PRINTED: 02/23/2023 FORM APPROVED OMB NO. 0938-0391

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>			(X3) DATE SURVEY COMPLETED	
		315280	B. WING _			08/	29/2022
	ROVIDER OR SUPPLIER			141	EET ADDRESS, CITY, STATE, ZIP CODE 7 BRACE ROAD ERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
I	INITIAL COMMENTS  A Life Safety Code S New Jersey Departments Survey and Field Oper 08/25/22, and 08/29/2 Center was found to be the requirements for p Medicare/Medicaid at Safety from Fire, and National Fire Protection Life Safety Code (LSC Health Care Occupant Silver Healthcare Cere that was built in the 1 Type V protected. The smoke zones. Multiple Occupancies CFR(s): NFPA 101  Multiple Occupancies Care Occupancies Care Occupancies Non-health care occup immediately next to a but are primarily interes services are permitted Business or Ambulate Occupancies, provide by construction havin resistance-rated conse	urvey was conducted by the ent of Health, Health Facility erations on 8/24/22, 2022, and Silver Healthcare be in noncompliance with participation in 42 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING (Iccy) atter is a two-story building 1980's. It is composed of the facility is divided into 19 and the contiguous Non-Health and the contiguous Non-Health contiguous Non-Health Care Occupancy, and the facilities are separated growth less than 2-hour fire	K	000	CROSS-REFERENCED TO THE APPROPRIA		
ADODATODY	four or more inpatient departments must be Health Care Occupar of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT by:	s. Outpatient surgical classified as Ambulatory regardless of the number			TITLE		(X6) DATE

Electronically Signed 09/22/2022

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315280	B. WING _			08/	29/2022
NAME OF PE	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				14	117 BRACE ROAD		
SILVER HE	EALTHCARE CENTER			C	HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 132	Based on observation and 08/25/22, the facitivo-hour fire resistance assemblies in accordate of NFPA 101, 2012 Educated by This deficient practice and was evidenced by During the survey ent AM, a request was man Maintenance Director the facility layout which rooms and smoke confacility provided layout (3) buildings that were Atrium, the Pavilion, a IMD further told the sur Dialysis Unit in the but On 08/24/22 and 08/2 with the Corporate Vice Environmental Service performed. Along the the following:  1. On 08/25/22 at app Surveyor, CVPES and floor dialysis unit and revealed the door had label.  2. On 08/25/22 at app surveyor, CVPES and second floor dialysis unit and revealed the door had label.	in and interview on 08/24/22 lity failed to provide ce-rated elements and ance with the requirements dition, Section 19.1.3.4. unit and the nursing facility. It could affect all residents of the following: In ance on 08/24/22 at 8:50 ande to the Interim (IMD) to provide a copy of the identified the various Inpartments. A review of the It identified there were three the connected together, the and the Court buildings. The arveyor that there was a ilding. In a tour of the building the President of the CVPES) and IMD was tour the surveyor observed In a tour the surveyor observed In a tour fire rating IMD observed that the first arroximately 10:47 AM, the IMD observed that the	K 1	32	1. Regarding inspection of fire door on first floor connecting to the dialysis cen which revealed the door had no 1-1/2 hire rating label, and the second floor dialysis unit and nursing facility fire door revealed the door had no means to late into its frame and no 1-1/2 hour fire ratilabel, maintenance reached out to vene for repair, vendor came and installed n doors that latch properly and have 1-1/hour fire rating label.  2. All residents have the potential to be affected by this deficient practice.  3. All other doors were confirmed to be compliance and checked by maintenand. Weekly audits of all fire doors will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that a fire doors are in compliance. Findings were brought to the QAPI committee monthly for 3 months.	ter nour or ch ng dor ew 2 in ce.	
	The CVPES and IMD	confirmed the findings at					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1417 BRACE ROAD CHERRY HILL, NJ 08034		
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K 132	The Administrator wa at the Life Safety Coo 08/29/22. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e)	ns. s notified of the deficiency le exit conference on	K 13:	2		
K 211 SS=E	exit locations, and ac with Chapter 7, and the continuously maintain full use in case of em 18/19.2.2 through 18/18.2.1, 19.2.1, 7.1.10 This REQUIREMENT by:  Based on interview a documentation on 08/1 the Interim Maintenar Corporate Vice Preside Services (CVPES), it facility failed to inspect accordance with S&C doors observed.  This deficient practice following:  From approximately 1/2 surveyor reviewed all from the IMD and CV	eneral eneral corridors, exit discharges, cesses are in accordance ne means of egress is ned free of all obstructions to ergency, unless modified by 19.2.11.	K 21	1. Regarding the facility □s failure to inspect the fire doors annually for 15 of fire doors observed, fire door inspection were initiated by maintenance.  2. All residents have the potential to be affected by this deficient practice.  3. All fire doors were inspected.  4. Weekly audits of all fire doors will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that fire doors are in compliance. Findings be brought to the QAPI committee monthly for 3 months.	e e all	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		315280	B. WING			08/	29/2022
	ROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 117 BRACE ROAD HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 211	during the document currently no further do provided on fire door last 12-months, as ide 17-38-LSC document.  The Administrator was the Life Safety Code of the Life Safety Co	ducted with the CVPES review. He stated that ocumentation could be inspections (Annual) for the entified in the S&C ation.  Is informed of the finding's at exit conference on 08/29/22.  1.2(e)  In Life Safety Code 7.2.1.15 benings. 7.2.1.15.1* to  On Life Safety Code 19.7.3 has of Egress 19.7.3.1		211			11/25/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDII	IPLE CONSTRUCTION NG <b>01</b>	, ,	(X3) DATE SURVEY COMPLETED		
		315280	B. WING _			08/29/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1417 BRACE ROAD CHERRY HILL, NJ 08034	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 222	to the staff at all times 18.2.2.2.5.1, 18.2.2.2 SPECIAL NEEDS LO Where special locking safety needs of the parameter of the process of the parameter of the process of power to protected by a supervisystem and the locke complete smoke deter constantly monitored within the locked sparameter of the protected by a supervisystem and detection system doors upon activation 18.2.2.2.5.2, 19.2.2.2 DELAYED-EGRESS ARRANGEMENTS Approved, listed delay installed in accordance permitted on door assordinary hazard content throughout by an apprize detection system automatic sprinkler sy 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLARRANGEMENTS Access-Controlled Equinstalled in accordance permitted.  18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EARRANGEMENTS Elevator lobby exit accordance with 7.2.5	c. 6, 19.2.2.2.5.1, 19.2.2.2.6 CKING ARRANGEMENTS of arrangements for the atient are used, all of the ocking requirements are, the locks must be il safely so as to release the device; the building is rised automatic sprinkler dispace is protected by a ction system (or is at an attended location be); and both the sprinkler is are arranged to unlock the complete see with 7.2.1.6.1 shall be seemblies serving low and ents in buildings protected roved, supervised automatic for an approved, supervised restance.  LED EGRESS LOCKING  LED EGRESS LOCKING	K2	222			

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	ROVIDER OR SUPPLIER  EALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 1417 BRACE ROAD CHERRY HILL, NJ 08034	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
K 222	detection system and automatic sprinkler's 18.2.2.2.4, 19.2.2.2.4 This REQUIREMEN' by: Based on observation of documentation on 08 facility management, facility failed to maining proper working condition the following:  During the survey en was made to the Interest (IMD) to provide a condentified the various compartments. A reliayout identified therest that were connected Pavilion, and the Cordinary of the Cordinary of the Service performed.  At 10:02 AM, during building, the surveyor located next to reside bar on the exit dischadoor did have a mag would release upon a system. A review of a diagram posted in the the primary exit dischadoor did have a mag would release upon a system.	ervised automatic fire d an approved, supervised system.  If is not met as evidenced on and review of other facility 8/24/22, in the presence of it was determined that the tain exit discharge doors in ition. The evidence includes of the facility layout which rooms and smoke wiew of the facility provided the were three (3) buildings together, the Atrium, the curt buildings.  If at 9:43 AM, a tour of the prorate Vice President of the prorate Vice President of the process (CVPES) and IMD was an inspection in the Pavilion of the surroom 421 that the push arge door was broken. This netic hold closed device that activation of the fire alarm an emergency evacuation are area identified this door as marge door.	K 22	1. Regarding the facility s f maintain exit discharge door working condition, maintenal immediately inspected the dopush bar was broken. Parts ordered and will be installed receipt. Vendor came and inspush bar and it is in good wow 2. All residents have the pote affected by this deficient praces. All exit discharge doors we and found to be in compliance. Weekly audits of all exit disconstitutions will be completed by No Director or Designee for four monthly thereafter for 3 mon that all exit discharge doors compliance. Findings will be the QAPI committee monthly months.	s in proper nce oor which the have been upon stalled new orking order. ential to be ctice. ere inspected ce. ischarge Maintenance r weeks, and oths to ensure are in brought to		

