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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	**1302 LAUREL OAK ROAD VOORHEES, NJ 08043**

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F 000	INITIAL COMMENTS Survey Date: 1/31/22 Census: 187 Sample: 36+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. In addition, a COVID-19 Focused Infection Control Survey was conducted.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		2/23/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/17/2022

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure that an updated advance directive was accurately maintained within a resident's medical record, in accordance with the facility policy. This deficient practice was identified for 1 of 2 residents (Resident #48) reviewed for Advance Directives and was evidenced by the following: During the initial tour of the facility on 01/24/22 at 10:32 AM, the surveyor observed Resident #48 seated in a reclining wheelchair at the bedside. The resident was EX Order 26.4B1 and did not maintain EX Order 26.4B1 when spoken to.	F 578	578- Request/refused/discontinued treatment, formulate Advance directives 1. Res #48 was not negatively affected by deficient practice. Social Service and Nursing Contacted responsible party to clarify current code status. Full vs DNR, DNI once clarification was received a new POLST was drafted signed by Responsible party and physician. 2. An audit of all medical records will be completed by Social Services, to ensure current orders and POLST form are in agreement. 3. POLST and Policy will be reviewed and updated. All Nurses, will be re-educated on A POLICY AND	

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F 578	Continued From page 2 Review of Resident #48's Admission Record that was printed on EX Order 26.4B1, revealed that the resident was readmitted to the facility in EX Order 26.4B1 with diagnoses which included but were not limited to: EX Order 26.4B1 [redacted] Further review of the Admission Record revealed that the resident's Advance Directive section of the form specified that the resident was a Ex.Order 26.4(b)(1) [redacted] Review of Resident #48's most recent significant change Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, revealed that the resident's Brief Interview of Mental Status (BIMS) score was EX Order (EX Order 26.4B1 [redacted]. Further review of the document revealed that the resident was EX Order 26.4B1, was EX Order 26.4B1, required Ex.Order 26.4(b)(1) of one person for activities of daily living and was Ex.Order 26.4(b)(1) [redacted]. Review of Resident #48's paper medical chart revealed a New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) form that was labeled with the resident's name and date of birth that was dated and signed by the Nurse Practitioner on 06/18/21. Further review of the POLST revealed that the resident's goal of care was to be a Ex.Order 26.4(b)(1) and receive Ex.Order 26.4(b)(1). Further review of the POLST indicated that Ex.Order 26 [redacted]	F 578	PROCESS TO ensure that orders with the resident goal of care matches the information of the POLST form and POLST and orders are matched. Nurse AND SS are re-educated to review the medical record for any possible changes in the hospital code status as well as to review with responsible family annually, quarterly and on significant change. 4. Social service director or designee will audit 3 resident medical records per week to compare current physician order to current POLST form to ensure there is no deficiencies that will be 3 charts a week for 90 days. The result of this audit will report to the QAPI monthly x 3 months.	

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Ex.Order 26.4(b)(1) and EX Order 26.4B1 as needed (a is placed in the to help EX Order 26.4B1 EX Order 26.4B1) should be provided if resident's condition warranted. Further review of the POLST revealed that a verbal signature was obtained from the resident's responsible party on behalf of the resident.

Review of Resident #48's Order Summary Report that was contained within the resident's paper medical chart and was dated EX Order 26.4B1 revealed that an order was placed on EX Order 26.4B1 for EX Order 26.4B1) and EX Order 26.4B1 EX Order 26.4B1. The surveyor was unable to locate any additional information within the resident's paper medical chart to explain the discrepancy between the POLST dated 06/18/21 which specified that the resident was a Ex.Order 26.4(b)(1) and required Ex.Order 26.4(b)(1) if resident's medical condition warranted and the current order for Ex.Order 26.4(b)(1) which prohibited Ex.Orde .

Review of Resident #48's Care Plan revealed an entry dated 09/09/21 which indicated that the resident requested that Ex.Order 26.4 measures be performed (Ex.Order 26.4(b)(1)). A related intervention specified "please follow my instructions as detailed inside my Advance Directives & /or Living Will if I have one."

During an interview with the surveyor on 01/26/22 at 09:46 AM, the Director of Social Services (DSS) stated that the discrepancy between Resident #48's POLST form and Order Summary Report presented a conflict. The DSS

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stated that the resident should have been designated as a Ex.Order 26.4(b)(1) according to the latest IDT (Interdisciplinary Team) Meeting Notes dated EX Order 26.4B1 in which the resident's responsible party was a participant.

During a follow up interview with the surveyor at 10:43 AM, the DSS explained that when Resident #48 returned from the Ex.Order 26.4(b)(1) on EX Order 26.4B1 a Ex.Order 26.4(b)(1) order for EX Order 26.4B1 was implemented at the facility and Social Services was not aware of the order change in resident status from Ex.Order 26.4(b)(1) to EX Order 26.4B1 She stated that after surveyor inquiry, the facility became aware of the discrepancy as the documentation and discussion with the resident's responsible party on EX Order 26.4B1 indicated that the resident was a Ex.Order 26.4(b)(1).

During an interview with the surveyor on 01/27/22 at 09:12 AM, the Registered Nurse/Unit Manager (RN/UM) stated that when she attended the family care conference on EX Order 26.4B1 she missed the order for EX Order 26.4B1 that was written on 11/04/21 and did not realize that the POLST did not reflect the current order. She stated that if Resident #48 had a medical emergency she would have Ex.Order 26.4(b)(1) and initiated Ex.Order 26.4(b)(1) as that was what the POLST that was contained within the resident's paper medical record specified. She stated that the resident's Admission Record also should have been updated to match the order for EX Order 26.4B1 and instead it indicated that the resident was a Ex.Order 26.4(b)(1). She further stated that she took responsibility for the discrepancy as she missed the change in status at the IDT meeting. The RN/UM stated that the resident's responsible

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party was contacted in response to the discrepancy for clarification and a new POLST was drafted and awaited physician's signature which specified that the resident would remain [redacted].

During an interview with the surveyor on 01/27/22 at 11:57 AM, the Director of Nursing (DON) stated that when there was a change in order status that originated from a [redacted] transfer, the nursing staff should call the attending physician for clarification. She stated that once a new order was obtained nursing should have generated a new POLST and filed it as it was no longer considered active. She stated that they should have changed the computer dashboard and resident's Admission Record to ensure that it accurately reflected the change in the Advance Directive status. She further stated that Social Services should have been notified when the change was originated by the nurse who took the order as they were responsible to upload the new POLST form into the Electronic Health Record (EHR). The Licensed Nursing Home Administrator (LNHA) who was present at that time, stated that SW does periodic audits to check for this type of discrepancy and the information has been monitored by Quality Assurance on an ongoing basis.

Review of the facility policy titled, "Advance Directive Policy and Procedure" (Reviewed 12/21) revealed the following:

During the quarterly RAI (Resident Assessment Instrument) process and with any significant changes of condition, facility staff will:
Identify, clarify and review the existing care

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F 578	Continued From page 6 instructions and whether the resident wishes to change or continue instructions from the advance directive. Define and clarify medical issue, review the resident's condition and existing choices and present information regarding relevant health care issues to the resident or resident representative as appropriate to determine continuation or modification of choices of care. Changes to the resident choices for advance directives will be documented, included in the resident plan of care, State specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable, and all items will be communicated to staff providing resident care. The interdisciplinary team will identify, clarify, and review, as part of the comprehensive care planning process, the existing care instructions along with the resident's ...wishes as the resident's medical condition changes. NJAC 8:39-4.1(a)4	F 578		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was	F 658	1. Resident #108 suffer no ill from deficient practice.	2/23/22

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F 658	Continued From page 7 determined that the facility failed to administer a medication in accordance with a physician's orders and consistent with professional standards. This deficient practice was identified for 1 of 5 residents (Resident #108) reviewed for medications and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 01/24/22 at 11:21 AM, the surveyor observed the Resident #108 in bed.	F 658	2. All resident receiving Ex.Order 26.4(b)(1) medications has to the potential to be affected by the deficient practice an audit will be conducted of all resident receiving their Ex.Order 26.4(b)(1) medication as per doctor's order . 3. A review was conducted to determine what nurses currently have an access to the back-up drug supply . Additional nurses were given access to dispense medication out of the backup supply, to ensure that 2 nurses are always available to complete the process. All nurses are educated with the policy and procedure on Re-education of Ex.Order 26.4(b)(1) reordering process will be completed to ensure there is no lapse in resident Ex.Order 26.4(b)(1) supply. Pharmacy has been directed to email to DON/ADON the notification of resident requires of new scripts for medication. Staffing coordinator will update daily staffing sheet to indicate what staff member has access to our back up supply. 4. Unit Manager will audit 3 residents per week for Ex.Order 26.4 administration and DON check the audits weekly for compliance to ensure that resident receive medication as physician orders. The DON will also ensure that any necessary script are obtain to complete Ex.Order 26.4 reordering. DON/ADON will review daily Nurses schedule x 90 days to ensure 2 nurses has an access to back up supply at all times and both audits will present to QAPI meeting monthly x 3 months.	

