logs of facility temperatures.</li> <li>Residents are provided with extra their rooms as appropriate.</li> </ul>		

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY MPLETED
		315205	B. WING			C 7/19/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		1113/2023
				TWO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 835	Continued From page	o 106	F 83	F		
1 000			ГОЗ			
		on for the facility's failure to staff were knowledgeable		Residents		
		ate and execute the written		· All residents without adequ	late	
		ir heat emergency plan that		temperature control in their		
		at risk for serious harm, injury		have the potential to be affe		
	and death during pro	olonged indoor heat		practices.		
	exposure.					
The surveyors identified an IJ situation for F 835				Element Three – Systemic C	Change:	
				The permanent New Jeres	vlicenced	
	Administration at a scope and severity (s/s) of L The IJ began on and the facility was			The permanent New Jerse     Nursing Home Administrator	-	
		. The IJ was removed on		started employment at the fa		
		y provided an acceptable		17, 2023 replacing both the		
	removal plan on			Director and the temporary I		
	an on-site visit			Licensed Nursing Home Adr		
	for F835 remained or			record. The permanent New	•	
	-	al for more than minimal		Licensed Nursing Home Adr		
	harm that is not imme	ediate jeopardy.		was oriented by the Regiona		
	As suideneed by the	following		Nursing Home Administrator		
	As evidenced by the	Tonowing.		consultant Licensed Nursing Administrator.		
	During a telephone ir	nterview on		Administrator.		
		n., when the surveyor asked		• The Nursing Home Admini	strator and	
		nistrator (DA) about a		consultant administrator me		
	NJDOH hotline call, h	ne stated he had only been		morning and at the end of ea	ach day to	
	working at the facility	for two weeks and he		discuss events of the day ar	nd actions	
	-	ne facility's air conditioning		taken including the emerger	ncy operation	
		tioning, he was unsure of the		plan.		
		t started not working and		The maintenance directory		
		e facility had air conditioning eas were limited. The		The maintenance director re-educated on maintaining		
	surveyor then inquire			logs of facility temperatures	<u> </u>	
		s in the facility. The DA was				
		numbers or temperature				
		t provide information on the		· Logs are submitted to the I	Department of	
	-	affected by the heat		Health daily as required by t	-	
		currently in the facility.		plan of correction.		
		icated that the Emergency				
	Plan was being follov	ved.		<ul> <li>Nursing Staff were re-educ</li> </ul>	cated on	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 11/22/2023 RM APPROVED IO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· · ·	E SURVEY IPLETED
		315205	B. WING			0	7/19/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			WO COOPER PLAZA AMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	Continued From page	e 107	F	835			
	On 7/15/2023, at 5:02 on-site visit by survey facility based on the la information communic facility staff about the who are being effecte units that were not ful and floors. On 7/15/2023 at 5:19 the floor and humid. The surveyor temperature readings he replied that he did The surveyor continue the floor. At 5 knocked and walked if who was in a wheelch was in bed. The surv and humid. The roor but Resident #4 state the air conditioner in the working. The resident knows about it, includ asked what the facility and the resident state small fan, but that he/ #4 stated that "if you" ask for it. No one car	2 p.m. and 7:30 p.m. an fors was conducted to the ack of clear and concise cated over the phone from a condition of the residents of by the air conditioning ly functioning on the p.m. the Surveyor toured found the air warm and interviewed LPN#1 if room were being taken and the n't know about that. ed to observe residents on :22 p.m., the surveyor into room of Resident #4, nair and whose roommate eyor noted room was warm		835	<ul> <li>recognizing and assessing for signs a symptoms of heat related illness and reporting to supervisor/designee any temperature abnormalities and transferring residents to cooler areas July 16, 2023.</li> <li>The Emergency Preparedness Plan reviewed and revised with assistance the consultant Administrator, and bind were placed on each unit, and front lo desk, nursing office and Administrato office. Staff were re-educated on the location and content of the Emergency Preparedness Plan binder and their responsibilities.</li> <li>All residents were reassessed on Ju 17, 2023, and findings documented b facility Medical Director/Nurse Practit as required with no indication of heat related illness noted for any resident.</li> <li>All resident rooms, and common are were assessed for elevated temperat and results documented and sent to I Department of Health (DOH) daily as required by the Directed Plan of Correction (DPOC).</li> <li>A temperature log is utilized to moni and track room and common space a temperatures.</li> <li>All residents were assessed by nurse</li> </ul>	air on was of ders obby rs' ey ole lly y ioner eas ures NJ	
	-	AC unit, despite the unit			practitioner for signs and symptoms of heat related illness and an acuity list designating high risk residents was		
	The surveyor interview	wed LPN #1 at 5:25 p.m.			generated and placed on each nursin	g	