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K 222	Continued From page	e 6	K 222			
	at the Life Safety Coo 08/29/22. NJAC 8:39 -31.2 (e).					
K 227	NFPA 101 2012 7.2.1 Ramps and Other Ex	• •	K 227			10/22/22
SS=E						
	alternating tread devi in accordance with th 7.2.12.	its ways, fire and slide escapes, ces, and areas of refuge are e provisions 7.2.5 through or 19.2.2.6 to 19.2.2.10				
	by: Based on observation in the presence of the Director (IMD) and Continuous Environmental Service determined that the fathe requirements of Note that the pertaining to exit ram was identified for 1 of the evidenced by the follows:  At 1:18 PM, the surve exterior ramp outside rooms 326 and 327 with the presence of t	acility failed to comply with IFPA 101:2012 sect. 7.2.5 ps. This deficient practice 1 exit/egress ramps and as owing: eyor observed that the of unoccupied resident vere missing approximately ng on the right-side of the		1. Regarding the facility □s failure to comply with the requirements of NFPA 101:2012 sect. 7.2.5 pertaining to exit ramps, maintenance immediately inspected the railing.     2. All residents have the potential to be affected by this deficient practice.     3. All exit ramps were inspected and found to be in compliance. Maintenancimmediately repaired the railing.     4. Weekly audits of all exit ramps will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that a exit ramps are in compliance. Findings be brought to the QAPI committee	e ce pe	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G <b>01</b>	(X3) DATE SURVEY COMPLETED
		315280	B. WING		08/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1417 BRACE ROAD CHERRY HILL, NJ 08034	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
K 227	The IMD and CVPES guard rail during the common the Life Safety Code of the Life Safety Code of the ramp 19.2.3 Capacity of Me 7.2.5.3 Ramp Details through (7) 7.2.5.3.3 Drop-Offs NJAC 8:39-31.1(c)	confirmed the missing	K 22	monthly for 3 months.	
K 293 SS=D	CFR(s): NFPA 101  Exit Signage 2012 EXISTING Exit and directional si accordance with 7.10 also served by the en 19.2.10.1 (Indicate N/A in one-s with less than 30 occu travel is obvious.) This REQUIREMENT by: Based on observatio documentation on 08 facility management, facility failed to ensur- sign was in one (1) lo exit access path to re	gns are displayed in with continuous illumination hergency lighting system.  Itory existing occupancies upants where the line of exit is not met as evidenced and review of other facility 1/24/22, in the presence of it was determined that the exit cation to clearly identify the ach an exit discharge door.	K 29	1. Regarding the facility s failure to ensure that an illuminated exit sign to one location to clearly identify the exaccess path to reach an exit dischar door, maintenance immediately insp the exit sign in question to determine repair needed. New illuminated exit was immediately installed.  2. All residents have the potential to	vas in kit ge ected e sign

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		315280	B. WING _			08	/29/2022	
	ROVIDER OR SUPPLIER	,		14	TREET ADDRESS, CITY, STATE, ZIP CODE 417 BRACE ROAD HERRY HILL, NJ 08034	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION S		3E	(X5) COMPLETION DATE	
K 293	Reference: NFPA. Lit 7.10.1.5.1 Exit Acces marked by approved cases where the exit not readily apparent in NFPA Life Safety Coc Continuous Illuminating Every sign required to 7.10.7, and 7.10.8.1 illuminated as required section 7.8, unless of 7.10.5.2.2  During the survey en AM, a request was mand smoke confacility layout white rooms and smoke confacility provided layout one enclosed center Atrium building.  During a tour of the body confaction of English Covpes) and IMD at the outside enclosed Atrium building was conserved no evidence above one (1) exit according to the enclosed center. This was a primary a route to reach an exit The CVPES and IMD the time of observation.	fe Safety Code 2012 ss. Access to exits shall be a readily visible signs in all or way to reach the exit is to the occupants.  de 2012 7.10.5.2.1 on. o be illuminated by 7.10.6.3, shall be continuously ed under the provisions of therwise provided in  trance on 08/24/22 at 8:50 hade to the Interim or (IMD) to provide a copy of the identified the various or mpartments. A review of the suit identified that there was court yard located in the  devironmental Services 12:11 PM an inspection of center courtyard in the conducted. The surveyor of an illuminated exit sign dess door that leads you out the conducted of the	K	293	affected by this deficient practice.  3. All illuminated exit signs were insperand found to be in compliance.  4. Weekly audits of all illuminated exit signs will be completed by Maintenand Director or Designee for four weeks, a monthly thereafter for 3 months to ensith that all illuminated exit signs are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	ce nd ure		

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K 293	Continued From page at the Life Safety Cod 08/29/22.		К	293			
K 321 SS=E	Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Coo Hazardous Areas - Er CFR(s): NFPA 101		К	321			10/26/22
	having 1-hour fire res fire rated doors) or an system in accordance. When the approved a system option is used separated from other partitions and doors in Doors shall be self-cle and permitted to have protective plates that from the bottom of the Describe the floor and hazardous areas that 19.3.2.1, 19.3.5.9  Area  Separation N/A a. Boiler and Fuel-Fire b. Laundries (larger the c. Repair, Maintenand	protected by a fire barrier istance rating (with 3/4 hour automatic fire extinguishing with 8.7.1 or 19.3.5.9. utomatic fire extinguishing I, the areas shall be spaces by smoke resisting accordance with 8.4. using or automatic-closing an accordance with 8.4. using or automatic-closing an anitomated or field-applied do not exceed 48 inches adoor. It is a consideration of the area deficient in REMARKS.  Automatic Sprinkler and Heater Rooms and 100 square feet) be, and Paint Shops is (exceeding 64 gallons) promises.					

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILD		LE CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED	
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K 321	by: Based on observation documentation on of the Interim Maintena Corporate Vice Presservices (CVPES), if facility failed to ensure hazardous areas we were separated by saccordance with NF19.3.2.1, 19.3.2.1.3, 19.3.6.4, 8.3, 8.3.5.1  This deficient praction hazardous storage in the following:  During the survey er was made to the IMI facility layout which is and smoke comparting provided layout iden buildings that are conthe Pavilion and the Later during the buildings that are conthe Pavilion and the Later during the building areas were observed storage areas that we storage areas that we 1) Unoccupied residuation 336, 337, 340, 342, 2) Court One, B Windows	on and review of other facility 8/25/22, in the presence of ance Director (IMD) and ident of Environmental t was determined that the are that fire-rated doors to are self-closing, labeled and amoke resisting partitions in PA 101, 2012 Edition, Section 19.3.2.1.5, 19.3.6.3.5, 1, 8.4, 8.5.6.2 and 8.7.  The dwas identified in 9 of 9, sooms and was evidenced by an and was evidenced by the identified the various rooms ments. A review of the facility tified there were three (3) nected together, the Atrium, Court buildings.  Iding tour, in the presence of 10, the following hazardous d and utilized as hazardous were not smoke resistant:  Ident rooms: 127, 317, 335, and 344.  Ing, shower room.	K 32	1. Regarding the facility's failure to ensure that fire rated doors to hazard areas (in unoccupied resident rooms 317, 335, 336, 337, 340, 342, and 34 and Court One, B Wing, shower room and Central Supply room) were self-closing, labeled, and were separa by smoke resistant partitions in accordance with NFPA guidelines. Maintenance immediately checked al doors to check what was needed to hall doors in compliance.  2. All residents have the potential to be affected by this deficient practice.  3. All doors needing doors closers we inspected and parts were ordered. Do closers have been installed in resider rooms 317, 335, 336, 337, 340, 342, 344, and Court One, B Wing, shower room, and Central Supply room. Storwas removed from room 127.  4. Weekly audits of all doors needing closers will be completed by Maintens Director or Designee for four weeks, amonthly thereafter for 3 months to en that all door closers are in compliance Findings will be brought to the QAPI committee monthly for 3 months.	127, 4, 1, ated I ave De	
		ing a closure test of the n, 1-1/2 hour fire rated				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION 01	(X3) DATE COMF	SURVEY
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K 321 K 324 SS=E	self close and positive required. The survey 44 feet by 20 feet (88 larger than 50 square multiple combustible of the IMD and CVPES during the observation. The Administrator was the Life Safety exit consultation. NJAC 8:39-31.2 (e) Life Safety Code 101 Cooking Facilities.	rformed. The door did not e latch into its frame as or recorded the room was 0 square feet), which is feet. The room housed cardboard boxes.		321			10/22/22
	with NFPA 96, Standa and Fire Protection of Operations, unless: * residential cooking of appliances such as m toasters) are used for cooking in accordanc * cooking facilities ope compartments with 30 with the conditions un or * cooking facilities in s 30 or fewer patients of 18.3.2.5.4, 19.3.2.5.4 Cooking facilities protections	dicrowaves, hot plates, food warming or limited e with 18.3.2.5.2, 19.3.2.5.2 en to the corridor in smoke of or fewer patients comply ader 18.3.2.5.3, 19.3.2.5.3, smoke compartments with comply with conditions under					