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F 658	Continued From page 8 During an interview with the surveyor at that time, Resident #108 stated that he/she could not sleep the night prior ([redacted]) because his/her medication, [redacted] was not available. The resident further stated that staff have needed to obtain this medication from back-up supply for the past several nights which required two nurses, and there was only one nurse available the night prior. On 01/25/22 at 9:40 AM, the surveyor observed the resident sitting up in bed eating breakfast. During an interview with the surveyor at that time, Resident #108 stated that he/she did not receive his/her [redacted] again the night prior [redacted]) because there was only one nurse. The resident further stated that his/her [redacted] is currently on order, but that he/she was used to taking it, so it was hard for him/her to sleep without it. Review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included that the resident had a Brief Interview for Mental Status of [redacted] out of 15, which indicated that the resident had a [redacted]. A review of the Face Sheet (admission record) for Resident #108 revealed a diagnosis including, but not limited to [redacted] A review of the Physician's Order Sheet for	F 658		

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January 2022 revealed an order for EX Order 26.4B1 EX Order 26.4B1), give one tablet by mouth at bedtime for EX Order 26.4B1 , targeting EX Order 26.4B1 . In addition, EX Order 26.4B1 is a [redacted]

A review of the Medication Administration Record (MAR) (a recording document) revealed that the EX Order 26.4B1 was not administered on EX Order 26.4B1 as ordered.

A review of the resident's current Care Plan revealed that Resident #108 used EX Order 26.4B1 for EX Order 26.4B1 .

A review of the back-up medication supply log for EX Order 26.4B1 revealed that EX Ord tablets were available at the time Resident #108's EX Order 26.4B1 was due to be given on 01/23/22 and 01/24/22.

During an interview with the surveyor on 01/26/22 at 12:36 PM, the Director of Nursing (DON) confirmed that EX Order 26.4B1 was available in the back-up medication supply. The DON further clarified that if a resident required a EX Ord mg dose, nursing staff should sign out EX Order 26.4B1 for administration.

During an interview with the surveyor on 01/27/22 at 11:34 AM, the Licensed Practical Nurse (LPN) addressed the process for obtaining medication for residents. The LPN stated that medication refill requests were to be completed by requesting them within the computer system or making a request on paper via facsimile (fax). The LPN further stated that if a particular

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medication was unavailable, it was necessary to determine if that medication was available in the back-up supply. If the medication was still unavailable, the nurse should notify the physician for further orders to either obtain the medication through special order, place the medication on hold, or substitute it with an alternative medication. In addition, the LPN stated that all facility nurses had access to back-up supply medication, but agency nurses do not. The LPN further stated that if a medication was a Ex.Order 26.4(b)(1), two nurses must sign the medication out of the back-up supply to verify the amount(s) removed and the amount(s) remaining.

During an interview with the surveyor on 01/27/22 at 1:15 PM, the nursing Unit Manager (UM) addressed the procedure for obtaining medication. She stated it was necessary to check the back-up medication supply, indicating that agency nursing staff must check with a facility nurse or supervisor, as agency nurses do not have access to back-up medication supplies. The UM stated that if a medication was not available in back-up supply, to call the pharmacy for immediate delivery (within 4 hours), call the physician to advise him/her of the situation, and document the physician's response.

The UM also described the process for refilling medication, indicating that it was best to refill medication supplies when there were six dosage forms remaining and reiterated that the refill process could be initiated electronically through the computer or by paper request via the fax machine. In addition, the UM stated that if a renewal prescription was needed, the pharmacy

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would fax the notice to the facility. If the medication was not delivered in a couple of days, it was important to follow-up with the physician for further instruction and the pharmacy to check the status of the refill processing, as there were sometimes insurance-related issues.

In addition, the UM acknowledged that Resident #108 asked her about the missing medication EX Order 26.4B1 and advised the resident that it was readily available in the back-up medication supply. The UM further stated that a new prescription for the EX Order 26.4B1 was needed, obtained the day prior (EX Order 26.4B1), and sent to the pharmacy. Finally, the UM acknowledged that she did not recall seeing any paperwork regarding Resident #108's EX Order 26.4B1 and that the two agency nurses who worked 01/23/22 and 01/24/22 should have obtained the required doses out of the back-up supply, with the assistance of the nursing supervisor.

In a follow-up interview with the surveyor on 01/27/22 at 1:45 PM, the UM repeated that the nurses should have obtained the doses of EX Order 26.4B1 out of the back-up supply and if it was still unavailable, they should have notified the physician for an alternative medication. The UM also stated that doing so was important because the resident requires the referenced medication EX Order 26.4B1.

During an interview with the team, surveyor, and in the presence of administrative staff on 01/28/22 at 11:35 AM, the DON acknowledged that EX Order 26.4B1 should have been given as ordered, by the physician, to Resident #108 on 01/23/22 and 01/24/22. In addition, she stated

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that it was necessary to check the back-up medication supply for availability of the medication and if it was not available, it was necessary to follow up with the physician for further instruction. Although the medication was available in the back-up supply of medications, the DON could not offer any explanation as to why it was not obtained and subsequently administered to the resident. When asked about the details surrounding the refill process in this regard, the DON stated that she wanted to investigate matters further and would advise the survey team on her findings.

During an interview with the team, surveyor, and in the presence of administrative staff on 01/28/22 at approximately 10:00 AM and at exit conference on the same date at 11:28 AM, the DON was not able to provide any additional details regarding the refill processes for the referenced medication.

A review of the facility's policy titled, "Medication Administration" revised 09/2021, revealed it is important to notify the physician of any important changes to the resident, as related to medication. In addition, the policy references "medication as ordered" as a "supply" but does not provide further detail.

A review of the facility's policy titled, "Reordering, Changing, & Discontinued Medication Orders" failed to reveal an effective date and a revision date. According to the policy, medication refill requests could be submitted to the pharmacy with a "Refill Order Form" faxed to the pharmacy or by making a verbal request.

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F 658	Continued From page 13 NJAC 8:39-29.2(d)	F 658		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documentation it was determined that the facility failed to serve hot and cold foods at an acceptable temperature for the residents. This deficient practice was identified for 5 of 5 residents who attended a Resident Council group meeting, and on 1 of 4 nursing units during the lunch meal service and was evidenced by the following: During the initial tour of the [redacted] floor unit on 01/24/22 at 10:42 AM, Surveyor #1 interviewed Resident # 95 who stated that the food could be warmer. Resident #95 stated that when he/she eats in their room the breakfast meal is not hot. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed Resident #95 had a Brief Interview for Mental Status (BIMS) of [redacted] which indicated that the resident was EX Order 26.4B1.	F 804	A. CORRECTIVE ACTIONS The Director of Dining Services was immediately in-serviced on the proper temperature policy that food shall be maintained and served. The staff were in-serviced on proper food serving temperatures, and the importance of the Food Danger Zone. Continuing education will be conducted. The food temperatures are taken daily before each meal is served and documented for compliance. This process is monitored daily by the Director and Assistant Director of Dining Services. B. RISK POTENTIAL OF RESIDENTS All Residents have the potential to be affected. C. NEW INTERVENTIONS/ MEASURES New Meal delivery Insulated Dome Lids were purchased to keep the food at the appropriate serving temperature when delivered to the resident. The Insulated	2/23/22