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315205	B. WING				C 7/19/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/15/2025
					VO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			AMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 835	Continued From non	o 109		005			
F 035	Continued From page		F (	835			
		nd the roommate lack of air			unit to be used in an emergency as		
		om. LPN #1 said that the			appropriate.		
	residents' PTAC unit room. The LPN #1 w	was not functioning in their			· Residents unable to effectively		
		he PTAC unit playing with the			communicate their feelings of comfort,		
		as no air coming from the			unable to ambulate, with a BIMS<12 of		
	vent. The LPN #1 st				unable to shift/roll independently were		
		ed that there was no air			placed in a higher acuity level and		
		AC unit, despite the unit			assessed more frequently for signs or		
	indicating that it was	"on." LPN #1 could not			symptoms of possible heat related illne	ess	
	provide information re	egarding how high the			or discomfort was reviewed and updat	ed	
	temperature was in tl	he room.			by the DON consultant and the		
					interdisciplinary team and staff		
		eyor continue to observe			re-educated.		
	residents' rooms on t						
	<b>U</b>	C units, fans in place and if			· Families were notified of the air		
	hydration needs were	e being met.			conditioner repair issue and updated a	IS	
		red at 5:27 p.m. while atill			were facility MD's.		
		/ed_at 5:37 p.m., while still a facility staff member			· Residents were updated verbally and	l at	
		ay carrying a plastic, red dye			scheduled Resident Council Meetings		
		This was the Executive			the repairs to the air conditioning units		
		r by phone with the surveyor			· Residents affected by increased		
		the facility. The surveyor			temperatures were offered temporary		
		icensed Nursing Home			room changes or temporary placemen	t in	
		) of the facility, and he stated			cool common areas, those that refuse		
		icense but not in New Jersey			move were provided with portable air		
	and was waiting for r	eciprocity to work in this			conditioning units.		
		asked the ED who was the					
		The ED indicated he was			· Facility purchased in room portable a		
		e would have to check. The			conditioners and placed in each reside	ent	
	ED stated that he wa				room on July 16, 2023.		
		at he was currently taking			Facility ranted also 5 tax wanted to 1		
	-	floor using the red dye			Facility rented six 5-ton portable air	h	
	-	He held it up for the			conditioner rentals and placed 2 on ea		
	surveyor while on the floor hallway near roo				floor in hallways/common areas on Jul 16, 2023.	ıy	
		on the thermometer was			10, 2020.		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		315205	B. WING				C 7/ <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				т	WO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			AMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 835	reading degrees F analog thermometers temperature. The survey on the floors. The ED using the thermometer believed that they had checking temperature it. The surveyor continue the ED at 5:50 p.m., v temperature dual lase which revealed the for 1. Room degrees air conditioner in the 3. Room degrees air conditioner in the 3. Room degrees air conditioner in the 3. Room degrees the surveyor and the temperature at 5:56 p roommate and it was contained no fan or fu the time, ED stated the The surveyor wanted for this resident and of The ED replied that h fans. He did acknowl had fans and air cond ED could not provide air conditioner system fixed for the residents ED that the DON had fans in use on the	ahrenheit, stating that the are "hard to tell" an exact veyor asked the ED if that vas checking temperatures explained that he was only er temporarily, and that he d an air temperature gun for as and was going to look for ed the form floor tour with who now had the room er infrared thermometer gun llowing room temperatures: egrees F. There was no fan rees F. There was no fan or coom. rees F. grees F. ED took the room m. of Resident #4 and degrees F. This room unctioning air conditioner. At that the room felt "too warm." to know what was the plan ther residents on the floor. e would try and bring more edged that not all residents litioning in their room. The a timeline as to when the ns and PTAC units would be the revealed that there were no floor. He stated that	F	835	<ul> <li>Temperatures are monitored and documented every shift per the requirements in the directed plan of correction (DPOC).</li> <li>The facility engaged the services of a hour a week LNHA to oversee and ass the Administrator as required in the Directed Plan of Correction. Weekly reports are sent to the department of health as required in the as required in the as required Plan of Correction.</li> <li>The facility engaged the services of a hour a week Director of Nursing consultant to oversee corrective action and assist the Directed Plan of Correction and assist the Director of Nursing as required in the Directed Plan of Correction.</li> <li>A weekend manager on duty schedul was implemented with a checklist including confirming air temperatures.</li> <li>A root cause analysis of the system breakdown was completed, and weekl Quality Assurance Performance Improvement (QAPI) meetings initiated continue until substantial compliance at then monthly thereafter.</li> <li>Element Four – Quality Assurance</li> <li>The Maintenance Director/designee monitor room and common area temperatures every two hours x 48 hout then every shift x 14 days and daily thereafter with no stop date. Results and solution and a solution and and and and and and and and and an</li></ul>	sist n the a 40 ns le ly d to and will urs,	
	fans in use on the there were fans clear	floor. He stated that				re	

