STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**06/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	**220 ST MARY'S DRIVE** **CHERRY HILL, NJ 08003**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		8/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. BUILDING **01** B. WING _____	**06/21/2022**

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E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents on 06/21/22, the facility failed to establish and maintain the facility contracts and agreements at least annually. This deficient practice was evidenced by the following: At 12:05 PM, during review of the facility documents and interview, it was observed that facility contracts and transfer agreements were not updated at least annually. The following contracts and transfer agreements not properly updated are listed: 1. Generator fuel company agreement for fueling the fire pump and generator with diesel fuel in the event of an emergency was dated: 09/30/2020 2. Pharmacy Services Provider Agreement: dated 02/01/2019;	E 004	E-004 (F) Develop EP Plan, Review and Update Annually This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the goal of this facility to ensure that the Emergency Preparedness Plan gets an annual review. 1. Facility contracts and transfer agreements will be annually updated even if date of expiration is greater than a year. The facility will update Generator Fuel supplier, Pharmacy, Foo Service provider, Oxygen supplier, compactor supplier, medical transport agreement and backup agreement, Laboratory agreement, diagnostic services agreement, facility transfer agreement, and any other	

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E 004	Continued From page 2 3. Food Service Provider: dated 05/01/2020 (good for 12-months will be updated annually); 4. Oxygen Cylinder Product Sale Agreement: dated 01/11/2016; 5. Compactor services agreement: dated 09/30/2020; 6. Medical Transportation Agreement I : dated 12/28/2019; 7. Medical Transportation Agreement II : dated 02/15/2018, (document indicates agreement shall remain in effect for a period of one-year); 8. Clinical Laboratory Services Contract: dated 11/02/2015; 9. Facility Diagnostic Services: dated 12/18/2015; and 10. Facility to Facility Transfer Agreement (The Pines at Voorhees) signed by St Mary's: 07/25/2020; signed by Voorhees: 7/21/2020. For LTC Facilities at §483.73(a): Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The findings were verified by the Maintenance Director at the time of the review of the facility documents. The Administrator was informed of the findings at the Life Safety Code exit conference on 06/21/22. NJAC 8:39-31.2(e), 31.6(i)	E 004	agreements determined by staff. 2. The full EP manual will be reviewed annually. 3. Education completed with Maintenance staff regarding annual reviews and updates. 4. Every month Maintenance Director or designee will review random sections of EP for compliance. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	

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	315060	A. BUILDING **01** B. WING _____	**06/21/2022**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/14/22 and 06/15/22 and St. Mary's Center for Rehabilitation and Healthcare was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. St. Mary's Center for Rehabilitation and Healthcare is a two story, Type II Protected building that was built in January 1986. The facility is divided into 13 smoke zones.	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations on 06/14/22 and 06/15/22, it was determined that the facility failed to ensure that illuminated exit signs were in two (2) locations to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following:	K 293	K-0293 (E) NFPA 101 Exit Signage This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of	8/15/22

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K 293	Continued From page 4 Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 06/14/2022 during the survey entrance at 9:08 AM, a request was made to the Director of Plant Operations (DPO) to provide a copy of the facility layout which identified the various rooms and smoke compartments. Starting at 9:33 AM on 06/14/2022 and continued on 6/15/2022, in the presence of facility's DPO, a tour of the building was conducted. During the tour on 06/15/22, the surveyor observed the following locations that failed to to have illuminated exit signs to clearly identify the exit access route: 1. At 9:18 AM, one (1) illuminated exit sign above the exit access door in the outside enclosed center courtyard near elevator number 3. 2. At 11:12 AM, one (1) illuminated exit sign above the exit access door in the outside enclosed center courtyard adjacent to the residents' dining room. The findings were verified and confirmed by the DPO during the observations.	K 293	deficiencies. It is the practice of the facility to maintain illuminated exit signage in the courtyards 1. Illuminated Exit sign will be installed in 2 enclosed courtyards. 2. Facility wide exit sign inspection for June has been completed on June 28th and all existing illuminated exit signs functioning as per design. 3. Education completed with Maintenance staff to observe during rounds. 4. Every month Maintenance Director or designee will check a random floor of the facility to ensure exit signs are functioning. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	

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K 293	Continued From page 5 The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/15/2022 at 12:43 PM. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 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) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 06/14/22 and 06/15/22, it was determined that the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New	K 351	K-0351 (D) NFPA 101 Sprinkler System-Installation This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrongdoing, nor does it	8/15/22