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F 804	Continued From page 14 During the initial tour of the [EX Order] floor unit on 01/24/22 at 10:48 AM, Surveyor #1 interviewed Resident #53 who stated that when he/she ate in their room, the food was cold. Review of the Quarterly MDS, dated [EX Order 26.4B1], revealed Resident #53 had a BIMS of [EX Orde] which indicated that the resident was EX Order 26.4B1. On 01/25/22 at 08:53 AM, Surveyor #1 observed Resident # 95 sitting in bed, awake and [Ex.Order 26.4] with the breakfast tray on the overbed table. The resident's breakfast consisted of eggs with peppers. Resident # 95 stated the eggs were warm, not hot. On 01/25/22 at 08:36 AM, Surveyor #1 observed Resident #53 sitting in bed with the breakfast tray on the overbed table. Resident #53's breakfast consisted of eggs with peppers. Resident #53 stated the eggs were cold. On 01/26/22 at 10:40 AM, the surveyors conducted a group meeting with 5 residents who regularly attended the facility resident council meetings. 5 out of 5 residents indicated the food was usually cold when they ate in their room. On 01/27/22 at 12:22 PM, two surveyors conducted a test tray with the Food Service Director (FSD). Surveyor #2 interviewed the FSD regarding the calibration of the FSD's thermometer and the FSD confirmed the thermometer he brought to take the food temperatures was calibrated. The test tray was plated and the temperatures were checked by the FSD which resulted in the following:	F 804	Pellet warmer and the Plate Heater are also in use to assure compliance in the serving temperatures. The Director of Dining Services monitors the time of tray line to assure the meal carts are delivered to the units quicky and then the care staff immediately passes the meal trays to the residents D. MONITORING CORRECTIVE ACTION The Director of Dining services or the Assistant Director of Dining Services will assure that the temperatures of the food are in the appropriate range prior to leaving the kitchen and record before each meal is served. Test trays will be completed three times per week for 12 weeks, the results will be recorded and presented in the Monthly QAPI Meetings and used as a reference to resolve the issue at hand. The Director of Dining Services will review results of test tray results and develop and present QAPI. The Director of Dining Services and the Assistant Director of Dining Services will make daily meal rounds to discuss with residents' actual meal service temperatures and use the results for the quarterly QA meetings. The Regional Director will monitor the process and assure compliance.	

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F 804	Continued From page 15 Ham 140.4 degrees Fahrenheit (F) Peas/corn 126.5 degrees F Mandarin oranges 54.8 degrees F Coffee 136.5 degrees F At 12:28 PM, the dietary aide left the kitchen with the [redacted] floor [redacted] wing lunch trays. At 12:31 PM, two surveyors arrived on the [redacted] floor [redacted] wing with the test tray and the FSD. At 12:36 PM, the last resident tray was served and the surveyors observed the FSD take the following food temperatures: Ham 125.4 degrees F Peas/corn 105.5 degrees F Mandarin oranges 57.6 degrees F Coffee 128.6 degrees F At that time, Surveyor #2 interviewed the FSD regarding what the appropriate food temperatures should be when the food was served. The FSD stated the hot foods should be at least 130 degrees, "Pinnacle says 125-130 degrees" and the cold foods should be at least 38 degrees or lower. The FSD further stated that it was important to serve food at correct temperatures to prevent food borne illness. Review of the facility's "Hot Food Policy," dated 6/3/2013, revealed Procedure: 3. Any food item not meeting the proper temperature will be reheated or quick chilled in the freezer to reach required temperature. 7.d. Hot food should be at 135 degrees F or above at the time food is served to the residents.	F 804		

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F 804	Continued From page 16 Review of the facility's "Cold Food Policy," dated 6/3/2013, revealed Policy: Kitchen will receive and deliver cold foods to residents at a temperature of 41 degrees Fahrenheit or lower. Procedure: 6. Food will be delivered to resident at a temperature of 41 degrees Fahrenheit or lower.	F 804		
F 812 SS=F	NJAC 8:39-17.4 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of facility documentation it was determined that the facility failed to a.) properly handle and store	F 812	. A. IMMEDIATE CORRECTIVE ACTIONS	2/23/22

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F 812	Continued From page 17 potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination and c.) failed to maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and evidenced by the following: On 01/24/22 from 09:54 AM -11:55 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD) and observed the following: 1. The foot pedal trash can at handwashing sink #1 was not lined with a trash bag and both trash and debris were observed in the can. The FSD acknowledged the debris and stated they usually leave it like that as they empty it every day. The FSD stated they would put a bag in the can. 2. The cook prepping chopped turkey for lunch wearing a hairnet on the hair bun on top of her head leaving the bottom of her head exposed. The cook acknowledged the hairnet was not worn correctly and stated it should cover the whole head so no hair gets in the food. During and interview with the FSD at that time, he stated that hairnets should be worn over the whole head so no hair gets in the food. 3. In the walk-in refrigerator were four individual 17 ounce tofu packages with no received date and no expiration dates on the packages.	F 812	1. 1, 20, Trash can was immediately cleaned and trash can liner was placed in the trash can. Staff was in service on infection control. 2. 2, 23, 24, 26, dietary personal immediately replace their hair restraints to proper cover all hair. All staff was in serviced on the Personal Hygiene Policy. 3. 3, 4, 5, 7, 9, 11, 12, 13, 15, 19. All opened items that weren't properly labeled and dated with a use by or opened date were immediately discarded. The dietary staff was educated on the labeling and dating policy. 4. 8, 16, 17, 18, 25, All opened to air products that weren't proper sealed were immediately discarded. The dietary staff was in serviced on cross contamination. 5. 6, The FSD was immediately in serviced on the hand washing policy. 6. 14, The dented can was immediately placed in the designated dented can area. The dietary staff was educated on The Dented can policy. 7. 21, The cutting board was immediately removed and discarded. 8. 22, The hotel pans were re -washed, sanitized, and stored correctly. The staff was in serviced on the Pot Washing policy. B. RISK POTENTIAL OF RESIDENTS 1-26. All residents have the potential to be affected. C. NEW INTERVENTIONS/ MEASURES 1. 1, 20 All dietary staff were educated on infection control policy	

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F 812	Continued From page 18 4. On the bottom shelf of a metal tiered food cart there was one box containing 10 pounds of ground chuck with no received by date and no use by date. The FSD stated it came in today and put a received sticker on it. 5. In the walk-in freezer, on the bottom shelf of a metal rack, there was one large plastic bag of frozen pink meat the FSD identified as ground beef with several tears in the bag with the meat exposed. The bag had no label and no dates. The FSD stated the bag should not be ripped and should have a label and threw the meat in the trash. 6. The FSD then walked to handwashing sink #2 to wash his hands. The surveyor observed the FSD wet his hands, lather his hands with soap, then rinse his hands with the whole process totaling 13 seconds. The FSD acknowledged he should have washed his hands for 20 seconds to remove bacteria and germs. 7. In the walk-in freezer, on the bottom shelf of a metal rack, there was a sealed bag of frozen dark red meat the FSD identified as beef cubes with no label and no dates. The FSD acknowledged there was no label or dates on the bag. The FSD stated that the meat was taken out of a box that was labeled and dated, that it came in a week ago, and that the staff should have left it in the box. The FSD put a dated sticker on the bag. 8. Resting on a large sheet pan was a clear plastic bag with frozen white dough that the FSD identified as pizza crusts. The bag was open and the crusts were exposed to air. The bag had a received sticker dated 1/19/22 and the FSD	F 812	2. 2, 23, 24, 26 All dietary staff was educated Personal Hygiene Policy. 3. 3, 4, 5, 7, 9, 11, 12, 13, 15, 19 All dietary staff were educated labeling and dating. 4. 8, 16, 17, 18, 25 All dietary staff was educated on cross contamination. 5. 6, The FSD was education on hand washing and completed a competency. 6. 14, All staff was education on the dented can policy and where to place dented cans. 7. 21, The FSD will round the kitchen daily and ensure all food service equipment and serving ware is intact. 8. 22, All staff were educated on the Pot Washing policy and how to avoid wet nesting. 4. MONITORING INTERVENTIONS/ MEASURES 1. The Director of Dining Service will conduct weekly handwashing in-services with the dietary department staff for 12 weeks, to assure compliance. The Regional team will conduct weekly Handwashing in-services with the Director of Dining Services and the rest of the management team for 12 weeks and follow up for additional Inservice Monthly times three months. All findings will be reviewed quarterly at QA committee meetings. 2. The FSD to complete daily routine inspections x 8 weeks to ensure the	