Facility ID: NJ60412

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STATEMENT (	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		315205	B. WING			C 7/19/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1110/2020
				TWO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 835	an air conditioner issu At 5:59 PM, the surve Director of Maintenar he had only been em approximately four m The DoM stated that hot in the facility" and with the air conditioni the facility had severa beginning of one of the systems. I also an "air handler w floor." He cor floor, that the the air conditioner syst which required the er on to be shut fire." The DoM stated July 6th to address th processed until yester was for to dia surveyor requested d diagnostic visit from t findings.	use on the form floor, he didn't know that there was ue on the floor. Every was introduced to the floor. Every was introduced to the floor. Every was introduced to the floor. Every was introduced to the floor. Every was introduced to the floor by the facility for onths, since floor onths, since floor onths, since floor on the last few days it's been I that there had been issues ing systems. He stated that al bids out since the since there was a leak in He added that there was vith a bad condenser for the third floor had an issue with stem causing "sparking" tire air conditioning system coff, "or there would be a d that they received a bid on he problem, but it was not rrday floor in the bid gnose the problem. The ocumented evidence of that	F 8:	<ul> <li>daily to the department health substantial compliance is achie Results are also shared at the Quality Assurance Performance Improvement (QAPI) meeting as appropriate.</li> <li>The Administrator/designee r random daily rounds with the r staff to confirm room air temper assure the comfort of residents are discussed with the Director daily and in aggregate at the w Quality Assurance Performance Improvement (QAPI) meeting action as appropriate.</li> <li>The Director of Nursing/desig audit 5 random at-risk resident records for signs and symptom related illness daily x 7 days, w and monthly x 2. Findings are at clinical meetings and acted appropriate. Results are share aggregate at the weekly Qualit Assurance Performance Improvement (QAPI) meeting for further actin needed.</li> </ul>	eved. weekly be for action makes maintenance eratures and s. Results r of Nursing weekly be for further gnee will ts medical ms of heat weekly x 4 discussed upon as ed in ty ovement	
	full capacity. The Dol no room temperature time he kept a room t a month ago" and ha administrator but "he confirmed there were	no room temperature logs information on how the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		315205	B. WING			07	C 7/ <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 835	temperatures, since to over a given period of At 6:16 PM, the DoM he only works the nursing staff shout temperatures on wee how the nursing staff should be noted at the correspond with the a with LPN #1 and LPN were not aware of sta indicating that they we process. At 6:25 PM, the DoM the system had to be on for the survey of the survey assigned to for the survey assigned to for the survey assigned to for the survey as a satisfies the temperatures on the the temperatures on the the heat situation on the she was assigned for basic resident care. So encourage hydration turgor if a resident be otherwise there was re had to do. The surve had to be hospitalized were none.	hey were not checking them f time and recording them. stated to the surveyor that and that d be taking room kends. He was not aware of take room temperatures. It is time that this did not forementioned interviews #2 who stated that they ff taking room temperatures ere not involved in the and the surveyor went to DoM replied that the ading on this unit because shut down due to sparking eyor observed the LPN #3 in the hallway passing out nts. The LPN #3 stated that his floor were """""""""""""""""""""""""""""""""	F	835	5		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		315205	B. WING				C