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
K 324		.3.2.5.4, 19.3.2.5.1 through	K 32	24		
	by: Based on observation in the presence of the Director (IMD) and Continuous Environmental Service determined that the factor of the Environmental Service determined that the factor of the fallowing equipment with NFPA (National Fig. 1 working electric stort the following:  At 12:20 PM, the survicenter, across from universed the presentation of the survicenter of the survival of the surv	orporate Vice President of es (CVPES), it was acility failed to ensure that as protected in accordance Fire Protection Association) octice was evidenced for 1 of wes and was evidenced by reyor observed in the activity noccupied resident room		1.Regarding the facility's failure to that cooking equipment was protect accordance with NFPA 96, paper wimmediately removed from the top heating element.  2.All residents have the potential to affected by this deficient practice.  3.All heating elements were inspectent that nothing combustible was stored on top of the element and for be in compliance. Activities staff in-serviced on not placing any non-cooking equipment on a heating that cooking equipment on a final transfer to the total cooking equipment on a heating that cooking equipment on a heating equipment equipmen	eted in eted in eted in eted to es eted to es eted to	
	white paper was bein heating element of the An interview was con time of the observation	nately one inch stack of g stored on the left-back e working electric stove.  ducted with the IMD at the on, and he stated that should be stored on the		element.  4. Weekly audits of all heating elem will be completed by Maintenance I or Designee for four weeks, and mothereafter for 3 months to ensure the cooking equipment is in compliance Findings will be brought to the QAF committee monthly for 3 months.	Director onthly nat all e.	
	The Administrator wa observation at the Life conference on 08/29/	e Safety Code exit				
K 341 SS=E	NFPA 96 NJAC 8:39-31.2(e) NFPA 101-2012 : 19. Fire Alarm System - I		K 34	11	10/22/22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315280	B. WING _			08/	29/2022
	ROVIDER OR SUPPLIER	•		14	TREET ADDRESS, CITY, STATE, ZIP CODE 417 BRACE ROAD HERRY HILL, NJ 08034	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 341	components approve accordance with NF and NFPA 72, Nation provide effective was building. In areas no detection is installed unit. In new occupar at notification applia and supervising stat	Installation is installed with systems and led for the purpose in PA 70, National Electric Code, and Fire Alarm Code to rning of fire in any part of the it continuously occupied, at each fire alarm control lacy, detection is also installed lace circuit power extenders, ion transmitting equipment. iring or other transmission for integrity.	K3	341			
	by: Based on observati in the presence of fa determined that the supervised smoke/h with NFPA 101, 201; 9.6.1.8, NFPA 70, 2 2010 Edition. This c observed in 1 of 1 at the following:  During the tour of the the Corporate Vice F Services (CVPES) a Director (IMD), the s	T is not met as evidenced on and interview on 08/25/22, acility management, it was facility failed to install eat detection in accordance 2 Edition, Section 19.3.4.1, 011 Edition and NFPA 72, leficient practice was reas and was evidenced by the building, in the presence of President of Environmental and Interim Maintenance urveyor observed that the de supervised smoke/heat wing location:			1. Regarding the facility's failure to insupervised smoke/heat detection in accordance with NFPA 101. Vendor installed a smoke/heat detector within feet of the stove as required by code.  2. All residents have the potential to be affected by this deficient practice.  3. All areas in need of a smoke detect according to NFPA guidelines were for to be in compliance.  4. Weekly audits of all areas in need of smoke detectors will be completed by Maintenance Director or Designee for weeks, and monthly thereafter for 3 months to ensure that all areas in need smoke detectors have a smoke detectin place and are in compliance. Findin	20 e or und f four d of or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		` '	` ′		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315280	B. WING			08/	29/2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1417 BRACE ROAD  CHERRY HILL, NJ 08034		417 BRACE ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 341 K 351 SS=F	kitchen was performe no evidence of a smo feet of the stove as restricted in the time of observation. The Administrator was at the Life Safety Cod 08/29/22.  Fire Safety Hazard. NJAC 8:39 -31.2 (a). Sprinkler System - Inst CFR(s): NFPA 101  Spinkler System - Inst 2012 EXISTING Nursing homes, and home construction type, are approved automatic saccordance with NFP. Installation of Sprinkle In Type I and II construction type are permitted in the construction of Sprinkle In Type I and II constructions are permitted.	aspection inside the main d. The surveyor observed ke/heat detector within 20 equired by code.  confirmed the findings at ans.  s notified of the deficiency le exit conference on  stallation  nospitals where required by a protected throughout by an prinkler system in A 13, Standard for the		341	will be brought to the QAPI committee monthly for 3 months.		10/22/22
	or local regulations pr In hospitals, sprinkler closets of patient slee of the closet does not sprinkler coverage co required by NFPA 13, Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19 19.4.2, 19.3.5.10, 9.7	sohibit sprinklers. s are not required in clothes eping rooms where the area exceed 6 square feet and vers the closet footprint as Standard for Installation of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G <b>01</b>		(X3) DATE SURVEY COMPLETED	
		315280	B. WING			08/29/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
0111/EB 111				1417 BRACE ROAD			
SILVER HI	EALTHCARE CENTER			CHERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 351	Continued From page	e 15	K 3	51			
K 351	Based on observation other facility documer 08/25/22, it was deter to a.) provide proper areas of the facility, a sprinklers as required §483.90(a) physical eaccordance with their 2012 Edition, Section National Fire Protecti Installation of Sprinkle and as required by the Construction Code N. I-2 (health care) use of the deficient practice following,  Reference #2: Unifor Special detailed required occupancy section 40 Automatic sprinkler system in 903.3.1.1. The smoke equipped with approversidential sprinklers 903.3.2.  During the survey ent AM, a request was moment and smoke control and smoke contr	n, interview, and review of ntation on 08/24/22 and mined that the facility failed fire sprinkler coverage to all nd b.) properly install by CMS regulation environment to all areas in requirements of NFPA 101 19.3.5.1, 9.7, 9.7.1.1 and on Association (NFPA) 13 er Systems 2012 Edition, e New Jersey Uniform J.A.C. 5:23, for use group occupancy.  The Construction Code, irements based on use and 07 group I-2, [F] 407.5 ystem. Smoke ning patient sleeping units oughout with an automatic in accordance with Section e compartment shall be red quick-response or in accordance with section	K 3	1. Regarding the facility s failuprovide proper fire sprinkler covall areas of the facility, and proper sprinklers as required by CMS and in accordance with the requof NFPA 101. Maintenance immore placed the escutcheon caps of Pavilion building sunroom next 421, and 416, in the Pavilion building sunroom next 421, and 416, in the Pavilion building escutcheon caps missing from sprinkler heads, vendor contact repair. Maintenance also replace escutcheon caps in resident roc closet, and 328 closet. Maintenance immediately the tape on all sprinkler heads on Court One, B Wing. Maintenance replaced missing escutcheon caps in resident room 239. Maintenance replaced missing escutcheon caps in resident room 239. Maintenance replaced missing escutcheon caps in the kitchen's dry storage room. Vercalled to add fire sprinkler proteinside the HVAC closet in the kitchen's dry storage room. Vercalled to add fire sprinkler proteinside the HVAC closet in the kitchen the vendor, and was scheduled with the vendor, and was scheduled to add sprinkler in the kitchen HVAC closet to b compliance.  4. Weekly audits of all sprinkler be completed by Maintenance in Designee for four weeks, and not be completed by Maintenance.	verage to perly install regulations uirements nediately missing in to rooms uilding main g two fire ted to ced missing oms 308 nance of the Pantry / removed in rooms nance ap in the ndor was ection itchen. The ced were en will be to verage er in the neds will Director or		
	(3) buildings that were Atrium, the Pavilion a	e connected together, the nd the Court buildings. The veyor that there was a		thereafter for 3 months to ensu areas in need of sprinkler head them in place and are in compli	re that all s have		

TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  K 351  Continued From page 16  Dialysis Unit in the building.  On 08/24/22 and 08/25/22 a tour of the building with the Corporate Vice President of Environmental Services (CVPES) and IMD was performed. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations:  On 8/24/22,  1) At 10:02 AM, in the Pavilion building sunroom (next to resident room #421) one fire sprinkler head had no escutcheon cap leaving a 1/4 of an inch gap in the ceiling tile.  2) At 10:05 AM, in the Pavilion building sunroom (next to Resident room #416) one fire sprinkler head had no escutcheon cap leaving a 3/8 of an inch gap in the ceiling tile.  3) At 10:06 AM, in the Pavilion building main Dining/Activity room high ceiling had two (2) fire sprinkler heads missing escutcheon caps leaving	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01			E SURVEY IPLETED	
SILVER HEALTHCARE CENTER    SILVER HEALTHCARE CENTER   SILVER HEALTHCARE CENTER   SILVER HEALTHCARE CENTER   SILVER HEALTHCARE CENTER   SILVER HEALTHCARE CENTER   SILVER HEALTHCARE CENTER			315280	B. WING _		<del></del>	0:	3/29/2022
PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY			•		14	117 BRACE ROAD		
Dialysis Unit in the building.  On 08/24/22 and 08/25/22 a tour of the building with the Corporate Vice President of Environmental Services (CVPES) and IMD was performed. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations:  On 8/24/22,  1) At 10:02 AM, in the Pavilion building sunroom (next to resident room #421) one fire sprinkler head had no escutcheon cap leaving a 1/4 of an inch gap in the ceiling tile.  2) At 10:05 AM, in the Pavilion building sunroom (next to Resident room #416) one fire sprinkler head had no escutcheon cap leaving a 3/8 of an inch gap in the ceiling tile.  3) At 10:06 AM, in the Pavilion building main Dining/Activity room high ceiling had two (2) fire sprinkler heads missing escutcheon caps leaving	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
gaps in the ceiling tiles and one (1) fire sprinkler head hanging down three inches, leaving a 1/2 inch gap between the escutcheon cap and ceiling tile.  4) At 11:38 AM, resident room #308's closet had one (1) fire sprinkler head with no escutcheon cap leaving a 1/4 of an inch gap in the wall board ceiling.  5) At 12:27 PM, resident room #328's closet had one (1) fire sprinkler head with no escutcheon cap leaving a 3/4 of an inch gap in the wall board ceiling.  6) At 12:58 PM, the Pantry area fire sprinkler	K 351	Dialysis Unit in the b On 08/24/22 and 08/ with the Corporate V Environmental Service performed. Along the that the facility failed sprinkler protection in On 8/24/22, 1) At 10:02 AM, in the (next to resident rook head had no escutch inch gap in the ceilin 2) At 10:05 AM, in the (next to Resident rook head had no escutch inch gap in the ceilin 3) At 10:06 AM, in the Dining/Activity room sprinkler heads missing gaps in the ceiling till head hanging down inch gap between the tile.  4) At 11:38 AM, resione (1) fire sprinkler cap leaving a 1/4 of a ceiling.  5) At 12:27 PM, resione (1) fire sprinkler cap leaving a 3/4 of a ceiling.	uilding.  25/22 a tour of the building fice President of ces (CVPES) and IMD was e tour, the surveyor observed to provide proper fire in the following locations:  The Pavilion building sunroom in #421) one fire sprinkler theon cap leaving a 1/4 of an ing tile.  The Pavilion building sunroom with #416) one fire sprinkler theon cap leaving a 3/8 of an ing tile.  The Pavilion building main high ceiling had two (2) fire sing escutcheon caps leaving es and one (1) fire sprinkler three inches, leaving a 1/2 in escutcheon cap and ceiling in the wall board in the dad with no escutcheon an inch gap in the wall board in the wa	K	351			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED		
		315280	B. WING	<del> </del>	08/29/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1417 BRACE ROAD  CHERRY HILL, NJ 08034	1 00/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
K 351	ceiling tile.  On 8/25/22,  7) An inspection of 19 of 21 resident rook heads in each room covering the frangible heads. These sprint properly in the event 8) At 12:09 PM, insifire sprinkler head haleaving a 3/8 of an inceiling.  9) At 10:32 AM, insifire sprinkler head haleaving a 3/8 of an inceiling.  9) At 10:32 AM, insifire sprinkler head haleaving a 3/8 of an inceiling.  10) At 10:25 AM, insifire sprescutcheon cap leav wallboard ceiling.  10) At 10:25 AM, insifire surveyor observed in protection inside the feet long Heating, Verloset. At this time, CVPES, do you see The CVPES looked in the time of observation.	Court One, B Wing, revealed oms had two (2) fire sprinkler that had masking tape e glass of the sprinkler klers would not function of a fire.  de resident room #239, the ad no escutcheon cap in the wallboard  de the Kitchen's dry storage rinkler head had no ring a 1/2 inch gap in the  side the main Kitchen, the o evidence of a fire sprinkler 27 inch deep by seven (7) entilation and Air Conditioning the surveyor asked the a fire sprinkler in the closet. Inside and said, "No."	K 35	51		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		315280	B. WING		08/29/2022	
	ROVIDER OR SUPPLIER  EALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1417 BRACE ROAD  CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
K 351	Continued From page NJAC 8:39-31.1(c), 3		K 35	1		
K 372 SS=E	NFPA 13. Subdivision of Buildin	g Spaces - Smoke Barrie	K 37	2	10/22/22	
	Construction 2012 EXISTING Smoke barriers shall fire resistance rating permitted to termine Smoke dampers are repenetrations in fully dan approved sprinkler smoke compartments barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanin REMARKS. This REQUIREMENT by: Based on observation documentation on 08/determined that the faintegrity of smoke barsmoke barrier walls a following:  During the survey ent AM, a request was mand smoke confacility layout which rooms and smoke confacility provided layout 19 smoke zones in the During a tour of the barriers.	not required in duct ucted HVAC systems where r system is installed for adjacent to the smoke  lical smoke control system  is not met as evidenced in and review of other facility (24/22 and 08/25/22, it was acility failed to maintain the rier partitions for 2 of 14 is evidenced by the  rance on 08/24/22 at 8:50 adde to the Interim (IMD) to provide a copy of the identified the various impartments. A review of the t identified that there were		1. Regarding the facility s failure to maintain the integrity of smoke barrier partitions for 2 of 14 smoke barrier was The penetrations on Court One and Atrium area were sealed.  2. All residents have the potential to be affected by this deficient practice.  3. All smoke barrier walls were check for penetrations to determine if any of areas were affected.  4. Weekly audits of smoke barriers we completed by Maintenance Director of Designee for four weeks, and monthly thereafter for 3 months to ensure that areas in need of smoke barriers have them in place and are in compliance. Findings will be brought to the QAPI	ed ther sill be or y	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G <b>01</b>		OATE SURVEY OMPLETED	
		315280	B. WING _			08/29/2022
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 1417 BRACE ROAD CHERRY HILL, NJ 08034	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
K 372	and IMD, an inspectitiles of 14 fire/smoke. The surveyor observe barrier walls failed to fire-rated construction following locations:  1. On 8/24/22 at 11: in the Atrium building where the generator located) the surveyor tiles of the corridor of 1-1/2 inch by 1-1/2 in running through the  2. On 8/25/22 at 12:: One, B Wing, identified doors, the surveyor approximately eight two inch, one (1) approximate one inch penetration plastic coated wires barrier walls.  These penetrations of through the smoke be was not sealed close and fire from passing compartment.  The CVPES and IMI the time of observations was a construction of the surveyor of the smoke be was not sealed close and fire from passing compartment.	mental Services (CVPES) ion above the corridor ceiling be barrier walls was performed. Wed the following smoke or maintain the 1/2 hour on as required by code in the  1.52 AM, during an inspection of (next to the nurses station of cannunciator panel is or observed, above the ceiling oliuble smoke doors, one onch hole with two black wires smoke barrier wall.  36 PM, an inspection of Court ited above the corridor smoke observed one (1) inch, one (1) approximately oroximately three inch, and ly six inch by approximately is with various BX cables and running through the smoke  were observed on both sides overrier walls, indicating that it ed to prevent smoke, fumes of through to the other smoke	К3	committee monthly for	3 months.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED		
		315280	B. WING _			08/	29/2022	
	ROVIDER OR SUPPLIER		1	14	TREET ADDRESS, CITY, STATE, ZIP CODE 417 BRACE ROAD HERRY HILL, NJ 08034	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 372	Continued From page 20 Fire Safety Hazard. NJAC 8:39- 31.2(e).		K	372				
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie			K 374			11/17/22	
	Doors 2012 EXISTING Doors in smoke barrich bonded wood-core do resists fire for 20 min plates of unlimited he are permitted to have assemblies per 8.5. Eautomatic-closing, do are not required to swegress travel. Door of clear width of 32 inchedoors. 19.3.7.6, 19.3.7.8, 19.3.7.8, 19.3.7.6, 19.3.7.8, 19.3.7	Doors are self-closing or not require latching, and ving in the direction of pening provides a minimum es for swinging or horizontal 0.3.7.9  To is not met as evidenced on and review of other facility 1/24/22 and 08/25/22, in the			1. Regarding the facility □s failure to maintain smoke barrier doors to resist transfer of smoke. Maintenance adjust the doors on Court 1 to ensure that the is no gap between the smoke doors. Vendor contacted to repair smoke doo on Court 2 to ensure that there is no gabetween smoke doors. Vendor came out and repaired all smo doors on court 2 to ensure that there is gap between smoke doors.  2. All residents have the potential to be affected by this deficient practice.  3. All smoke barrier doors were checked for proper closing to determine if any other areas were affected.	ed ere rs ap ke s no		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION  1		(X3) DATE SURVEY COMPLETED	
		315280	B. WING _			08/	/29/2022	
	ROVIDER OR SUPPLIER  EALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 1417 BRACE ROAD CHERRY HILL, NJ 08034				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE		
K 374	AM, a request was m Maintenance Directo the facility layout whi rooms and smoke co facility provided layou (3) buildings that wer Atrium, the Pavilion a IMD also told the sur Dialysis Unit in the bufourteen (14) sets of barrier doors in the the Later, in the presence Vice President of Env (CVPES) and IMD, a performed. The survof the fourteen (14) s doors in the corridors of the fourteen (14) s doors in the corridors of the fourteen (14) s doors in the corridors of the fourteen (14) s doors in the corridors of the fourteen (14) s doors in the corridors of the fourteen (14) s doors in the corridors of the fourteen (14) s doors in the corridors of the fourteen (14) s doors in the corridors of the surveyor into their frame not close into the not	trance on 08/23/22 at 8:50 made to the Interim r (IMD) to provide a copy of ch identified the various impartments. A review of the at identified there were three are connected together, the and the Court buildings. The veyor that there was a cuilding. The facility had corridor double smoke incee buildings.	K	374	4. Weekly audits of smoke barrier doo will be completed by Maintenance Dire or Designee for four weeks, and mont thereafter for 3 months to ensure that areas in need of smoke barrier doors have them in place and are in complia Findings will be brought to the QAPI committee monthly for 3 months.	ector hly all		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>			(X3) DATE SURVEY COMPLETED	
		315280	B. WING			08/	29/2022
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 417 BRACE ROAD CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 374 K 511 SS=E	the transfer of smoke gap greater than 1/8 meeting edges. The recorded a 3/8 of an imeeting edges near to This test was repeated the same results.  This would allow the poisonous gasses to compartment to another than the time of observation.  The CVPES and IMD the time of observation.  The Administrator was at the Life Safety Cool 08/29/2022.  N.J.A.C. 8:39-31.1(c) Utilities - Gas and Electrical complies with NFPA 5 electrical wiring and 6 NFPA 70, National Electrical size of the recorded and r	aled it was not resistant to . The surveyor observed a of an inch between the surveyor measure and nch gap between the he bottom of the doors. In two additional times with transfer of smoke, fire and pass from one smoke her in the event of a fire.  confirmed the findings at ons.  Is notified of the deficiency de exit conference on  31.2(e)  extric  cetric  or related gas piping 54, National Fuel Gas Code, equipment complies with ectric Code. Existing inue in service provided no		511			10/28/22
	This REQUIREMENT	is not met as evidenced					