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F 812	Continued From page 19 stated they were good for 30 days. 9. There were two sealed bags of frozen dark brown pieces of meat with no labels and no dates. The FSD identified them as spicy chicken tenders. There was one opened bag of dark brown pieces of meat the FSD identified as spicy chicken tenders. The bag was wrapped in clear plastic wrap and dated use by 12/9/21. The FSD stated it was the wrong date and that it should have been marked with the received by date. The FSD further stated that it was important to date food correctly so that residents were not served spoiled food. At 10:45 AM the Regional FSD (RFSD) joined the kitchen tour. During an interview with the surveyor at that time, the RFSD acknowledged the three bags of spicy chicken tenders that had no labels or dates and stated the bags should have a label identifying what the product was and that it should have had a received date and an open date. The RFSD further stated that the chicken would be thrown away. 11. There was one opened clear plastic bag of frozen light pink meat labeled tilapia that was wrapped with clear plastic wrap with the meat exposed. There was a sticker marked "Healthshake" use by 1/27/22. The RFSD acknowledged the open bag, stated it should have been wrapped correctly, removed the bag from the freezer, and stated it would be discarded. 12. There was one box labeled French fries with the inner clear plastic bag unsealed and opened with the French fries exposed. The FSD	F 812	proper label and dating protocol is performed. All unlabeled and undated items will be discarded. Results to be reviewed at the next QAPI meeting. 3. The FSD to complete daily routine inspections x 8 weeks to identify cross contamination hazards and educate as necessary. Results to be reviewed quarterly at QA meeting 4. The FSD to complete weekly inspection x 8 weeks to ensure dented cans are placed in designated area. Results to be reviewed quarterly at QA meeting 5. The FSD will notify the facility of all equipment in need of replacement or repair on a weekly basis. The Regional Team will audit all equipment weekly for 12 weeks and report the findings to the Administrator of the Building on each visit and follow up on each visit. All equipment not working properly will be on the administrator Summary report as well as entered the Facility Electronic Maintenance System, to generate a work order to be investigated and resolved. The Maintenance Director will make weekly Audits on all kitchen equipment for 12 weeks. Results to be reviewed quarterly at QA committee meeting. 6. The Food service director will complete daily routine inspections x 8 weeks to identify staff personal hygiene. Results to be reviewed quarterly at QA	

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F 812	Continued From page 20 acknowledged the bag should not have been opened and stated that it should have been rolled up. 13. On the spice rack were one opened 3 ounce jar parsley flakes with no expiration, received or opened dates and one opened 5 ounce jar dill weed dated 11/25/20 with the expiration date marked 3/25/21. The RFSD acknowledged there were no dates on the parsley and that the dill weed was expired. The RFSD threw the spices away. 14. In the dry storage room on the can rack was one dented 6 pound can of mandarin oranges. The RFSD acknowledged the can should not have been there and moved it to the dented can section. 15. There was one opened 16 ounce jar of garlic powder with no expiration date and no opened date and one opened 3 ounce jar of parsley flakes with no expiration date and no opened date. The RFSD acknowledged there were no dates and stated that when something was received it should have been dated. 16. There was one bag of egg noodles opened with the noodles visible and exposed to air. 17. There was one box labeled lemon sugar free cookies with the inner clear plastic bag opened with the cookies exposed to air. 18. There was one box containing an opened bag of vanilla instant pudding wrapped in clear plastic wrap with the plastic wrap open and the pudding exposed to air.	F 812	meeting. 7. The FSD to complete daily routine inspections x 8 weeks to ensure proper pot washing procedures to prevent wet nesting. Results to be reviewed quarterly at QA meeting. 8. The FSD to complete daily routine inspections x8 weeks to ensure proper infection control practices are preformed. Results to be reviewed quarterly at QA meeting.	

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F 812	Continued From page 21 During an interview at that time, the RFSD stated that the egg noodles, lemon cookies, and vanilla pudding mix should not be exposed to air and should have been thrown away. 19. In the cooking area was one large covered white bin with contents the RFSD identified as rice and one large covered white bin with contents the RFSD identified as flour with no labels or dates on the bins. The RFSD stated they should be labeled and dated. 20. The foot pedal trash can at handwashing sink #3 was not lined with a trash bag and both trash and debris were observed in the can. The RFSD acknowledged the debris and stated that there should be a bag in the can. 21. On the third shelf on a metal rack in the drying area of the dish room was a white cutting board with brown gauges and black smudges. The FSD stated they were from use and that they use the other side of the board. 22. On an epoxy coated rack there were hotel pans wet nested. The FSD acknowledged the wetness and stated that the pans should not be wet in the dry area. The FSD further stated it was important that stagnant water not get into the food and that the pans would be sanitized. 23. On 01/24/22 at 11:50 AM, the surveyor observed the stock person loading dry plate lids onto the food line. The stock person was wearing a beard cover with facial hair exposed around the cover. The stock person stated the purpose of a beard cover was to not have hair show and that	F 812		

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F 812	Continued From page 22	F 812		

his beard should have been totally covered to prevent hair from getting on the dishes.

24. On 01/24/22 at 11:52 AM, the surveyor observed the starter on the food line setting up meal trays with utensils, hot plates, and condiments. The starter was wearing a beard cover with facial hair exposed around the cover. The starter stated the beard cover should be covering all of his facial hair for safety, hygiene and to prevent hair from getting into the food.

25. On 01/25/22 at 12:08 PM, on the second shelf of a metal table under the coffee area, the surveyor observed a pile of large coffee filters exposed to air. The FSD acknowledged the coffee filters and stated the filters should have been inside a bag. The FSD placed the filters in a clear plastic bag.

26. On 01/27/22 at 12:04 PM, the surveyor observed a dietary aide (DA) opening six large cans of apples for preparation of making cinnamon apple desserts. The DA was wearing a baseball hat with her hair in a bun outside of the hat with no hairnet worn. The DA acknowledged her hair was not covered with a hairnet and stated that she wasn't sure she had to wear a hairnet because she wore a hat. The DA further stated it was important to cover all hair so hair would not get in the food.

Review of facility's "Handwashing Policy," with a revision date of 2/14/2017, revealed Procedure: ...Lather hands and wrists with soap for 20 seconds.

Review of facility's "Personal Hygiene Policy,"

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F 812	Continued From page 23	F 812		

with a revision date of 6/3/2013, revealed Procedure: 3. Cover all hair and facial hair with a restraint (hairnet, cap or hat).

Review of facility's "Receivable and Storage Policy," with a revision date of 6/3/2013 revealed Procedure: 11. Ensure that all foods are securely covered, dated, and labeled.

Review of the facility's "Dating and Labeling Policy," with a revision date of 4/2019, revealed Policy: Kitchen will assure food safety by maintaining proper dates and labels to all ready to eat food products. Procedure: 2. Label products in storage with date the package was opened or expiration date with no more than 48 hours after opening, whichever is appropriate. 3. Label all dry goods with date received. 4. Use the Pinnacle address label and dating and labeling system to date all items. 8. Discard all foods that expire immediately.

Review of the facility's "Dry Foods Policy," with a revision date of 6/3/2013, revealed Procedure: 4. Keep products in original packaging or in tightly covered, clearly labeled containers.

Review of the facility's "Dented Can Policy," with a revision date of 6/3/2013, revealed Policy: Account Manager or designee will identify cans with dents on the top or bottom lip of the can as well as any dents appearing on the vertical seam of the can ...Procedure: 2. Purchasing Officer will verify that the Facility has followed the "Dented Can Policy" and that all cans have been labeled with the current date/vendor and cans have been placed on the appropriate shelf labeled "Dented Cans."