	ROVIDER OR SUPPLIER	515205	D: WING		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	19/2023
	CONDER OR SOFFLIER				WO COOPER PLAZA		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			CAMDEN, NJ 08103		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 835	Continued From page	112	Í -	835			
1 000	was very hot and hea			000			
	temperature reading of 88 degrees F.						
	At approximately 6:42	DM the survey of cheery of					
		2 PM, the surveyor observed ext to the window. The					
	resident was	and the room air					
		t had no fan and no air					
		om and this was confirmed					
	-	surveyor interviewed the and the resident stated, '					
		d the resident began to wipe					
	sweat from his/her	. At that time the					
	resident stated, "I						
	<b>The second second second</b>						
	The surveyor observe	from the wall,					
	but the resident was r	-					
		esident if he/she utilized					
		ent responded that he/she					
		and wear it. The surveyor					
	observed the resident	and take some					
		8:35 PM, the surveyor					
		of Resident #1 and took a					
	room temperature wh						
		no fan or functioning air					
		om. The resident stated that					
	he/she was still	well. At					
	approximately 1:28 a.	m. on the second s					
		end over to the nurses					
	station to meet with th						
	Practitioner performe						
		oximately at 1:50 AM, the					
		ency Management (OEM)					
	officer called for medi resident to be transfe	cal transportation for the					
	hospital Emergency F						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		315205	B. WING				/19/2023
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	C CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	Continued From page	9 113	F	835	5		
	facility was not being preventive measures of the residents' healt conditions existing in that they need to be p residents don't want t The surveyor inquired keeping the resident's temperature for resident's temperature for resident's their needs. The ED t provide the following: face; provide fans and conditioning units. He all residents have fan conditioning units des conditioner units in th	the facility. The ED replied proactive and not wait, but if o move, they don't have to. I how the facility was s rooms at an acceptable ents that did not want to who could not verbalized old the surveyor staff can ice;a cool cloth for their d received portable air e did acknowledge that not					
	room of Resident #2 of The resident's bed was to the window and PT on the inter- resident's bed acting resident's bedside table and a pitcher of warm bedside table out of the PTAC unit was turned warm air was flowing the resident's room and read degrees F. didn't know if doctors nurses check or should	eyor and the ED went to the who was in bed and awake. as against the wall adjacent AC unit. There was a large floor adjacent to the as a manufacture mat. The ble was at the foot of the bed a water was resting on the he resident's reach. The d on but a small amount of from it. There was no fan in and the room temperature . The ED stated that he were called or how often ld check the vital signs in ted that the staff does go					

