PRINTED: 05/20/2021 FORM APPROVED OMB NO. 0938-0391

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG 01	COMPLETED
		315205	B. WING _		06/25/2019
	ROVIDER OR SUPPLIER CENTER FOR REHAB	& SUB-ACUTE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103	, 30.20.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
E 000	Initial Comments		E 0	00	
	Appendix Z-Emerger Provider and Supplie Guidance 483.73, Re Care (LTC) Facilities	equirements for Long Term			
K 000	INITIAL COMMENTS		K 0	00	
K 321 SS=D	The facility is not in s	ubstantial compliance with fety Code requirements as -2786R.	К3	21	7/22/19
55-5	Hazardous Areas - E Hazardous areas are having 1-hour fire res fire rated doors) or a system in accordance When the approved a system option is use separated from other partitions and doors Doors shall be self-ca and permitted to hav protective plates that from the bottom of the Describe the floor and	e protected by a fire barrier sistance rating (with 3/4 hour n automatic fire extinguishing e with 8.7.1 or 19.3.5.9. automatic fire extinguishing d, the areas shall be a spaces by smoke resisting n accordance with 8.4. osing or automatic-closing e nonrated or field-applied do not exceed 48 inches e door.			
	c. Repair, Maintenan	ed Heater Rooms han 100 square feet)			
LABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATURE	'	TITLE	(X6) DATE

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.

Electronically Signed

07/16/2019

PRINTED: 05/20/2021 FORM APPROVED OMB NO. 0938-0391

CORRECTION	IDENTIFICATION NUMBER:		1	COMPLETED	
	315205	B. WING		06/25/2019	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			WO COOPER PLAZA		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
e. Trash Collection F (exceeding 64 gallor f. Combustible Stora (over 50 square feet g. Laboratories (if cla Hazard - see K322) This REQUIREMEN by: Based on observation in the presence of fa determined that the self-closing doors to basement level. This deficient practic following: Throughout a tour of 10:10 AM, the surve Maintenance Director Maintenance Director observed there were that were not provide follows: 1. The Housekeepir Room measured gre contained combustib supplies. The door w not latch into the frame previously been insta 2. The old "Dieticiar measured greater th contained combustib supplies. The door w not latch into the frame onto latch into the frame to previously been insta The door w not latch into the frame onto latch into the frame to previously been insta The door w not latch into the frame onto latch into the frame to previously been insta The door w not latch into the frame to previously been instal The door w not latch into the frame to previously been instal The door w not latch into the frame	Rooms (as) (ge Rooms/Spaces) (assified as Severe T is not met as evidenced (con and interview on 6/25/19, cility management, it was facility failed to provide hazardous areas in the If the basement, beginning at yor along with the facility's for (MD), Assistant for (AMD), and Administrator (A hazardous area rooms and with self-closing doors as (as) (as) (b) (c) (c) (d) (d) (d) (d) (e) (e) (e) (e) (e) (e) (e) (e) (e) (e	K 321	The plan of correction is the facility's credible allegation of compliance. Preparation and/ or execution of this of correction does not constitute admission or agreement by the providing the truth of the facts alleged or conclusions set forth in the statement deficiencies. The plan of correction is prepared and/or executed solely becaute it is required by the provision of federand state law. 1. All storage room doors indicated in statement of deficiencies were immediately mended to self close and positively latch. 2. All residents have the potential to the affected by this deficient practice. 3. All Maintenance Personnel will be serviced regarding this LSC requirement. The Facility Director of Maintenance maintain weekly audits of all Hazardo Area Enclosures to ensure all fire rate doors are self closing and positively in accordance with all applicable guidelines set forth in this requirement.	plan der of t of sause al this d pe in hent. pe will bus ed atch nt. t	
	CENTER FOR REHAB SUMMARY ST (EACH DEFICIENC REGULATORY OR CONTINUED FROM PAGE 1) Continued From page e. Trash Collection From (exceeding 64 gallor from from from from from from from fr	TOORNECTION 315205 ROVIDER OR SUPPLIER C CENTER FOR REHAB & SUB-ACUTE CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/25/19, in the presence of facility management, it was determined that the facility failed to provide self-closing doors to hazardous areas in the basement level. This deficient practice was evidenced by the following: Throughout a tour of the basement, beginning at 10:10 AM, the surveyor along with the facility's Maintenance Director (MD), Assistant Maintenance Director (AMD), and Administrator observed there were 4 hazardous area rooms that were not provided with self-closing doors as	ROVIDER OR SUPPLIER CENTER FOR REHAB & SUB-ACUTE CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/25/19, in the presence of facility management, it was determined that the facility failed to provide self-closing doors to hazardous areas in the basement level. This deficient practice was evidenced by the following: Throughout a tour of the basement, beginning at 10:10 AM, the surveyor along with the facility's Maintenance Director (MD), Assistant Maintenance Director (AMD), and Administrator observed there were 4 hazardous area rooms that were not provided with self-closing doors as follows: 1. The Housekeeping Department Equipment Room measured greater than 50 square feet and contained combustible cardboard boxes of supplies. The door was not self-closing and would not latch into the frame where a door closer had previously been installed. 2. The old "Dietician Office" (now storage room) measured greater than 50 square feet and contained combustible cardboard boxes of supplies. The door was not self-closing and would not latch into the frame. There were holes in the door and the frame where a door closer had	A BUILDING 01 STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103 SUMMARY STATEMENT OF DESCRIPTIONS (PACH) DEPTISATION OR LSC IDENTIFYING INFORMATION) CONTINUED From page 1 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This RECUIREMENT is not met as evidenced by: Based on observation and interview on 6/25/19, in the presence of facility management, it was determined that the facility failed to provide self-closing doors to hazardous areas in the basement level. This deficient practice was evidenced by the following: Throughout a tour of the basement, beginning at 10:10 AM, the surveyor along with the facility's Maintenance Director (MD), Assistant Maintenance Director (MD), Assistant Maintenance Director (MD), Assistant Maintenance Director (MD), Assistant Maintenance Director (MD), Sasistant Maintenance Derector (