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ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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F 812	Continued From page 24 Review of the facility's "Pot Washing Policy," with a revision date of 2/14/2017, revealed Procedure: 10. Air dry all clean and sanitized pots and wares (place in angles at least 20 degrees -30 degrees). Do not wipe dry. Do not stack.	F 812		
F 880 SS=D	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		2/25/22

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F 880	Continued From page 25 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure infection control practices were implemented in accordance with facility policy and accepted national standards to prevent the possible spread of infection by failing to: a) properly don (put on) and doff (take off) personal protective equipment (PPE) and b) perform hand hygiene after glove removal for 1 of 3 residents reviewed for Ex.Order 26.4(b)(1) (Resident #132) and c) ensure Ex.Order 26.4(b)(1) was kept in a clean and sanitary condition, and stored properly for 1 of 2 residents reviewed for Ex.Order 26.4(b)(1) (Resident #692). This deficient practice was evidenced by the following: 1. During the initial tour of the facility on 01/24/22 at 11:22 AM, the surveyor observed a clear plastic, three-drawer storage unit which housed Personal Protective Equipment (PPE) (garments or equipment used to protect the body from injury or infection) outside of Resident #132's room. There was no signage posted on the outside of the resident's door or door frame to detail required usage. At that time, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that both a gown and gloves were required to enter the resident's room as the resident was on Ex.Order 26.4(b)(1) (EX Order 26.4B1) for EX Order 26.4 EX Order 26.4B1	F 880	F-880 INFECTION CONTROL 1. EX Order 26.4B1 went inside the room without proper PPE due to being a newly hired Provider and lack of knowledge regarding proper procedure of the facility causing a potential for Infection. Resident #132 was not negatively affected by incorrectly placed signage or failure of the EX Order 26.4B1 to use correct PPE. 2. All residents on Ex.Order 26.4(b)(1) are at risk to be affected by deficient practices. 3. ROOT CAUSE ANALYSIS (RCA) was done by facility to determine the problem. All residents currently on Ex.Order 26.4(b)(1) will be reviewed to have proper signage. A review of process for educating incoming Providers (potential for having resident contact) was reviewed all new providers will have initial meeting with nursing with the facility IP or designee regarding all necessary infection practices including but not limited to donning and doffing of PPE, hand washing practices. A signed in-service sheet will be maintained. All nurses are educated about Ex.Order 26.4(b)(1) protocol including hanging of signage at the time of infection identification. The Facility provided In-services training to appropriate staff. These are the lists of videos provided to staff. 1. Module 1- Infection Prevention Control Program Topline staff and Infection Preventionist. 2. Keep Covid-out! Frontline Long care	

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F 880	Continued From page 27 found in some strains of Ex.Order 26.4(b)(1) [redacted] EX Order 26.4B1 [redacted]) in the [redacted]. At 11:23 AM, the surveyor observed a physician who wore a face mask and a lab coat over her clothing outside of Resident #132's room. The surveyor greeted the physician who identified herself as a EX Order 26.4B1 before she entered the resident's room and closed the door behind her. At 11:25 AM, the surveyor knocked on Resident #132's door. When the surveyor opened the door, the EX Order 26.4B1 was observed at the EX Order2 of the resident's bed and the resident's EX Order 26 were exposed. The surveyor observed that the EX Order 26.4B1 wore gloves but did not wear a gown as required. When interviewed, she stated that it was her first time at the facility. She stated that when she arrived at the unit she checked in with the nurse at the desk. She stated that she sanitized her hands and wore gloves as she was here to Ex.Order 26.4(b)(1) EX Order 26.4B1. She stated that no one told her that the resident was on Ex.Order 26.4(b)(1) or that a gown was required to enter the resident's room. The EX Order 26.4B1 stepped out of the resident's room into the hallway and failed to doff her gloves beforehand. She then answered her cell phone with her gloved hands. When interviewed, she stated, "I can put a gown on if you want me to." She opened the bottom drawer of the isolation cart with her gloved right hand which was empty. She then opened the middle drawer and removed a disposable isolation gown which she then donned. The EX Order 26.4B1 t did not doff her gloves and apply a clean pair before she returned to the resident's room and closed the	F 880	staff 3. Clean Hands- Frontline Staff 4. Monitor Residents- Frontline staff 5. Use PPE correctly for Covid-19 6. Module 5 Outbreaks- Topline staff and Infection Preventionist 7. Module 11B Environmental Cleaning and Disinfection 8. Module 4 Infection Surveillance- Topline staff and infection Preventionist 9. Module 7 Hand Hygiene- All staff including Topline staff and Infection Preventionist 10. Module 6A Principle of Standard Precautions- all staff including Topline staff and Infection Preventionist 11. Module 6B Principle of transmission Based precaution- All staff including topline staff and Infection Preventionist 12. Module 11A Reprocessing reusable resident Care equipment- Topline staff and Infection Preventionist only 1. The IP will be alerted at the time of each vendor entrance of the facility to verify they receive IC in-service or education (including but not limited to donning and doffing, hand washing). A list of all educated vendors or providers will be presented to QAPI committee monthly x 3 months. Infection Preventionist will review daily o Ex.Order 26.4(b)(1) room to ensure we are following proper policy and procedure of Ex.Order 26.4(b)(1) including hanging of proper signage. Infection Preventionist presented to QAPI monthly x 3 months.	

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F 880	Continued From page 28 door behind her. At 11:27 AM, the surveyor observed the EX Order 26.4B1 as she exited Resident 132's room and wore a disposable isolation gown and gloves out into the hallway. A facility Certified Nursing Assistant (CNA) observed that the EX Order 26.4B1 failed to doff the gown and gloves when she exited the resident's room and instructed her to return to the resident's room to both doff and dispose of the gown and gloves in the trash can that was within the resident's room. The EX Order 26.4B1 doffed both the gown and gloves as instructed. She exited the resident's room and utilized alcohol-based hand rub (ABHR) that was available on top of the isolation cart and performed hand hygiene before she went to see another resident. The surveyor then visually inspected the isolation cart and noted that there was a canister of disinfectant wipes and a bottle of ABHR that was placed directly on top of cautionary signage related to PPE requirements needed to enter the resident's room which was obstructed from view and only the word "STOP" was visible. During an interview with the surveyor on 01/24/22 at 12:20 PM, the Registered Nurse Unit Manager (RN/UM) stated that when the EX Order 26.4B1 arrived at the unit, she furnished her with a list of residents that needed to be seen but did not speak with her as she was assigned to the medication cart and administered medications at that time. She stated that both a gown and gloves were required to be worn into the resident's room when care was rendered as the resident was on Ex.Order 26.4(b)(1) for [redacted]. She further stated that the resident required EX Order 26.4B1	F 880	Unit Managers has to do Weekly audits for those residents on Ex.Order 26.4(b)(1) per floor to ensure proper signage is observe. DPOC requirements in POC completed in reference to Infection Control. 1. Resident # 682 was not negatively affected by improper storage and dating of EX Order 26.4B1 mouthpiece and tubing. Ex.Order 26 cup changed immediately and put in proper storage. 2. All residents receiving current EX Order 26.4B1 treatments audited were check to ensure proper storage and properly checked and dated. 3. 3. All nurses re-educated about proper storage and dating of tubing and equipment. ROOT CAUSE ANALYSIS was done by the Facility to determine the problem. Staff did not follow proper storage and dating of tubing as per Policy and Procedure. All residents using Ex.Order 26.4(b)(1) equipment will be reviewed to have proper storage and dating. All nurses were re-educated for proper storage and dating of Ex.Order 26.4(b)(1) equipment. The Facility provided In-services training to appropriate staff. These are the lists of videos provided to staff. 1. Module 1- Infection Prevention Control Program Topline staff and Infection Preventionist. 2. Keep Covid-out! Frontline Long care	

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F 880	Continued From page 29 to treat the Ex.Order 26.4(b)(1) and was scheduled to have a EX Order 26.4B1 [redacted]) placed today for EX Order 26.4B1 administration. The Infusion Nurse arrived at that time and the RN/UM advised him to donn a gown and gloves before he entered the resident's room to insert the EX Order 26.4B1 as Resident #132 was on Ex.Order 26.4(b)(1). The surveyor reviewed the Electronic Health Record (EHR) which contained laboratory results and indicated that on 1/23/22 at 11:47 AM, the RN/UM was notified that Resident #132 was EX Order 26.4B1 and Ex.Order 26.4(b)(1) were indicated. On 01/26/22 at 10:15 AM, the surveyor observed a sign posted on the outside of Resident #132's room, directly below the resident's name plate, which cautioned the following: STOP, Ex.Order 26.4(b)(1), Everyone must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person ... During an interview with the surveyor on 01/28/22 at 9:53 AM, the LPN stated that when she went to work on 01/24/22, the isolation cart was already set up outside of Resident #132's room. She stated that there should have been a sign hung on the outside of the resident's door	F 880	staff 3. Clean Hands- Frontline Staff 4. Monitor Residents- Frontline staff 5. Use PPE correctly for Covid-19 6. Module 5 Outbreaks- Topline staff and Infection Preventionist 7. Module 11B Environmental Cleaning and Disinfection 8. Module 4 Infection Surveillance- Topline staff and infection Preventionist 9. Module 7 Hand Hygiene- All staff including Topline staff and Infection Preventionist 10. Module 6A Principle of Standard Precautions- all staff including Topline staff and Infection Preventionist 11. Module 6B Principle of transmission Based precaution- All staff including topline staff and Infection Preventionist 12. Module 11A Reprocessing reusable resident Care equipment- Topline staff and Infection Preventionist 4. DON designee, will audit of 3 residents per week x 90 days to ensure that Ex.Order 26 equipment is in proper storage and dated properly. Result will be reported to QAPI committee monthly x 3 months.	