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/22/202 AAPPROVEI 0. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	ONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		315205	B. WING					_ 19/2023
	ROVIDER OR SUPPLIER	& SUB-ACUTE CARE	STREET ADDRESS, CITY, STATE, Z TWO COOPER PLAZA CAMDEN, NJ 08103			•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BI		(X5) COMPLETION DATE
F 835	At approximately 7:00 the DON's office with the surveyor the name record and noted that around the bow informed here air conditioner issues The DON and ED act no room temperatures instructed anyone to temperatures. They temperatures were not how can the facility how can the facility how can room temperature records	5 PM, the surveyor entered the ED. The DON provided the ED. The DON provided the of the current LNHA on t the new LNHA started on or e DON explained again that r only yesterday about the and the room temperatures. knowledged that there were logs and that they never take document acknowledged that if ot monitored and logged, ave knowledge on how to tated that she believed the quirement was not to exceed at she was not aware that the	F	335				
	who conference in te DON and the ED that maintain adequate ro accordance with regu- implement a system temperatures when th were known to not be functioning at full cap summer months, incl was degrees F ou high-risk residents to temperature control to related emergency, w	h (NJDOH) management lephonically informed the t the facility's failure to oom temperatures in alatory requirements, to monitor room he air conditioning systems e operational or not bacity during the heat of the uding on this date when it tside, failure to identify ensure they had adequate o reduce the risk for a heat						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 11/22/2023 RM APPROVED IO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315205	B. WING			0	C 7/19/2023	
NAME OF PI	ROVIDER OR SUPPLIER		•	STR	REET ADDRESS, CITY, STATE, ZIP CODE			
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		тw	O COOPER PLAZA			
	OENTERT OR REIAD			CA	MDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 835	risk situation that requ Emergency Response Emergency Manager At approximately 8:48 surveyors the facility? (EP) Manual stored in surveyors asked about Emergency Plan and The ED stated that it and he would have to any urgency, he step surveyors where to fil began sifting through surveyors were unab about facilities to whit transferred in the ever evacuation. Inside the red binder Preparedness Planni revised October 2012 Considerations for Ut specified very generic identify all critical ope conditioning systems communication syste and maintenance per familiar with all buildin procedures for restor need for back up syste maintenance schedul equipment. The attached Severe	by sin an immediate safety uired the activation of their e Plan and the local Office of ment (OEM). 5 PM, the ED provided two is Emergency Preparedness in a red binder. The ut the Heat Response relocation/evacuation plan. was in there somewhere, o look. At that time, without ped out without showing the nd it, and the surveyors the EP manual. The le to find any information ch residents could be int of an emergency or was an Emergency ing and Resource Manual which indicated "Planning ility Outages" which c information such as to trations including air , emergency generators and ms; Ensure that key safety sonnel are thoroughly	F	835				
		it and remains so for four						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		315205	B. WING				C 1 <b>9/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	• •	
MAJESTI	C CENTER FOR REHAB	& SUB-ACUTE CARE			WO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	air-conditioned part of Encourage residents keep the residents hy necessary and record wash cloths as needed cooler outside air in a 5. Monitor body temp and notify attending p Notify 911 if a resident be in danger of heat-rr residents if necessary thermometers. 9. Not The Emergency Oper the Evacuation Plan rr response for a Heat E equipped with air con and individual units in Temperatures in the fr Fahrenheit and below start to rise above 79 following procedures Maintenance: 1. Com ensure: a. Window cu offices are drawn to b windows and doors at temperatures at all stat minimum of every fou interior facility temper degrees Fahrenheit o immediately. 3. Turn offices and common at light would cause safe available fans. a. inve of all portable and wa additional ice, quantit Administrator or desig	f the facility, if available. 2. to take in more fluids and drated. Force fluids if I fluid intake. 3. Provide cold ed. 4. Open windows to let nd utilize fans to move air. eratures of the residents hysicians if necessary. 6. tr/staff member appears to related stress. 7. Evacuate 7. 8. Monitor environmental tify Medical Director. rations Plan located within evised 7/10/15 included Emergency. "The facility is dition in all common areas e each patient room. acility must be 81 degrees 7. Should the temperature degrees Fahrenheit the should take place: plete facility rounds to irtains in resident rooms and lock direct sun. b. all re closed. 2. log ations initially and at a r (4) hours. a. Report all	F	835			