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED			
		315280	B. WING _			08/	29/2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1417 BRACE ROAD  CHERRY HILL, NJ 08034		117 BRACE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 531 SS=E	on 08/25/22, in the primaintenance Director President of Environing was determined that the and maintain gas pipi 54, National Electric (1) This deficient practice observed gas line instevidenced by the followard of the followard of the service observed in the facility approximately 50' of expipe, Corrugated Stail was installed from the tothe upper ceiling all room. The CSST was above and was observed or installation floor and was installed unprotected.  The IMD and CVPES during the observation of the Life Safety Code of NJAC 8:39-31.2(e) NFPA 70 Elevators	n and interview conducted esence of the Interim (IMD) and Corporate Vice nental Services (CVPES), it the facility failed to install ng that complied with NFPA Code.  was evidenced for 1 of 1 tallations and was eving:  By AM, the surveyor y laundry wing, that exposed yellow flexline gas nless Steel Tubing (CSST), four (4) commercial dryers rea through the supply/break then installed to the floor eved to not have the required from one floor to another d through the concrete floor		531	1. Regarding the facility's failure to ins and maintain gas piping that complied with NFPA 54, National Electric Code. Maintenance staff installed Corrugated Stainless-Steel Tubing as required for exposed flex line gas pipe in the laundroom area.  2. All residents have the potential to be affected by this deficient practice.  3. All other gas lines were checked to determine that they were in compliance and had the proper tubing.  4. Weekly audits of gas lines will be completed by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that a gas lines have proper tubing on them a are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	he y e	12/23/22
	NFPA 70 Elevators CFR(s): NFPA 101 Elevators		K !	531			12/23/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG <b>01</b>	(X3) DATE SURVEY COMPLETED
		315280	B. WING _		08/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1417 BRACE ROAD CHERRY HILL, NJ 08034	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
K 531	Elevators are inspect ASME A17.1, Safety Escalators. Firefights monthly with a writte Existing elevators co Safety Code for Exis Escalators. All existing distance of 25 feet of level that best serves personnel for firefighter's Service A17.3. (Includes firefighter's Service Foperation, machine relevator lobby smoked 19.5.3, 9.4.2, 9.4.3. This REQUIREMENT by:  Based on interview adocumentation on 08 Interim Maintenance Corporate Vice Preside Services (CVPES), it facility failed to test annually with the Net Community Affairs Distandards Elevator Spractice was evidence A review of the facility certificate, revealed to devices were marked Certificate Occupant devices #1 and #2. Tile 12/31/20 was good to the service of the facility and the facility certificate Occupant devices #1 and #2. Tile 12/31/20 was good to the facility of the facility and the facility of the facility devices were marked the facility of the fac	the the provision of 9.4.  Ited and tested as specified in Code for Elevators and er's Service is operated in record.  Inform to ASME/ANSI A17.3, ting Elevators and ing elevators, having a travel or more above or below the set the needs of emergency ting purposes, conform with Requirements of ASME/ANSI inghter's service Phase I key rector automatic recall, whase II emergency in-car key soom smoke detectors, and ite detectors.)  It is not met as evidenced and review of other facility 8/25/22, in the presence of Director (IMD) and dent of Environmental is was determined that the land inspect the elevator in Jersey Department of invision of Codes and Safety Division. This deficient ited by the following:  y's elevator inspection that 2 of 2 hydraulic elevator	K	1. Regarding the facility s failure complete annual elevator inspectifacility contacted the elevator ven schedule repairs and inspection. It technician arrived onsite 10/28/22 address the violations to allow the inspection to be scheduled. Inspectived on and Completed inspective arrived on and Completed inspective 11/21/22 and elevator passed insupplemental affected by this deficient practice. 3. All elevators were checked and proper working condition at the tir repairs are in progress and inspectively in the scheduled once repairs has completed on the elevator in quest. Weekly audits of elevator inspections.	ion. The dor to Elevator 2 to ector ction on pection. ate of to be d were in me, ctions ve been stion.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		NSTRUCTION	(X3) DATE COMP	SURVEY
		315280	B. WING _			08/	29/2022
	ROVIDER OR SUPPLIER			1417	ET ADDRESS, CITY, STATE, ZIP CODE BRACE ROAD RRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 712 SS=F	due.  During an interview, a stated he will communelevator vendor and Daffairs to schedule and possible.  The Administrator was the Life Safety Code of NJAC 8:39-31.2(e) NFPA 101 Life Safety Elevator Testing 9.4.6.3 (2) Fire Drills CFR(s): NFPA 101  Fire Drills Fire drills include the signal and simulation conditions. Fire drills a unexpected times uncleast quarterly on each with procedures and i established routine. Note the designal and simulation conditions are designed and simulation conditions. Fire drills a unexpected times uncleast quarterly on each with procedures and i established routine. Note the designation of the design	Imost eight months past  It 11:30 AM, the CVPES nicate with their contracted Department of Community Inspection as soon as  Is informed of this issue at exit conference on 08/29/22.  Code 2012 edition 9.4.6  It ansmission of a fire alarm of emergency fire are held at expected and der varying conditions, at h shift. The staff is familiar is aware that drills are part of Where drills are conducted 16:00 AM, a coded e used instead of audible	K 7	ra E n ttl iri F c	ecords will be completed by Maintenar Director or Designee for four weeks, ar nonthly thereafter for 3 months to ensure that all elevators are up to date on inspections and are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	nd ure	9/9/22
		m Maintenance Director Vice President of		ir	ndicate the transmission of a fire alarm signal. The facility immediately contact he fire alarm vendor to troubleshoot th	n ed	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE S COMPL	
	315280	B. WING		08/2	29/2022
			STREET ADDRESS, CITY, STATE, ZIP CODE  1417 BRACE ROAD  CHERRY HILL, NJ 08034		
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
determined that the failed to indicate the failed to indicate the alarm signal was not facility in accordance Edition, Section 19 deficient practice of was evidenced by the CVPS and facility had three set they currently do not extraction performed and locations are as the findings were set the findings were set they currently do not extraction performed and locations are as they currently do not extraction performed and locations are as they currently do not extraction performed and locations are as they currently do not extraction performed and locations are as they currently do not extraction performed and locations are as they currently do not extraction performed and locations are as they currently do not extract the times of the currently do not extract the cu	e facility fire alarm vendor, at the transmission of a fire of activated throughout the ce with NFPA 101, 2012.7.1.4 through 19.7.1.7. The ould affect all residents and the following:  urveyor reviewed the facility ports which revealed that in the e and Two and the Pavilion, on of the fire alarm was fire alarm vendor document ility." The system was tested it was confirmed that the eparate fire alarm panels and of communicate with each offirmed with a system d by the CVPES. The systems is follows:  Honeywell panel- location  Hochiki panel- location Boiler  Verified by the IMD and CVPES observations.  Vas notified of the deficiency at the exit conference on 08/29/22.		issue. The facility initiated fire watch immediately until the repairs could be made to connect all fire alarm panels fire alarm panels were connected by vendor and confirmed to be communicating properly between the panels by activating the fire alarm in areas of the different panels.  2. All residents have the potential to affected by this deficient practice.  3. All individual fire alarm panels were checked and were in proper working condition in each area, and fire watch initiated immediately until the fire alarmels could be linked together.  4. Weekly audits of fire alarm panel communication will be completed by Maintenance Director or Designee for weeks, and monthly thereafter for 3 months to ensure that all fire alarm pare communicating properly and are compliance. Findings will be brought the QAPI committee monthly for 3 months.	The the 3 all 3 be e was m r four anels in to	10/22/22
Smoking Regulatio	iis	K /2	* 1		10/22/22
	SUMMARY (EACH DEFICIEIN REGULATORY OF CONTINUED FROM PARTY OF CONTINUED FROM P	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26 determined that the facility fire alarm vendor, failed to indicate that the transmission of a fire alarm signal was not activated throughout the facility in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. The deficient practice could affect all residents and was evidenced by the following:  On 08/25/22, the surveyor reviewed the facility fire drill monthly reports which revealed that in the Atrium, Courts One and Two and the Pavilion, that the transmission of the fire alarm was checked off on the fire alarm vendor document "throughout the facility." The system was tested by the CVPES and it was confirmed that the facility had three separate fire alarm panels and they currently do not communicate with each other. This was confirmed with a system activation performed by the CVPES. The systems and locations are as follows:  1. Honeywell panel- location Boiler room  3. Simplex panel- location Boiler room  The findings were verified by the IMD and CVPES at the times of the observations.  The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22.  NJAC 8:39-31.2(e)  NFPA 101 Life Safety Code 2012 edition 19.7.1.4	A BUILDIN  315280  B. WING  SOVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26  determined that the facility fire alarm vendor, failed to indicate that the transmission of a fire alarm signal was not activated throughout the facility in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. The deficient practice could affect all residents and was evidenced by the following:  On 08/25/22, the surveyor reviewed the facility fire drill monthly reports which revealed that in the Atrium, Courts One and Two and the Pavilion, that the transmission of the fire alarm was checked off on the fire alarm vendor document "throughout the facility." The system was tested by the CVPES and it was confirmed that the facility had three separate fire alarm panels and they currently do not communicate with each other. This was confirmed with a system activation performed by the CVPES. The systems and locations are as follows:  1. Honeywell panel- location Court Kitchen 2. Hochiki panel- location Boiler room 3. Simplex panel- location Boiler room The findings were verified by the IMD and CVPES at the times of the observations.  The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22.  NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	A BUILDING 01  BUNDER OR SUPPLIER  SALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEPOILENCY MUST BE PRECEDED BY STILL REGULATORY OR LSG IDENTIFYING INFORMATION)  Continued From page 26  determined that the facility fire alarm vendor, failed to indicate that the transmission of a fire alarm signal was not activated throughout the facility in accordance with NFPA 101, 2012  Edition, Section 19.7.1.4 through 19.7.1.7. The deficient practice could affect all residents and was evidenced by the following:  On 08/25/22, the surveyor reviewed the facility fire drill monthly reports which revealed that in the Atrium, Courts One and Two and the Pavilion, that the transmission of the fire alarm was checked off on the fire alarm vendor document "throughout the facility" had three separate fire alarm panels and they currently do not communicate with each other. This was confirmed with a system activation performed by the CVPES. The systems and locations are as follows:  1. Honeywell panel- location Boiler room  3. Simplex panel- location Boiler room  The findings were verified by the IMD and CVPES at the times of the observations.  The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22.  NJAC 8.39-31.2(e)  NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	A BULDING 81  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26  determined that the facility fire alarm vendor, failed to indicate that the transmission of a fire alarm signal was not activated through 19.7.1.7. The deficient practice could affect all residents and was evidenced by the following:  On 08/25/22, the surveyor reviewed the facility fire drill monthly reports which revealed that in the Artium. Courts One and Two and the Pavilion, that the transmission of the fire alarm was checked off on the fire alarm was checked for the fire alarm was they currently do not communicate with each other. This was confirmed with a system activation performed by the CVPES. The systems and locations are as follows:  1. Honeywell panel- location Court Kitchen 2. Hochiki panel- location Boiler room 3. Simplex panel- location Boiler room The findings were verified by the IMD and CVPES at the times of the observations.  The Administrator was notified of the deficiency at the Life Safety Code exit conference on 08/29/22.  NJAC 8.39-31.2(e)  NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	TIPLE CONSTRUCTION (X3) DATE SUICOMPLET		
		315280	B. WING		08/29/2022	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  1417 BRACE ROAD  CHERRY HILL, NJ 08034	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