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F 880	Continued From page 30 that informed if someone went into the room, they must wear a gown and proper protective equipment to prevent the spread of infection. She stated that the signage was required, and they must not have gotten around to hanging one up yet at that time. The LPN further stated that the [redacted] should have spoken with the nurse before she entered the resident's room. During an interview with the surveyor on 01/28/22 at 10:40 AM, the Assistant Director of Nursing/Infection Control Nurse (ADON/ICN) stated that once [redacted] was identified an isolation cart should be placed outside of the resident's room and a sign should have been visible and hung on the resident's door immediately to make sure that everyone knew to see the nurse first before they entered the resident's room. She stated that the [redacted] was required to perform hand hygiene and donn both a gown and gloves before she entered the resident's room. She further stated that she was required to doff all PPE and perform hand hygiene before she left the resident's room to prevent the spread of infection. Review of Resident #132's Care Plan revealed an entry dated 01/24/22, which detailed that the resident required [redacted] related to [redacted] and included the following interventions: Place sign '[redacted] On 01/28/22 at 11:30 AM, the surveyor reviewed	F 880		

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F 880	Continued From page 31 the facility policy, "Transmission Precautions-Contact" (Reviewed 12/2021) which revealed the following: Policy: To provide guidance on when to implement contact precautions. The facility is committed to providing a safe and healthy environment for residents and to minimize or prevent the spread of infections. Procedure: ...Gloves and hand washing: Wear clean, non-sterile gloves when entering the room ...Remove gloves and discard properly before leaving the room and wash hands immediately with an antimicrobial agent. After removing gloves and hand washing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident's room. This will help to avoid transfer of microorganisms to other residents or environments. Gowns: Wear a clean, non-sterile gown upon entering the resident's room if you anticipate substantial contact between your clothing and the resident, environmental surfaces, or any items in the room ...Remove the gown before leaving the resident's room. After gown removal, ensure that clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to other residents or surfaces. General Information: Direct contact with the resident includes hand or skin-to-skin contact that occurs when performing resident care activities that require touching the resident's dry skin.	F 880		

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F 880	Continued From page 32 2. According to the facility's Admission Record, Resident #682 was admitted to the facility in EX Order 26.4B1 with diagnoses which included but were not limited to: EX Order 26.4B1 EX Order 26.4B1 Review of a Quarterly Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, revealed the resident had a Brief Interview for Mental Status (BIMS) score of EX Order 8 which indicated that the resident's EX Order 26.4B1. Review of the resident's Order Summary Report revealed an order dated EX Order 26.4B1 (EX Order 26.4B1 EX Order 26.4B1 3 EX Order 26.4(b)(1) via EX Order 26.4B1 every 6 hours for Ex.Order 26.4(b)(1) 30 days. A EX Order 26.4B1 machine delivers EX Order 26.4B1 medication to the person via a mouthpiece and chamber/cup that holds the medication, via tubing that is attached to the machine. It is used to treat EX Order 26.4B1 conditions such as EX Order 26.4B1. Review of Resident #682's EX Order 26.4B1 Medication Administration Record (MAR) reflected EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4(b)(1) via EX Order 26.4B1 every 8 hours was documented as administered from EX Order 26.4B1 ml EX Order 26.4(b)(1) via EX Order 26.4B1 r every EX Ord hours was documented as administered from 01/19/2022 until 01/26/2022. On 01/24/2022 at 1:03 PM, during the initial tour of the EX Order 8 floor, Surveyor #2 observed a EX Order 26.4B1 machine on a side table in Resident	F 880		

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F 880	Continued From page 33 #682's room. The EX Order 26.4B1 mouthpiece with connected medication cup and tubing were exposed and resting in the top drawer of the side table with the tubing connected to the EX Order 26.4B1 machine. The resident stated that he put the EX Order 26.4B1 in the drawer when he was finished. On 01/26/2022 at 1:18 PM, Surveyor #2 observed a EX Order 26.4B1 machine on the resident's side table. The EX Order 26.4B1 mouthpiece with connected wet medication cup and tubing were exposed and resting in the top drawer of the side table with the tubing connected to the EX Order 26.4B1 machine. On 01/26/22 at 1:28 PM, the Licensed Practical Nurse (LPN) accompanied Surveyor #2 to Resident #682's room. The nurse acknowledged the EX Order 26.4B1 mouthpiece with connected medication cup and tubing were exposed and resting in the top drawer of the side table with the tubing connected to the EX Order 26.4B1 machine. The LPN stated that the mouthpiece should not be stored like that and that it should be stored in a bag. She further stated the mouthpiece should be cleaned before use then stored in a bag marked with the date to prevent bacterial growth that could cause infection. The LPN removed the mouthpiece, medication cup and tubing from the room and threw it in the trash. During an interview with Surveyor #2 on 01/26/2022 at 1:37 PM, the Director of Nursing (DON) was made aware of Resident #682's EX Order 26.4B1 mouthpiece with connected medication cup and tubing that were resting in the top drawer of the side table. The DON acknowledged that the EX Order 26.4B1 mouthpiece should not be	F 880		

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F 880	Continued From page 34 stored that way and stated that after each use the mouthpiece should be washed with soap and water, dried with a paper towel and stored in a plastic bag marked with the date to prevent infection. Review of the facility's policy Ex.Order 26.4(b)(1) [redacted] with a revision date of 08/2021, revealed Policy and Procedure 17. When treatment is complete, turn off the Ex.Order 26.4(b)(1) [redacted], remove the mask, disconnect the T-piece, mouthpiece, and medication cup. 19. Rinse and disinfect the Ex.Order 26.4(b)(1) [redacted] equipment according to manufacturer's recommendations or wash the pieces (except tubing) with warm water after each use. Allow the components to air dry completely on a paper towel. 21. When equipment is completely dry, store in a plastic bag marked with the resident's name and the date. NJAC 8:39-15.1(a), NJAC 8:39-19.4	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 7 of 14-day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance	S 560	S560 Mandatory Access to Care 1. The following corrective actions have been accomplished for the identified deficiency: - There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements during the 7:00am -3:00pm shift on the dates of 1/9/2022, 1/10/2022, 1/11/2022, 1/12/2022, 1/16/2022, 1/21/2022, and 1/22/2022	2/23/22

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

Electronically Signed | 02/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060408	A. BUILDING: _____ B. WING _____	01/31/2022