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AID SERVICES DVIDER/SUPPLIER/CLIA					NO. 0938-0391
			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
315205	B. WING			0	C 7/19/2023
		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CUTE CARE		тw	O COOPER PLAZA		
		CA	MDEN, NJ 08103		
E PRECEDED BY FULL	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
ands at a minimum of punds. 2. Complete Il residents to pent of their ents at greatest risk es: a. significant al dependence on s requiring enteral is compromised gh risk. Note: not all ) listed are ysical and lifestyle 4. Collate listing of implement reduce the risk. not limited to: a. y condition change. e Pulmonary n] saturation every warrants. 5. If the cility reaches 80 emperatures on all y four (4) hours or as pocate residents to ible, as conditions punds a minimum of assessment as 10. Maintain idents 11. Initiate 00 AM to 10:00 eeded, to maintain action plan.	F	835			
		315205       B. WING         ACUTE CARE       ID         OF DEFICIENCIES       ID         PRECEDED BY FULL       PREFI         TIFYING INFORMATION)       Fill         or designee. 7.       India at a minimum of         ounds. 2. Complete       III residents to         ill residents to       Interview         nent of their       Interview         ents at greatest risk       Interview         is compromised       gh risk. Note: not all         i) listed are       ysical and lifestyle         4. Collate listing of       Implement         reduce the risk.       Into limited to: a.         y condition change.       e Pulmonary         n] saturation every       warrants. 5. If the         cility reaches 80       Imperatures on all         y four (4) hours or as       ocate residents to         ible, as conditions       punds a minimum of         assessment as       .10. Maintain         idents 11. Initiate       00 AM to 10:00         eeded, to       maintain action plan.         cate to residents       Interview	315205       B. WING         ACUTE CARE       ID         OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION)       ID         OF DEFICIENCIES       ID         PREFIX TAG       PREFIX TAG         Or designee. 7.       Indextra a minimum of         Dunds. 2. Complete       IF         III residents to       Herein         Pents at greatest risk       Herein         Insta at greatest risk       Herein         Insta at greatest risk       Herein         III residents to       Herein         Pents at greatest risk       Herein         Hist at a condition change.       Herein         H	315205     B. WING       JCUTE CARE     STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103       OF DEFICIENCIES E PRECEDED BY FULL IPPRECEDED BY FULL PREFIX TAG     PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)       or designee. 7. Inds at a minimum of     PR 835       or designee to their ents at greatest risk tes: a. significant al dependence on s requiring enteral is compromised gh risk. Note: not all i) listed are syscial and lifestyle 4. Collate listing of limplement reduce the risk. In ot limited to: a. y condition change. e Pulmonary I) saturation every warrants. 5. If the cility reaches 80 emperatures on all y four (4) hours or as ocate residents to ible, as conditions junds a minimum of assessment as .10. Maintain idents 11. Initiate 00 AM to 10:00 eeded, to maintain action plan. cate to residents	315205     B. WING     0       STREET ADDRESS, CITY, STATE, ZIP CODE       TWO COOPER PLAZA CAMDEN, NJ 08103       OP DEFICIENCIES E PRECEDED BY FULL IPRYING INFORMATION)     D PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 835       Or designee. 7. Inds at a minimum of       Street ADDRESS, CITY, STATE, ZIP CODE       D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Or designee. 7. Inds at a minimum of       Street ADDRESS, CITY, STATE, ZIP CODE       THE ADDRESS, CITY, STATE, ZIP CODE       TWO COOPER PLAZA CAMDEN, NJ 08103       OT designee. 7. Inds at a minimum of       Street ADDRESS, CITY, STATE, ZIP CODE       TWO COORECTIVE ACTION SHOULD BE IPRICED TO THE APPROPRIATE DEFICIENCY)       Street ADDRESS, CITY, STATE, ZIP CODE       THE ADDRESS, CITY, STATE, ZIP CODE       TH