K 741	include not less than (1) Smoking shall be ward, or compartment combustible gases, of and in any other haz area shall be posted SMOKING or shall be international symbol (2) In health care occuprohibited and signs major entrances, see that prohibits smokin (3) Smoking by patie responsible shall be (4) The requirement where the patient is (5) Ashtrays of noncup design shall be provi- smoking is permitted (6) Metal containers devices into which as be readily available to permitted. 18.7.4, 19.7.4  This REQUIREMENT by: Based on observation in the presence of the Director (IMD) and Cenvironmental Servi- failed to maintain smowith the requirement	shall be adopted and shall the following provisions: prohibited in any room, at where flammable liquids, or oxygen is used or stored ardous location, and such with signs that read NO e posted with the for no smoking. cupancies where smoking is are prominently placed at all condary signs with language g shall not be required. Into classified as not prohibited. Of 18.7.4(3) shall not apply under direct supervision. In ombustible material and safe ded in all areas where shtrays can be emptied shall to all areas where smoking is  T is not met as evidenced  In and interview on 08/25/22, the Interim Maintenance corporate Vice President of ces (CVPES), the facility tooking areas in accordance of NFPA 101, 2012 Edition, practice of dumping cigarette	K 7-	1. Regarding the facility's failure to maintain smoking areas in accordan with the requirement of NFPA 101. T practice of dumping cigarette butts a ash into trashcans with other combustibles, increased the risk of fi facility occupants. The facility checke the placement of approved ashtrays	re to ed on	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		E CONSTRUCTION 11	(X3) DATE	SURVEY PLETED
		315280	B. WING			08	/29/2022
	ROVIDER OR SUPPLIER		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 417 BRACE ROAD CHERRY HILL, NJ 08034	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	occupants. This defice for 1 of 1 smoking are evidenced by the follow. At 11:48 AM, the survobserved, in the smot salon atrium, a trash/cups, gloves, cigarett together. The contain astray for disposal of no approved self-close containers for the dispashes.  The finding was verificat the time of the observed that the time of the observed that the time of the observed that the Life Safety Code (NJAC 8:39-31.2(e)) Electrical Systems - Formatten and the served that the served t	sed the risk of fire to facility ient practice was evidenced eas observed and was owing:  reyor, IMD and CVPES king courtyard by the beauty garbage container with e butts and ash mixed er was not an approved cigarette butts. There were sing covered metal posal of cigarette butts and ed by the IMD and CVPES ervation.  s informed of the finding at exit conference on 08/29/22.		912	smoking area in the Atrium, and Activit staff who conduct supervised smoking were re-educated about proper dispose of cigarette butts, and use of ashtrays.  2. All residents have the potential to be affected by this deficient practice.  3. The placement of the ashtray was checked for the smoking area to ensurthat the proper disposal of cigarette bu would be completed.  4. Weekly audits of the smoking area we be completed by Maintenance Director Designee for four weeks, and monthly thereafter for 3 months to ensure that ashtrays are in place and cigarette disposal is done in compliance. Finding will be brought to the QAPI committee monthly for 3 months.	e tts vill or	10/22/22
SS=E	highly dependable gramaintaining low-contaplug. In pediatric locarooms, bathrooms, plrooms, other than nuitamper-resistant or elfused in patient care interrupters (GFCI) at 6.3.2.2.6.2 (F), 6.3.2.	ave at least one, separate, counding pole capable of act resistance with its mating tions, receptacles in patient ay rooms, and activity reseries, are listed mploy a listed cover.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG <b>01</b>	(X3) DATE COMP	SURVEY LETED
		315280	B. WING _		08/	29/2022
NAME OF P	ROVIDER OR SUPPLIER	•	i I	STREET ADDRESS, CITY, STATE	, ZIP CODE	
SII VER H	EALTHCARE CENTER			1417 BRACE ROAD		
OILVLIXII	LALITIOANE GENTEN			CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
K 912	Continued From pag	e 29	K	012		
K 912	Based on observation documentation on 08 presence of facility metermined that the fof 7 electrical outlets source was equipped Ground-Fault Circuit protection. This deficibly the following:  During the survey en AM, a request was maintenance Directo the facility layout whi rooms and smoke confacility provided layout (3) buildings that wer Atrium, the Pavilion of Confacility provided layout (3) buildings that wer Atrium, the Pavilion of Environmy was performed. During the surveyor of (7) electrical outlets (wet locations with a Confacility, the surveyor of (7) electrical outlets (wet locations with a Confacility was performed. During the surveyor of (8/24/22 at 12:11 Salon, when the surveyor electrical outlet locations with a Confacility washing sink with de-energize, the outlive equired by code.	on and review of other facility 8/24/22 and 08/25/22, in the nanagement, it was facility failed to ensure that 1 located next to a water divide with proper working Interrupter (GFCI) sient practice was evidenced attrance on 08/24/22 at 8:50 nade to the Interim r (IMD) to provide a copy of chidentified the various ompartments. A review of the lutidentified there were three are connected together, the land the Court buildings.  at 9:43 AM, a tour of the land Corporate Vice mental Services (CVPES) ing the two-day tour of the lobserved and tested seven (within four feet of a sink) in GFCI tester to de-energize  PM, inside the Atrium Beauty reyor tested one duplex ed 42 inches to the left of a h a GFCI tester to et did not de-energize as	KS	1. Regarding the facil ensure that 1 of 7 electors a water source proper working Groun Interrupter (GFCI) prowas replaced with a Gimmediately as require 2. All residents have the affected by this deficie 3. All other GFCI outleand were confirmed to working condition.  4. Weekly audits of GFC completed by Mainten Designee for four weethereafter for 3 months GFCI outlets are in cowill be brought to the GMC monthly for 3 months.	etrical outlets located was equipped with d-Fault Circuit tection. The outlet eFCI outlet ed. he potential to be ent practice. ets were checked o be in proper FCI outlets will be nance Director or eks, and monthly s to ensure that empliance. Findings QAPI committee	
	The Administrator wa	as notified of the deficiency at				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION 1	(X3) DATE COMP	SURVEY LETED
		315280	B. WING			08/	29/2022
	ROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 417 BRACE ROAD HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 912	' '	e 30 exit conference on 08/29/22.	K	912			
K 915 SS=F	NJAC 8:39 -31.2 (e) NFPA 99 Electrical Systems - E CFR(s): NFPA 101	Essential Electric Syste	K	915			10/27/22
	Categories *Critical care rooms (celectrical system failurinjury or death of patienth where electric life supare served by a Type *General care rooms electrical system failurinjury to patients (Cat Type 1 or Type 2 EES *Basic care rooms (C system failure is not lipatients and rooms of are not required to be EES life safety branch power that will be effe 3.3.138, 6.3.2.2.10, 699), TIA 12-3 This REQUIREMENT by: Based on observation other facility documer presence of the Interi (IMD) and Corporate Environmental Service determined that the facility documer presence of the Interi determined that the facility determined the facility determined that the facility determined the facility determined that the faci	re is likely to cause major ents, including all rooms oper equipment is required, 1 EES. (Category 2) in which re is likely to cause minor egory 2) are served by a s. ategory 3) in which electrical			1. Regarding the facility's failure to provide a Type 1 Essential Electrical System in accordance with NFPA 99. Generator company identified Type 1 Etransfer switch and it has been clearly labeled and is in compliance with TYPE ESS (NFPA Essential Electrical System Classification Type).  2. All residents have the potential to be	≣ 1 1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION 1		E SURVEY PLETED
		315280	B. WING			08	3/29/2022
	ROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 417 BRACE ROAD HERRY HILL, NJ 08034	,	. — V. — V — —
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 915	At approximately 11:0 observed all docume for record review. The inspection dated 04/2 information on "Esset Design Standards." To Ventilator (vent) unit (NFPA Essential Electrype) system.  At approximately 12:1 interviewed the CVPE was not sure if the cuthe vent unit was a Telectrical System Clata At approximately 1:15 facility, the surveyor, locate the required the divided as follows:  1) L 2) C 3) E (Each branch is 1-transfer switch)  The Administrator was the Life Safety Code  *Critical care rooms (electrical system failuinjury or death of patility in the surveyor of the system failuinjury or death of patility in the surveyor of the system failuinjury or death of patility in the surveyor of the system failuinjury or death of patility in the surveyor of the system failuinjury or death of patility in the surveyor of the system failuing or death of patility of the system failuing of	20 AM, the surveyor ints provided by the facility a provided electrical annual 29/22 did not provide any intial Electrical System. The facility currently had a sthat required a TYPE 1 ESS strical System Classification.  15 PM, the surveyor ES who indicated that he irrent electrical system for YPE 1 ESS (NFPA Essential assification Type) system.  5 PM, while touring the IMD and CVPES could not ree branch panels that are  Life Safety Critical Equipment  5 required to have at least  15 sinformed of the findings at exit conference on 08/29/22.  Category 1) in which irre is likely to cause major ents, including all rooms oport equipment is required,	K	915	affected by this deficient practice.  3. All other transfer systems have bee checked by the generator company to ensure that they are in compliance wit the TYPE 1 ESS (NFPA Essential Electrical System Classification Type).  4. Weekly audits of all electrical system will be completed for TYPE 1 ESS (NFEssential Electrical System Classificat Type) by Maintenance Director or Designee for four weeks, and monthly thereafter for 3 months to ensure that electrical systems are in compliance. Findings will be brought to the QAPI committee monthly for 3 months.	ns FPA ion	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING <b>01</b>	(>	X3) DATE COMP	
		315280	B. WING			08/2	29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1417 BRACE ROAD CHERRY HILL, NJ 08034	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	E	(X5) COMPLETION DATE
K 915	Continued From page NFPA 99- 6.7.5.1.1 6.7.5.1.3* Critical Bra 6.7.5.1.4 Equipment I 6.7.5.1.2 Life Safety I	nch Branch Branch		915			44/47/00
K 918 SS=F	CFR(s): NFPA 101  Electrical Systems - E Maintenance and Tes The generator or oth and associated equip service within 10 secc criterion is not met du process shall be prov capability for the life s Maintenance and test transfer switches are with NFPA 110. Generator sets are in under load 30 minute day intervals, and exe months for 4 continuo under load conditions simulated cold start a transfer of all EES loa competent personnel stored energy power accordance with NFP circuit breakers are in program for periodica components is establ manufacturer requirer maintenance and test readily available. EES circuits are marked, re separate from normal	er alternate power source ment is capable of supplying onds. If the 10-second ring the monthly test, a ided to annually confirm this rafety and critical branches. Fing of the generator and performed in accordance spected weekly, exercised as 12 times a year in 20-40 ercised once every 36 fous hours. Scheduled test include a complete and automatic or manual ads, and are conducted by Maintenance and testing of sources (Type 3 EES) are in A 111. Main and feeder spected annually, and a lly exercising the ished according to ments. Written records of cing are maintained and cedily identifiable, and power circuits. Minimizing age of the emergency power	K	918			11/17/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED
		315280	B. WING		08/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1417 BRACE ROAD  CHERRY HILL, NJ 08034	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
K 918	111, 700.10 (NFPA 70 This REQUIREMENT by: Based on observation other facility document presence of the Interior (IMD) and Corporate Environmental Service determined that the fatime needed by their to the building was with time in accordent ensure that a remote generator was provide requirements of NFP 5.6.5.6 and 5.6.5.6.1 the required load barronce every 36 month.  This deficient practice generator logs provide President of Environments of NFP 1.0 on 08/25/22, a regenerator records for did not reveal documnum generator would start building within ten sewas performing a more every and the sewas	FPA 99), NFPA 110, NFPA  2)  This not met as evidenced  In, interview, and review of entation on 08/25/22, in the emm Maintenance Director  Vice President of theses (CVPES), it was eacility failed to a.) certify the generator to transfer power eithin the required 10-second ance with NFPA 99 for generator systems, b.)  In manual stop station for the ed in accordance with the PA 110, 2010 Edition, Section et al., and c.) failed to conduct the test for 1 of 4 generators, as for 4 continuous hours.  The was evidenced for 4 of 4 ed by the Corporate Vice mental Services (CVPES)  Where of the facility's the previous twelve months, ented certification that the enter and transfer power to the conds. Currently, the IMD enthly load test, but he was uired transfer times on the	K 91	1. Regarding the facility □s failure to certify the time needed by their gene to transfer power to the building was within the required 10- second time f in accordance with NFPA 99 for emergency electrical generator systeb.) ensure that a remote manual stop station for the generator was provide accordance with the requirements of NFPA 110, and c.) failed to conduct trequired load bank test for 1 of 4 generators, once every 36 months for continuous hours. Generator log upd to note the time of the transfer. Generator log upd to note the time of the transfer. Generator log upd to note the time of the transfer. Generator log upd to note the time of the transfer. Generator log upd to note the time for the potential to affected by this deficient practice.  3. All other generators were inspected ensure that the time frame for transfer power is within the acceptable time from Generator log updated to note the time frame for transfer. Generator company instremote manual stop stations for all generators. 4-hour load bank test was conducted for all generators by vend 4. Weekly audits of all generators will completed by Maintenance Director of Designee to ensure the transfer time remote manual stop station, and load the property of the p	rator rame, rame, ms, od in he r 4 ated rator ed boad t was be d to er rame. he of alled s or. l be or
		ducted with the CVPES at riew, who confirmed no		bank tests are completed and in place four weeks, and monthly thereafter for	e for

