PRINTED: 07/07/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG 01	1, ,	ATE SURVEY OMPLETED
		315517	B. WING _			09/24/2019
NAME OF PROVIDER OR SUPPLIER POWERBACK REHABILITATION MOORESTOWN				STREET ADDRESS, CITY, STATE, ZIP CODE 212 MARTER AVENUE MOORESTOWN, NJ 08057		
(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
E 000	Initial Comments		E 0	00		
E 037 SS=D	Appendix Z-Emergen Provider and Supplie Guidance 483.73, Re Care (LTC) Facilities. EP Training Program	equirements for Long Term	E 0	37		11/19/19
29=D	*[For RNCHIs at §40: Hospitals at §482.15, at §484.102, "Organi: OPOs at §486.360, F Training program. Th following: (i) Initial training policies and procedur staff, individuals prov arrangement, and voi expected roles. (ii) Provide emer at least every 2 years (iii) Maintain doc preparedness training (iv) Demonstrate emergency procedure (v) If the emerge and procedures are s [facility] must conduct policies and procedure	3.748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs zations" under §485.727, RHC/FQHCs at §491.12:] (1) to e [facility] must do all of the in emergency preparedness res to all new and existing iding services under lunteers, consistent with their gency preparedness training secure and the interest of all emergency gency preparedness training secure at a staff knowledge of the interest of the inter				
	(i) Initial training policies and procedu hospice employees, a	in emergency preparedness res to all new and existing				
ARODATORY	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATURE	:	TITI F		(X6) DATE

Electronically Signed 10/27/2019

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED	
		315517	B. WING _		09/24/2019	
	PROVIDER OR SUPPLIER	MOORESTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 212 MARTER AVENUE MOORESTOWN, NJ 08057		
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E 037	(ii) Demonstrate emergency procedures at least every 2 year (iv) Periodically emergency prepare employees (includin special emphasis plants procedures necessations (v) Maintain dorpreparedness training (vi) If the emergency procedures are hospice must conduct policies and procedures are emergency procedures training (iii) Demonstrate emergency procedures are procedures and procedures are procedures and procedures are procedures and procedures and procedures are proce	e staff knowledge of res. ergency preparedness training rs. review and rehearse its dness plan with hospice g nonemployee staff), with acced on carrying out the ary to protect patients and cumentation of all emergency rig. gency preparedness policies significantly updated, the act training on the updated ares. 1.184(d):] (1) Training must do all of the following: g in emergency preparedness are to all new and existing viding services under colunteers, consistent with their raining, provide emergency rig every 2 years. e staff knowledge of res. cumentation of all emergency rig. ency preparedness policies significantly updated, the atraining on the updated	EO	37		

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	ROVIDER OR SUPPLIER ACK REHABILITATION IN	IOORESTOWN	•	STREET ADDRESS, CITY, STATE, ZIP C 212 MARTER AVENUE MOORESTOWN, NJ 08057	ODE		
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E 037	policies and procedur staff, individuals provarrangement, and voi expected role. (ii) Provide emer at least annually. (iii) Maintain doc preparedness training (iv) Demonstrate emergency procedure. *[For CORFs at §485 CORF must do all of (i) Provide initial preparedness policie and existing staff, indiservices under arrange consistent with their equivalent (ii) Provide emer at least every 2 years (iii) Maintain doc (iv) Demonstrate emergency procedure be oriented and assign responsibilities remergency plan within workday. The training instruction in the local systems and signals (v) If the emerging and procedures are secons and procedure and policies and procedure. *[For CAHs at §485.6] The CAH must do all	in emergency preparedness res to all new and existing iding services under unteers, consistent with their gency preparedness training umentation of all emergency g. staff knowledge of es. .68(d):](1) Training. The the following: training in emergency s and procedures to all new ividuals providing gement, and volunteers, expected roles. gency preparedness training i. umentation of the training. staff knowledge of es. All new personnel must greating the CORF's in 2 weeks of their first grogram must include tion and use of alarm and firefighting equipment. ency preparedness policies ignificantly updated, the training on the updated res. 125(d):] (1) Training program.	E	037			

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E 037	reporting and extinguand where necessary personnel, and guest cooperation with authorities, to all nevindividuals providing and volunteers, roles. (ii) Provide emetat least every 2 years (iii) Maintain doo (iv) Demonstrate emergency procedur (v) If the emergand procedures are stocked and procedures and procedures and procedures and procedures and procedures and existing staff, incurder arrangement, with their expected redocumentation of the demonstrate staff knoprocedures. Thereast emergency prepared years. This REQUIREMENT by: Based on interview a preparedness trainin 09/23/19, in the presit was determined that	res, including prompt uishing of fires, protection, y, evacuation of patients, ts, fire prevention, and firefighting and disaster y and existing staff, services under arrangement, consistent with their expected regency preparedness training s. cumentation of the training. e staff knowledge of res. gency preparedness policies significantly updated, the raining on the updated res. 5.920(d):] (1) Training. The initial training in emergency res and procedures to all new dividuals providing services and volunteers, consistent roles, and maintain retraining. The CMHC must rowledge of emergency fiter, the CMHC must provide liness training at least every 2 T is not met as evidenced and a review of emergency g documentation on ence of facility management, at the facility failed to train recy Preparedness Plan (EPP)	EC	1. No patients were identified to heen directly impacted by this pract. 2. All patients had the potential to affected by this deficient practice s 60% of active staff did not have the annual re-training of Emergency.	be since

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E 037	This deficient practice following: A review of the facility 09/24/18 to 09/23/19 of 156 active staff me complete their on-line training by their due of the courses Director of documentation province completed so far and the staff to get their to NJAC 8:39-31.2(e), 3 INITIAL COMMENTS LIFE SAFETY CODITIONS THIS FACILITY IS IN MINIMUM LIFE SAFETY	y's staff training records from revealed that there were 62 embers (39%) that did not e emergency preparedness date. 5 PM, the facility's Human confirmed that the training ded was the training I said they try to keep up with raining completed on time. 81.6(a)		0000	Preparedness Policies and Procedures and 87% of all current staff had the training completed by the date of this survey. 3. All department managers were re-inserviced on the Appendix Z-Emergency Preparedness EP Training Program requirements. Workforce Cer Manager (HR Manager) will perform monthly EP Training completion audits monthly to ensure all current employed are trained on or before their due date. 4. Administrator/designee will review audit reports monthly for compliance a trending. Reports will be submitted to QAPI Committee to evaluate the need further audits and/or action monthly for months.	ng Iter es nd for		