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/2023 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		315205	B. WING				C 19/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	Administrator: 1. Impl and revise the facility Notify the Medical Dir Manager and Clinical Notify regulatory ager event that the indoor degrees Fahrenheit of period of four hours of notification of the New Health is required. 5. adequate to maintain procedures and meet the need to evacuate. There was an Evacuated date of 7/10/2015 but address specific facilit residents. At 9:45 PM, the survet the DON who stated to local facilities they hat transfer residents to in emergency. The ED surveyors to rememb facility for two weeks. speak to evacuation of in the event of an eme At 11:10 PM, a new fat the facility and office of he was "Second in co and and that he wanted plan to address the m conditioning system. trying to get every por available to the facility able to bring six over	ement, oversee, monitor, procedures as needed. 2. ector. 3. Notify the Regional Services Coordinator. 4. ncies as required. In the air temperature is 82 r higher for a continuous r longer the immediate v Jersey Department of Ensure staffing levels are facility emergency resident needs. 6. Assess  ation Plan with a revised the evacuation plan did not ty agreements for transfer of eyors interviewed the ED and that they were not sure what d an agreement with to n the event of an stated that he wanted the er he had only been at the The DON was unable to destinations for the residents ergency. acility representative entered of the LNHA and stated that ommand" with the company, ed to discuss the facility's	F	835			

Facility ID: NJ60412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315205	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE			WO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	cooler space if they d conditioner to give the At 11:41 PM, the surv administration that as there were resident residents who resided that had temperatures with malfunctioning P At approximately 1:00 second in command of that they went back u of the rooms again or many of the rooms we and that all the reside opportunity to leave the recreation room when two had refused to leave The surveyor went to Unsampled Residents respective rooms and facility had come to th to leave to a cooler lo stated that they would need to leave their ro observed that Unsam portable air conditioned Unsampled Resident asked if they wanted the cooler room when refused. The survey Resident #17 who pre- temperature of d conditioning, stated the	d relocate residents to the id not have a portable air em. revors discussed with facility of approximately10 PM, at rooms affecting d in those rooms on sexceeding degrees F TAC units. 0 AM on 7/16/2023, the regional administrator stated p to check the temperatures d degrees, and h and found that ere now below degrees, ents were offered the heir rooms to go to the e it was colder and all but ave their rooms. fo verify the report. s #14 and #15 were in their l stated that no one from the heir rooms and offered them cation. The residents both d be fine overnight and don't oms. The surveyor pled Resident #10 now a er unit in their room. #16 stated that he/she was to leave the room to go to e his/her roommate was, but or went to Unsampled	F	835			

Facility ID: NJ60412

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		315205	B. WING				/19/2023	
	ROVIDER OR SUPPLIER	& SUB-ACUTE CARE	1		STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103	1 01		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 835	that he/she would cor location because the resident stated he/she tour, a majority of the their rooms and the ro to the reduced outdoor At 2:00 AM, on 7/16/2	nsider moving to a cooler room was still hot. The e would notify the nurse. On residents were asleep in poms were less humid due	F	83	5			
	in the Administrator's This manual container evacuation that the surrequesting since arriv ED, DON and facility building. They were un acknowledge the resp before and during that	office located on the table. In the facility agreements for urveyors had been ring on 7/15/2023 from the staff that were present in the						
	another temperature the <b>second</b> in the pre- corporate maintenance contained a large fan The temperature chec	a.m., the surveyors initiated reading check of rooms on sence of a member of the ce staff. The unit hallway circulating the warm air. cks noted in the is revealed the rooms were						
	introduced to the Reg Home Administrator ( was licensed as an ad He stated that he is n provided the name of was out of the country the DON and ED did	7 PM, the surveyor was jional Licensed Nursing R/LNHA) who stated that he dministrator in New Jersey. ot the LNHA on record and the LNHA on record who y. The surveyor asked why not know that the LNHA was e R/LNHA didn't know why.						