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		LE CONSTRUCTION (X3) DATE SU COMPLE		
		315280	B. WING _			08/	29/2022
	ROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 117 BRACE ROAD HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 918	provided for four of for 2). On 08/25/22 at 12 and CVPES observed four generators did hashutoff.  An interview was concobservation with the I unaware that the four have a remote manual inadvertent or uninter (remote) of the encloss mover.  3.) At 12:15 PM, reco Genset 80 KW Unit A required load-bank te  The CVPES, in an int was not sure why the did not have the required Information of the I	urrently on the facility logs ur generators.  240 PM, the surveyor, IMD of that the facility's exterior ave an exterior remote ducted during the MD. He stated that he was exterior generators did not all stop station to prevent attional operation located sure housing the prime of review indicated that the generator did not have the st.  Berview, indicated that he Genset 80 KW generator fired load-bank test.  Besit informed of the findings at exit conference on 08/29/22.	KS	918	months to ensure that the generator/ systems are in compliance. Findings w be brought to the QAPI committee monthly for 3 months.	ill	
	•	Code 2012 edition 9.1.3.1 ncy and Standby Power					

#### **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
315280 <sub>Y1</sub>	B. Wing	Y2	1/23/2023	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER HEALTHCARE CENTER		1417 BRACE ROAD		
		CHERRY HILL, NJ 08034		