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During an interview with the surveyor on 1/25/22 at 9:30 AM, a CNA stated that they were assigned to 15 residents that day on the 7-3 shift. The surveyor requested staffing for weeks of 1/9/22 and 1/16/22. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -01/09/22 had 22 CNAs for 190 residents on the day shift, required 24 CNAs.	S 560	2. All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement ratios. 3. The following measures have been put into place to prevent the deficient practice from recurring: - Advertisements / Job postings for CNAs have been posted on hiring platforms, social media websites as well as flyers posted - Incentives are offered to CNAs to work extra shifts such as gift cards, and Bonuses - Many agencies are being utilized to fill in any open shifts. Bonuses are also being offered to agency staff to pick up shifts. 4. The Administrator or designee will review the staffing schedule weekly to monitor the staffing ratio on the 7am 3pm shift weekly x 90 days. The findings will be reported to the QAPI committee on a monthly basis x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 -01/10/22 had 22 CNAs for 190 residents on the day shift, required 24 CNAs. -01/11/22 had 22 CNAs for 190 residents on the day shift, required 24 CNAs. -01/12/22 had 22 CNAs for 190 residents on the day shift, required 24 CNAs. -01/16/22 had 21 CNAs for 192 residents on the day shift, required 24 CNAs. -01/21/22 had 21 CNAs for 190 residents on the day shift, required 24 CNAs. -01/22/22 had 19 CNAs for 190 residents on the day shift, required 24 CNAs. During an interview with the surveyor on 01/27/22 at 1:33 PM, the staffing coordinator stated she was aware of the staffing ratios. During an interview with the surveyor on 01/28/22 at 9:28 AM, the Administrator stated he was aware of the staffing ratios and that the staffing coordinator overstaffed the day shift in case there were call outs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315187 Y1	A. Building B. Wing Y2	4/13/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0578	Correction	ID Prefix F0658	Correction	ID Prefix F0804	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	02/23/2022	LSC	02/23/2022	LSC	02/23/2022
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	02/23/2022	LSC	02/25/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/31/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
060408 Y1	Y2	4/13/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/23/2022	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/31/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING **01** B. WING _____	**01/31/2022**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/24/22 and 01/25/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 5-story building that was built in 80's, It is composed of Type II protected. The facility is divided into 15- smoke zones. The generator does approximately 80% of the building. The fire sprinkler system utilizes an electric fire pump thats tested monthly by the fire sprinkler vendor. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/21/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 The facility has 240 certified beds. At the time of the survey the census was 187.	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/25/22, the facility failed to provide automatic emergency illumination that would operate automatically along the means of egress, and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.8, 7.8.1.1, 7.8.1.2, 7.8.1.4. The deficient practice was evidenced by the following: At 12:38 PM, the surveyor, Assistant Maintenance staff member and Regional Plent Operations Director observed in the gazebo/smoking courtyard that at the egress/discharge gate with a keypad and keyed-lockset there was no emergency lighting at the lock or beyond the gate to the public way. The findings were verified by the Assistant Maintenance staff member and Regional Plant Operations Director at the times of the	K 281	K281 1)Regarding no lighting at lock or beyond the gate to the public way, Maintenance director immediately ordered a floodlight which will be put up to illuminate area around keypad lock and beyond the gate to the public way. 2)All residents have the potential to be affected by this deficient practice. Maintenance director installed the floodlight and there is now light illuminating the area around keypad lock and beyond the gate to the public way. 3)Maintenance Director conducted an audit of all other areas that may potentially require additional lighting and has found that all other areas have sufficient lighting. 4)Maintenance Director/Designee will conduct weekly audits times four weeks and then monthly thereafter for three months to ensure all areas have sufficient lighting. All findings will be bought up	2/23/22

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K 281	Continued From page 2 observation. The Administrator was informed of the findings at the Life Safety Code exit conference on 01/25/22.	K 281	quarterly at the QA committee meeting.	
K 291 SS=D	NJAC 8:39-31.2(e) Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/25/22, it was determined that the facility failed to provide an operational battery backup emergency light above the emergency generator's transfer switches, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was observed for 2 of 2 transfer switches and was evidenced by the following: 1. At 11:28 AM, the surveyor, Assistant Maintenance staff member and Regional Plant Operations Director, observed in the basement main electrical room, where the generator transfer switch was located, that no emergency lighting was provided. The wall switch was shut-off and a light remained on, but the fixture was not provided with a battery backup to the fixture.	K 291	K291 1) In regard to the lack of emergency lighting where the generator transfer switch is located. Electrician was called to install a battery-operated emergency light that will operate for minimum 90 minutes independent of facility electric and generator. 2) All residents have the potential to be affected by this deficient practice. Electrician installed the battery backup lights to provide emergency lighting independent of facility electric and generator 3) Maintenance Director/Designee will ensure that battery backup lights are working properly once installed. 4)Maintenance Director/Designee will conduct audits by monitoring lighting monthly for three months to ensure proper function of the battery backup. All findings will be bought up quarterly at the	2/23/22

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K 291	Continued From page 3 This finding was verified by the Assistant Maintenance staff member and Regional Plant Operations Director at the time of observation. The Administrator was notified of the above findings at the Life Safety Code exit conference on 01/25/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	QA committee meeting.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on surveyor's observation and interview on 01/25/22, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents and was evidenced by the findings noted below: At approximately 12:00 PM, the surveyor observed along with the Assistant Maintenance staff member and Regional Plant Operations	K 345	K345 1)Concerning fire alarm panel that was in trouble mode, Fire alarm company was immediately called to address issue. 2)All residents have the potential to be affected by this deficient practice. Fire alarm vendor determined that heat detector needs to be replaced. Alarm vendor installed new heat detector and fire alarm panel is running properly with all systems running as normal. 3)Maintenance conducted audits on all alarm panels in the facility and ensured all	2/23/22

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K 345	Continued From page 4 Director, that the fire alarm annunciator panel indicated "trouble in system". The amber trouble light was activated in 2 of 2 panels observed. The annunciator panel indicated "trouble heat on the [redacted] floor dayroom bathroom." The alarm system was operating at the time of the finding. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70,National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. The Regional Plant Operations Director stated that the facility fire alarm vendor was scheduled to respond ASAP. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 01/25/22. NFPA 70 NFPA 72 NJAC 8:39-31.2(e)	K 345	fire alarm panels are running properly. 4)Maintenance Director/Designee will conduct weekly checks on all fire panels weekly for four weeks and then monthly thereafter for three months. All findings will be reviewed quarterly at the QA committee meeting.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		2/23/22

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K 353	Continued From page 5 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/25/22, it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. During a building tour from 09:30 AM, to 02:25 PM, the Surveyor, assistant Maintenance staff member and Regional Plant Operations Director, observed drop ceiling tiles missing and/or holes in the ceiling tiles (sheetrock) and bad cuts around the fire sprinkler heads in the following areas of the facility: Floor [redacted] resident scale area, broken ceiling tile and missing vent frame allowing approximately 2" opening around unfinished area. Floor [redacted] shower room, missing 3 ceiling tiles. Floor [redacted] resident room [redacted] ceiling tile not in place approximately 4' x 2'. Floor [redacted] resident room [redacted] bathroom ceiling approximately 2" ceiling opening around fire sprinkler head. Kitchen dish cleaning ceiling missing 3	K 353	K353 1)Concerning the drop ceiling tiles missing and/or holes in [redacted] floor resident scale area, fourth floor shower room, room [redacted] bathroom in room [redacted], kitchen dish cleaning area, kitchen fire suppression system, kitchen water storage closet. Maintenance immediately started working and repairing all mentioned ceiling tiles. 2)All residents had the ability to be affected by this deficient practice. Maintenance repaired and replaced all defected ceiling tiles. 3)Maintenance conducted an audit on all ceiling to ensure that there were no other ceiling tiles that needed to be repaired or replaced throughout the facility. 4)Maintenance Director/Designee will monitor and audit facility for any missing and/or damaged ceiling tiles weekly for four weeks and monthly for three months thereafter. All findings will be reviewed quarterly at QA committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 6 approximately 4' x 2' tiles Kitchen fire suppression system with bad ceiling tile cuts around the conduit pipe. Kitchen water storage closet, broken ceiling tile, approximately 3' x 2'. The Assistant Maintenance staff member and Regional Plant Operations Director stated and confirmed the above findings during the building tour on 01/25/22. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 01/25/22.. NJAC 8:39-31.2(e)	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed	K 363		2/23/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	**1302 LAUREL OAK ROAD** **VOORHEES, NJ 08043**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 7 when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview from 01/24/22 to 01/25/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 8 of 40 resident room door's and was evidenced by the following: From 01/24/22 to 01/25/22, during the building	K 363	K363 1)Concerning the doors to resident□s rooms EX Order 26.4B1 and EX Order that did not close and latch into the door frame. Maintenance was immediately called to inspect these doors. 2) All residents had the ability to be affected by this deficient practice. Maintenance Director determined that doors need new spring latches and/or levers. All required parts needed to fix doors were ordered. Maintenance Director will repair all mentioned doors once parts are received. 3)Maintenance Director audited all other doors throughout the facility and ensured that all other doors in the facility are	