PRINTED: 05/20/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 315205 B. WING 06/25/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA **MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE CAMDEN, NJ 08103** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PRFFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 321 Continued From page 2 K 321 3. The Diaper Storage Room measured greater The facility Administrator as well as the than 50 square feet and contained combustible Facility Director of Maintenance will packages of disposable diapers. The door was evaluate and present all findings in this not self-closing and would not latch into the area as well as general compliance in all frame. applicable guidelines set forth in this requirement to the Facility Quality 4. The Records Storage Room measured greater Assessment and Assurance Committee than 50 square feet and contained combustible on a quarterly basis. records storage. The door was not self-closing and would not latch into the frame. In an interview, at the time, the MD stated that some of these rooms were not hazardous areas in the past, and that self-closing devices would be added. NJAC 8:39-31.2(e) K 351 7/31/19 K 351 Sprinkler System - Installation CFR(s): NFPA 101 SS=D Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)

PRINTED: 05/20/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315205	B. WING			06/25/2019		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE				STREET ADDRESS, CITY, STATE, ZIP		•		
				T	WO COOPER PLAZA			
MAGEOTIC	O CENTER I OR REITAB	d OOD-AOOTE OAKE		С	AMDEN, NJ 08103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLET		
K 351	by: Based on observation in the presence of fact determined that the factor automatic fire sprinkly accordance with NFF. This deficient practical following: At 10: 40 AM, the sum Maintenance Director was no fire sprinkler access only storage storage of supplies a equipment. Equipment blower, leaf vacuum, and a container of gapenetrations through the kitchen that were spray insulation that construction. In an interview at the	on and interview on 6/25/19 cility management, it was facility failed to provide er protection to all areas in PA 13. The was evidenced by the everyor and the facility's r (MD) observed that there protection to the exterior room. The room contained and gasoline powered lawn ent included a trimmer, leafflawn mower, snow blower, asoline. The room had the concrete block walls to be sealed with yellow foam was not fire rated to the wall entire, the MD stated that the anger used since the hospital	K	3351	The plan of correction is the facility credible allegation of compliance. Preparation and/ or execution of the of correction does not constitute admission or agreement by the protection that the truth of the facts alleged or conclusions set forth in the statemed deficiencies. The plan of correction prepared and/or executed solely be it is required by the provision of fed and state law. 1. The container of gasoline as wellawn equipment indicated in this statement of deficiencies was immoremoved from the exterior access of the container of gasoline as wellawn equipment indicated in this statement of deficiencies was immoremoved from the exterior access of the container of gasoline as well as feet that the potential that affected by this deficient practice. 3. All Maintenance Personnel will be serviced regarding this NFPA guided. 4. The penetrations through the completion system will be installed in exterior access room in accordance. NFPA 13. The projected completion for this installation is 7/31/19. The facility and an automatic maintain mandatory quarterly sprinkler system inspection for this installation is 7/31/19. The facility Administrator as well as Facility Director of Maintenance will evaluate, review and present all quinspection findings to the Facility Quassessment and Assurance Committed.	is plan vider of ent of is ecause leral I as all ediately coom. to be the in eline. Increte exted the with the date facility froms. I arterly uality		

PRINTED: 05/20/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION NG 01		(X3) DATE SURVEY COMPLETED	
		315205	B. WING _			6/25/2019	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C TWO COOPER PLAZA			
MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE				CAMDEN, NJ 08103			
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 351			К3	DEFICIENC	·Y)		