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).

ITE	EM	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	I Reg. #	IFPA 101	Completed	Reg.#	NFPA 101		Completed
LSC	K0132	11/25/2022	LSC K	0211	10/03/2022	LSC	K0222		- 11/25/2022 -
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	I Reg. #	IFPA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0227	10/22/2022	LSC K	0293	10/22/2022	LSC	K0321		10/26/2022
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed		IFPA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0324	10/22/2022	_	0341	10/22/2022	LSC	K0351		- 10/22/2022 -
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	I Reg. #	IFPA 101	Completed	Reg.#	NFPA 101		Completed
LSC	K0372	10/22/2022	LSC K	0374	11/17/2022	LSC	K0511		10/28/2022
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	I Reg. #	IFPA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0531	12/23/2022	LSC K	0712	09/09/2022	LSC	K0741		10/22/2022
REVIEWED BY REVIEWED STATE AGENCY (INITIALS)		REVIEWED BY (INITIALS)	DATE	SIGNATURE	OF SURVEYOR			DATE	
REVIEWED BY CMS RO (INITIALS)			DATE	TITLE				DATE	

#### **POST-CERTIFICATION REVISIT REPORT**

				· • • · · ·							
045000 P Wing					- MAIN BUILDING 01				DATE OF REVISIT  1/23/2023 <sub>Y3</sub>		
NAME OF	FACILITY		Y1   B. Willig		STREET ADDRESS, CITY, STATE, ZIP CODE				1/23/202	23 <sub>Y3</sub>	
SILVER H	HEALTHCAF	RE C	ENTER			1417 BRACE ROAD CHERRY HILL, NJ 0803					
program, corrected provision	to show tho	se de te sud d the	eficiencies previously re ch corrective action was	ported on the accomplished	e CMS-2567, State ed. Each deficienc	I and/or Clinical Laborato ement of Deficiencies and cy should be fully identifie S-2567 (prefix codes show	d Plan of Cor ed using eith	rection, that have er the regulation	e been or LSC		
ITEM			DATE	ITE	Л	DATE ITEM				DATE	
Y4			Y5	Y4		Y5	Y4			Y5	
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg.#	NFPA 101		Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101		Completed	
LSC	K0912		10/22/2022	LSC	K0915	10/27/2022	LSC	K0918		11/17/2022	
REVIEWE		$\exists$	REVIEWED BY (INITIALS)	DATE	SIGNATI	JRE OF SURVEYOR	1		DATE		
REVIEWE	_		REVIEWED BY (INITIALS)	DATE	TITLE				DATE		
FOLLOWUP TO SURVEY COMPLETED ON 8/29/2022					CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					□ NO	