Facility ID: NJ60412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 11/22/2023 APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		315205	B. WING		_		C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•••	
				TWO COOPER PLAZA			
MAJESTIC	CENTER FOR REHAB	& SUB-ACUTE CARE		CAMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page The R/LNHA stated the update on what has be regarding the air condi- that they contracted will company and every re- was given their own pe for their room and the been good and "resid He stated that they all conditioner units for the BTU's, two per floor. rented a high power ge power necessary to s- units. From approxima- the surveyor toured the temperatures and cor- checks. The surveyor had the portable air cor- ble air cor- checks. The surveyor had the portable air cor- ble air cor- the surveyor the surveyor had the portable air cor- the surveyor the surveyor had the portable air cor- the surveyor the surve	e 121 hat he wanted to provide an een done in the facility litioning situation. He stated with an HVAC rental esident room in the building ortable air conditioning unit room temperatures have ents are totally comfortable." so installed six, five-ton air he hallways that are 60,000 He stated that they also generator to offload the upply the air conditioning ately 1:00 PM to 2:00 PM, he floor and took room inducted resident safety r verified all resident rooms onditioning units and room thin regulatory by or interviewed the stated that the LNHA, DON hould know how to report an ditioning to the New Jersey (NJDOH). sion/Discharge To/From reflected that the LNHA new admissions to the hen the air conditioner not be operating at capacity ted correction date.	F 83	1			
	implementation for the Nursing and the Admi	•					

Facility ID: NJ60412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, í		E CONSTRUCTION	(X3) DATE COMP	
		315205	B. WING				19/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTI	CENTER FOR REHAB	& SUB-ACUTE CARE			IWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	the Regional Director conduct resident safe temperatures. At 11:2 interviewed the Regional and the Regional LNH second surveyor. At the stated to the surveyor climbs over degrees important to implement prevent it from going a degrees F "is not safe when the Emergency implemented, and he specifically when it we stated however that the options first like access could not get portable move the residents w contact the local OEM out about the air cond functioning on was going to be a " Regional LNHA clarifi "outside" on Saturday conditioning systems capacity. A review of the Admin revealed that the posi the "Administering, di operations of the faciil Federal and State and PERFORMANCE #9. preparation for facility severe weather condi Department Heads in	of Building Operations to ty rounds and test the room 27 AM, the surveyor anal Maintenance Director AA in the presence of a that time, the Regional LNHA is that if the temperature es F in the room, it would be the measures for cooling to above degrees F, as the e." The surveyor asked Plan should be stated that couldn't speak build be implemented. He hey would try to exhaust all asing contractors and if they e air conditioner units or ithin an hour, then they will 4. He stated that he found	F	835			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315205	B. WING			C 07/19/2023		
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CO	ODE			
MAJESTI	MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			TWO COOPER PLAZA CAMDEN, NJ 08103				
(X4) ID PREFIX TAG					ON SHOULD BE	(X5) COMPLETION DATE		
F 835	Continued From page NJAC 8.39-9.2(a), 19		F	835				

Event ID: 5E8J11

Facility ID: NJ60412

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## STATE FORM: REVISIT REPORT

			-	
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	•
IDENTIFICATION NUMBER	A. Building			
060412 <sub>Y1</sub>	B. Wing	Y2	8/28/2023	Y3
			.1	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
MAJESTIC CENTER FOR REHAI	3 & SUB-ACUTE CARE	TWO COOPER PLAZA		
		CAMDEN, NJ 08103		

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEI	M	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. # LSC	S0765 8:39-9.2(a)	Correction Completed 07/21/2023	ID Prefix Reg. # LSC	S0870 8:39-9.4(e)(1)	Correction Completed 07/20/2023	ID Prefix Reg. # LSC	S1090 8:39-13.1(c)		Correction Completed 07/20/2023
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	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
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS)	DATE	SIGNATURE OF TITLE	SURVEYOR			DATE	
<b>FOLLOWI</b> 7/19/2023	JP TO SURVEY CO 3	OMPLETED ON		CK FOR ANY UNCORREC					5 🗌 NO

## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
315205 <sub>Y1</sub>	B. Wing	Y2	8/28/2023	Y3		
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).

ITEI	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0600 483.12(a)(1)	Correction Completed 07/21/2023	ID Prefix Reg. # LSC	F0658 483.21(b)(3)(i)	Correction Completed 07/21/2023	ID Prefix Reg. # LSC	F0761 483.45(g)(h)(1)(2)	Correction Completed 07/21/2023
ID Prefix Reg. # LSC	F0835 483.70	Correction Completed 07/21/2023	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	ID Prefix Reg. # LSC		Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS)	DATE	SIGNATURE C	DF SURVEYOR	<u> </u>	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 7/19/2023		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						