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	315187	A. BUILDING **01** B. WING _____	**01/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	**1302 LAUREL OAK ROAD** **VOORHEES, NJ 08043**

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K 363	Continued From page 8 tour from 9:00 AM, to 1:00 PM, the surveyor, in the presence of the Assistant Maintenance staff member and Regional Plant Operations Director, observed that the doors to resident rooms, did not latch into the door frame in the following room numbers: EX Order 26.4B1 An interview was conducted with the assistant Maintenance staff member who stated and confirmed that the above resident room doors, had hardware issues that prevented the doors from latching into there frame's properly. The Administrator was informed of the finding at the Life Safety Code exit conference on 01/25/22. NJAC 8:39-31.1(c), 31.2(e)	K 363	latching closed properly. 4) Maintenance Director/Designee will audit and monitor all residents room doors weekly for three weeks and monthly for three months thereafter. All findings will be reviewed quarterly at the QA committee meeting.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	K 374		2/23/22

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K 374	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations on 01/25/22 in the presence of the Assistant Maintenance staff member and Regional Plant Operations Director, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 2 of 10 smoke barrier doors observed and was evidenced by the following: 1. At 11:15 AM, the surveyor observed that 1 of 2 smoke barrier doors by resident room [EX Order 25] were blocked from fully closing due to the closing arm not attached to the door. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. This was confirmed when the fire alarm was activated on 01/25/22 at 12:37 PM to test the doors for proper operation. 2. At 01:20 PM, the surveyor observed that 1 of 2 smoke barrier doors by resident room [EX Order 2] were blocked from fully closing by a stored resident wheel chair. When the open doors were activated, the door on the resident room [EX Order] side was completely holding the door from closing due to the wheel chair blocking its release. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The assistant Maintenance staff member and Regional Plant Operations Director, confirmed the findings above.	K 374	K374 1) In regard to the facility□s failure to maintain smoke barrier doors to resist the transfer of smoke when completely closed, doors at room [EX Order] not closing properly due to closing arm not being attached to door, and doors at room [EX Order] not being able to close properly due to a wheelchair being in the way. Maintenance was immediately called to inspect fire doors. 2)All residents had the potential to be affected by this deficient practice. Wheelchair was immediately removed from blocking smoke doors at room [EX Order 2] Closing arm for smoke doors at room [EX Order 2] was immediately reattached and restored to proper function. 3)Maintenance audited all other smoke doors throughout the facility and ensured that they are closing properly. 4)Maintenance Director/ Designee will audit all smoke doors weekly for four weeks and then monthly for four months thereafter. All findings will be reviewed quarterly at the QA committee meeting.	

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K 374	Continued From page 10 The facility Administrator was informed of the findings during the Life Safety Code survey exit conference on 01/25/22. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/25/22, in the presence of the facility assistant Maintenance staff member and Regional Plant Operations Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 3 of 29 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: While touring the building on 01/25/22, from approximately 10:30 AM to 1:30 PM, the surveyor, in the presence of the assistant Maintenance staff member and Plant Operations	K 521	K521 1) In regard to ventilation in resident bathrooms not functioning in rooms EX Order 26.4B1. Maintenance was called to inspect exhaust fans in mentioned bathrooms. 2)All residents have the potential to be affected by this deficient practice. Maintenance reached out to electrical company to asses exhaust fans in mentioned rooms. Electric company was at the facility on 2/18/22 and determined that one of the main units was shut down causing this issue. electric company repaired mentioned unit and all units are now running properly. . 3)Maintenance Director audited all other	3/17/22

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K 521	Continued From page 11 Director, observed that the ventilation in the following resident room bathrooms did not function: Resident Room's #EX Order 26.4B1 The surveyor requested that the Assistant Maintenance staff member, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Assistant Maintenance staff member, who confirmed that the exhaust vents in the above resident room bathrooms, were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference on 01/25/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	exhaust fans in resident bathroom to ensure that they are functioning properly. 4) Maintenance Director/Designee will audit and monitor exhaust fans in resident bathrooms weekly for four weeks and monthly for three months thereafter. All findings will be reviewed quarterly at the QA committee meeting	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable	K 920		2/23/22

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K 920	Continued From page 12 patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/25/22, the facility did not prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was evidenced by the following:	K 920	K920 1) In regard to the facilities failure to prohibit the use of extension cords beyond temporary installation as a substitute for adequate wiring, which does not ensure the prevention of an electrical fire or electric shock hazard, which was found in rooms [redacted] and in the kitchen. Maintenance was immediately called to remove mentioned extension cords. 2) All residents have the potential to be affected by this deficient practice. All extension cords were immediately removed from above mentioned areas. 3)Maintenance Director audited other	

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K 920	Continued From page 13 1. At 09:40 AM, the surveyor and Assistant Maintenance staff member, observed in resident (private) room [redacted] that the duplex wall outlet on the left side of the entrance into the room, was missing its protective plate cover. The resident 4-draw dresser was blocking a part of the duplex wall outlet from being accessible. 2. At 10:20 AM, the surveyor and Assistant Maintenance staff member, observed in resident room [redacted] doorside, that a brown household grade extension cord had electronics plugged into the 3 prong plug. The brown extension cord was then plugged into the duplex wall outlet by the resident bed. The brown extension cord was pinched and twisted from over use. 3. At 11:48 AM, the surveyor and Assistant Maintenance staff member and Regional Plant Operations Director observed in the kitchen at the windowside outside wall prep area that a portable window A/C unit was observed to have its GFCI plug installed into the drop ceiling. The Assistant Maintenance staff member then lifted the drop ceiling tile and observed the cord plugged into an orange extension cord. The orange extension cord was then traced for its plug. The plug for the orange extension cord was not located. The finding was verified by the Assistant Maintenance staff member and Regional Plant Operations Director at the time of the observations. The Administrator was notified of the findings at the Life Safety Code exit conference on 01/25/22.	K 920	resident rooms and areas throughout the facility to ensure they were in compliance. 4) Maintance will audit facility weekly times four weeks and monthly times three months to ensure that no extension cords are being used beyond temporary installation. All findings will be reviewed and discussed quarterly at facility QA meeting.	

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K 920	Continued From page 14	K 920		
K 923 SS=E	NJAC 8:39-31.2(e) Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty	K 923		2/23/22

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K 923	Continued From page 15 cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview from 01/24/22 to 01/25/22, in the presence of the assistant maintenance staff and regional plant operations director, it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 3 of 14 portable oxygen cylinders and was evidenced by the following: 1. On 02/24/22 at 01:20 PM, the surveyor observed on floor [EX Orde] in resident room [EX Order 26] that at the window side resident bed, a full O2 cylinder was observed to be free standing and not secured from tipping, rupture and damage. 2. On 02/25/22 at 11:00 AM, the surveyor observed in the floor [EX Orde] oxygen storage room that 2 of 13 oxygen cylinders were free standing and not secured from tipping, rupture and damage.The oxygen cylinders were observed to have approximately 500 PSI each. An interview was conducted with the Assistant Maintenance staff member and Regional Plant Operations Director, who stated that the cylinders must be individually secured from tipping, rupture and damage at all times in the facility.	K 923	K923 1) In regard to Oxygen tanks that were found freestanding and not secured from tipping in room [EX Orde], and the two tanks found in oxygen room on [EX Order 2] floor. All mentioned oxygen tanks were immediately placed in appropriate secure holders to prevent from tipping. 2) All residents had the potential to be affected by this deficient practice. 3) Maintance audited resident rooms and oxygen rooms to ensure that all oxygen tanks were secure and not freestanding. 4) Maintance/designee will audit and monitor resident room and oxygen rooms weekly times four weeks and monthly times three months thereafter to ensure all oxygen tanks are secured in accordance with regulation. All finding will be reviewed quarterly at QA committee meeting.	

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K 923	Continued From page 16 The Administrator was informed of the finding at the Life Safety Code exit conference on 01/25/22. NJAC 8:39-31.2(e) NFPA 99	K 923		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315187 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/13/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	02/23/2022	LSC K0291	02/23/2022	LSC K0345	02/23/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	02/23/2022	LSC K0363	02/23/2022	LSC K0374	02/23/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	03/17/2022	LSC K0920	02/23/2022	LSC K0923	02/23/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/31/2022	☐ YES ☐ NO