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K 351	Continued From page 6 Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice was observed and evidenced by the following: On 06/14/2022 during the survey entrance at 9:08 AM, a request was made to the Director of Plant Operations (DPO) to provide a copy of the facility layout which identified the various rooms and smoke compartments. On 06/14/22 at 9:33 AM, in the presence of facility's DPO, a tour of the building was conducted. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location: 1. At 9:35 AM, an inspection inside the facility's basement level Service Hall stairwell was performed. The surveyor observed no evidence of a fire sprinkler coverage inside the eight foot three inch by three foot nine inch lower level landing area. The findings were verified and confirmed by the DPO during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/15/2022 at 12:43 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to ensure building wide sprinkler coverage and can function as designed 1. Missing sprinkler head in service hall stairwell will be installed. 2. Facility wide sprinkler head inspection has been completed for June on June 28th. 3. Education completed with Maintenance staff to observe sprinklers, ceiling tiles, tamper switches and sprinkler escutcheons during rounds and check for proper building wide coverage. 4. Every month Maintenance Director or designee will check sprinkler system components on a random floor of the facility. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		8/15/22

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K 374	Continued From page 7 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of other facility documents on 06/14/22 and 06/15/22, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 2 of 9 set of smoke barrier doors tested and was evidenced by the following: Reference 1: 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 06/14/2022 during the survey entrance at 9:08 AM, a request was made to the Director of Plant Operations (DPO) to provide a copy of the facility layout which identified the various rooms and smoke compartments.	K 374	K-0374 (E) NFPA 101 Subdivision of Building Spaces-Smoke Barrier This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to ensure smoke barrier door free resist the passage of smoke. 1. Doors were repaired to allow for closure on June 28th, 2022 2. Doors throughout the facility were checked to allow for closure on June 28th, 2022 3. Education completed with Maintenance staff regarding monitoring doors to ensure they close properly. 4. Every month Maintenance Director or designee will check random doors	

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K 374	Continued From page 8 A review of the facility provided layout identified the building was a two-story building with nine sets of double smoke barrier doors in the facility. On 06/14/22 at 9:33 AM, in the presence of facility's DPO, a tour of the building was conducted. Along the tour the DPO and surveyor tested nine sets of double smoke barrier doors in the corridors with the following results: 1. At 10:19 AM, one set of double smoke doors, on the second floor Greentree Unit near the Social Services office, when both doors were released from their magnetic hold-open devices and allowed to self close into their frame, revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 1/8 of an inch between the meeting edges. One door did not fully close into its frame and left a 3/8 of an inch gap. This test was repeated two additional times with the same results. 2. At 10:48 AM, one set of double smoke doors, on the second floor Holly Avenue hall next to resident room #203, when both doors were released from their magnetic hold-open devices and allowed to self close into their frame, revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 1/8 of an inch between the meeting edges. One door did not fully close into its frame and left a two (2) inch gap. This test was repeated two additional times with the same results.	K 374	throughout the facility to ensure the doors fully close. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	

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K 374	Continued From page 9 This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The findings were verified and confirmed by the DPO during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/15/2022 at 12:43 PM. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations on 06/14/2022, in the presence of facility management, it was determined that the facility failed to ensure that 3 of 11 electrical outlets located next to a water source were equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following:	K 912	K-0912 (F) NFPA 101 Electrical Systems- This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. It is the practice of the facility to protect electrical wiring in accordance with	8/15/22

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K 912	Continued From page 10 On 06/14/2022 during the survey entrance at 9:08 AM, a request was made to the Director of Plant Operations (DPO) to provide a copy of the facility layout which identified the various rooms in the facility. Starting at 9:33 AM, in the presence of facility's DPO, a tour of the building was conducted. Along the tour the surveyor tested eleven (11) electrical outlets located in wet locations. When the surveyor used a Ground-Fault Circuit Interrupter (GFCI) tester to de-energize the electrical outlets, three (3) electrical outlets had not de-energize, as required by code in the following locations: 1. At 10:14 AM, inside resident room #236's bathroom, one GFCI electrical outlet when tested did not de-energize. 2. At 12:21 PM, inside the first floor doctor's office near the Sub-Acute unit, one Duplex electrical outlet, located twelve inches to the right of the bathroom sink when tested, did not de-energize. 3. At 12:30 PM, inside the Physical Therapy resident's bathroom, one GFCI electrical outlet, located eight inches to the right of the sink when tested, did not de-energize. The findings were verified and confirmed by the DPO during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/15/2022 at 12:43 PM.	K 912	NFPA99 2012 edition, 6.3.2.2.6.2. Electrical Testing of GFCI and Installation 1. New GFCI outlets have been installed in 3 locations that failed to de energize as designed on June 28th, 2022 2. A facility wide inspection of all installed GFCI has been completed on June 28th, 2022 3. Education completed with Maintenance staff regarding testing and inspection of GFCI and electrical systems will be conducted. 4. Every month Maintenance Director or designee will check random areas of the facility s to ensure proper generator testing. This information will then be entered on a log will be presented to monthly QAPI meeting Date of Compliance: 8/15/2022	

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K 912	Continued From page 11 NJAC 8:39 -31.2 (e) NFPA 99	K 912		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315060 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/28/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE	220 ST MARY'S DRIVE CHERRY HILL, NJ 08003

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0293	08/15/2022	LSC	K0351	08/15/2022	LSC	K0374	08/15/2022
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0912	08/15/2022	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/21/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO