STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING _____ B. WING _____	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857**

(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
F 000	INITIAL COMMENTS Complaint #'s: 169289, 179188, 179362, 179561 Survey Date: 12/4/2024 -12/11/2024 Census: 88 Sample Size: 18 + 3 Closed Records THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint # NJ 179632 Based on observation, interviews, review of medical records and facility documents, it was determined that the facility failed to follow [NJ Ex] prevention interventions as written on the resident's individual comprehensive care plan (ICCP). This deficient practice was identified for 1 of 4 residents (Resident # 44) reviewed for [NJ Ex Order 26.4(b)(1)]	F 689	The root cause for this deficient practice was the nurse failed to properly oversee the agency aide assigned to resident #44 to ensure the appropriate [NJ Ex] interventions were in place when the resident was in bed. The nurse was re-educated on her responsibility to oversee the care provided by a CNA and to ensure the residents under her care have the appropriate safety interventions in place.	1/10/25

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

Electronically Signed | 12/23/2024

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.

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F 689	Continued From page 1 This deficient practice was evidenced by the following: On 12/04/24 at 12:30 PM, during the initial tour of the 1st floor unit, the surveyor observed Resident #44 in a reclining chair in the day room with other residents and staff members. The surveyor observed a NJ Ex Order 26.4(b)(1) leaning against the wall in the resident's room. The surveyor reviewed the electronic medical record (EMR) for Resident # 44. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4, revealed Resident #44 had a Brief Interview for Mental Status of NJ out of 15, indicating the resident was NJ Ex Order 26.4(b)(1). Further review of the MDS, revealed the resident required NJ Ex Order 26.4(b)(1), NJ Ex Order 2 does NJ Ex Order 26.4(b)(1). A review of the " NJ Ex Order 26.4(b Assessment- NJ Ex Orde Category" completed on NJ Ex Order 26.4(b revealed "Total: NJ Ex Order 26.4(b)(1)	F 689	All residents who are severely cognitively impaired, have a fall risk score above 10, and who have fall interventions of a low bed and floor mats, have the potential to be affected by this deficient practice. Residents Fall Risk Scores, BIMS scores, and Care Plans will be reviewed to identify residents at risk to ensure the information provided on the Resident Care Needs form is accurate. The unit managers/nursing supervisors will be educated on checking the daily staffing sheet to identify any agency staff assigned in the facility and will ensure they have received the Resident Care Needs form, which was created to easily and quickly be able to identify the care needs of residents. Licensed nursing staff will be re-educated on their responsibility to provide supervision and oversight to any CNA providing care to a resident under their care and to ensure all safety interventions are in place. A weekly Agency Staff Supervision form will be in the staffing office with the daily staffing sheets. The unit managers/nursing supervisors will complete this form daily. The form will be reviewed by the DON weekly x 12 weeks, then monthly x3 months to ensure agency staff have received the necessary information to provide safe resident care. The results of the reviews will be presented at the quarterly quality assurance meetings for the March and June meetings.	

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F 689	Continued From page 2	F 689		

A review of Resident # 44's ICCP revealed a Focus: NJ Ex Order 26.4 Resident is at risk NJ Ex Order 2 due to: NJ Ex Order 26.4(b)(1) .. NJ Ex Order 26.4(b)(1) ...interventions included: NJ Ex Order 26.4(b) to the NJ Ex Order 26.4(b)(1). Bed in NJ Ex Order 2 position, Active Effective NJ Ex Order 26.4(b)(1) ...Hourly visual checks when resident is in bed, Active Effective: NJ Ex Order 26.4(b)(1 ... Keep "NJ Ex Order 26.4(b)(1" even with a NJ Ex Order 26.4(b)(1), and 2 NJ Ex Order 26.4(b)(1) next to each other on the NJ Ex Order 26.4(b)(1) when resident is in bed, Active effective: NJ Ex Order 26.4(b)(1).

A review of facility progress notes revealed a nursing note dated NJ Ex Order 26.4(b)(1) at 01:14 AM, "Called to patient room observed with NJ Ex Order 26.4(b)(1)) to the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1) to NJ Ex Ord and NJ Ex Order 26.4(b)(1)) to NJ Ex Order 26.4(b)(1) called MD (medical doctor) via service and received call back and received TVO (telephone verbal order) to send patient to the ER (emergency room) to rule out NJ Ex Order 26.4(b)(1)."

A review of the facility provided investigation revealed: "An investigation was conducted, and it was determined that the bed had NJ Ex Order 26.4(b)(1) but the NJ Ex Order 26.4(b)(1 identified in the care plan (CP) were NJ Ex Order 26.4(b)(1) at the time of NJ Ex Order 26 ... The CNA (Certified Nursing Assistant) NJ Ex Order 26.4 the bed prior to leaving the room but at the time of NJ Ex Order 26 the floor nurse noted that bed was not in the NJ Ex Order 26.4(b)(1)." Further reviewed revealed: "Summary: We could not substantiate NJ Ex Order 26 but we did identify that the care plan was not followed for NJ Ex Order

On 12/06/24 at 11:00 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated the CNA caring for the resident was an

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F 689	Continued From page 3	F 689		

agency CNA who did not know the resident. She stated the nurse gave the CNA report but was unable to verify exactly what was said. The [U.S. FOIA] stated a form "Resident Care Needs" was made so all staff can be made aware of resident's needs.

On 12/06/24 at 1:23 PM, the surveyor interviewed the [U.S. FOIA (b) (6)], who stated Resident #44 was always in the day room so that staff can observe the resident. She also stated that the resident liked [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b) (6)] stated all [NJ Ex Or] should be on the CP. She then stated the CP purpose was to know what care the resident needs and how to get the best outcomes for residents.

On12/09/24 at 9:31 AM, the surveyor interviewed Resident #44's assigned CNA, who stated she knows the resident well. She stated when the resident was in bed, the bed must be in the [NJ Ex Order 26.4(b)(1)] and the [NJ Ex Order 26.4(b)(1)] need to be [NJ Ex Order 26.4(b)(1)] to keep the resident safe. She stated she knows this because I reviewed the care plan.

A review of the facility's policy "Fall Risk Assessment" revised 1/2019, revealed Procedure: 3. Residents with a score of 10 or more will be considered risk for falls and interventions will be implement. 4. A person-centered Fall Care Plan will be developed, and interventions will be reviewed with each new fall, quarterly, annually, and significant change assessment, and as needed.

NJAC 8:39-27.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030709	A. BUILDING: _____ B. WING _____	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 3 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	To ensure all residents have access to the care they need, Reformed Church Home has cross-trained our nursing staff to perform CNA duties during the day shift in emergencies. All residents have the potential to be affected by the staffing shortage. In addition to using our nurse managers to perform direct care, we have also contracted with additional staffing agencies to provide temporary CNAs in the event of shortages. Overtime is offered to existing staff since we are usually trying to fill vacancies due to illness.	12/31/24

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

Electronically Signed | 12/23/24

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The survey team requested staffing for the following weeks 11/17/2024 to 11/30/2024. The facility was deficient in CNA staffing as follows: -11/18/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -11/24/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -11/25/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. On 12/06/24 at 11:25 AM, the surveyor interviewed the Staffing coordinator, who stated she was aware of the CNA staffing rations. She stated we usually meet the ratios but sometimes call outs are difficult to cover. A review of the facility's policy, "Staffing" reviewed 12/11/2024, revealed: Reformed church employs a full time Staffing	S 560	The facility has taken multiple steps to address the CNA concern. Efforts are made to stay ahead of the pay scale and to have Reformed Church Home at the top of the wage scale. Reformed Church Home is also offering an additional health family plan which is lower in cost than our traditional plans. The hope again is that we will be able to attract more CNAs with families due to our competitive rates and enhanced health coverage for families. We have also partnered with the CNA school, Above and Beyond in Colonia NJ to provide guidance and graduating CNAs job opportunities. We have also contracted with additional staffing agencies to provide temporary CNAs in the event of shortages. We have also petitioned 6 visas for CNAs from United Methodist Healthcare Recruitment out of Chicago. To ensure the deficient practice does not recur, the Director of Nursing and Staffing Coordinator will review daily/weekly staffing levels daily to ensure compliance with the required ratios. A quarterly report will be made at the QA committee.	

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S 560	Continued From page 2 Coordinator who is responsible for the nursing schedule. If there are vacancies in the schedule, the staffing coordinator will first try to fill the vacancies with per diem staff. If the per diem staff do not pick up the shift, calls will be placed to all agencies.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315417	A. Building B. Wing	1/10/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

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 F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 01/10/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON
12/11/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
030709		1/10/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/31/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
12/11/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING **01** B. WING _____	**12/11/2024**

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REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH** **OLD BRIDGE, NJ 08857**

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E 000	Initial Comments Reformed Church Home Nursing Home was in compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/04/2024 and 12/09/2024 and Reformed Church Home 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. The nursing home building construction was stated to be 1990's with no current major renovations or noted additions. It is a two story building Type II (222) construction and is fully sprinklered. The facility has 17 smoke zones, 2-exterior 750 Kilo Watt (KW) Diesel Generators that do 100% of the building and 1-exterior 125 KW Diesel Generator. The building has a partial basement with no access to residents. There are thirteen (13) smoke compartments in the facility. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life	K 000		

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K 000	Continued From page 1 safety components utilized for preservation of life. The facility has 108 certified beds. At the time of the survey the census was 88.	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) 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:	K 321		12/31/24

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REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH** **OLD BRIDGE, NJ 08857**

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K 321	Continued From page 2 Based on observation and interview on 12/05/2024 and 12/09/2024 in the presence of facility management, it was determined that the facility failed to ensure that 1 of 8 fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was evidenced by the following: An observation on 12/05/2024 at approximately 9:20 AM, revealed the basement level Activities room door did not close to the frame when tested by the U.S. FOIA (b) (6)). When the U.S. F. opened the door, the door did not self-close into its frame. The surveyor observed that the door's automatic door closure had been removed. Inside the room the surveyor observed several combustible cardboard boxes, activity crafts and other combustible products. At this time the surveyor observed, measured and recorded the room to be 91.875 square feet, greater than 50 square feet. The U.S. F. confirmed the finding at the time of observation. The U.S. FOIA (b) (6) and U.S. F. were informed of the deficient practice during the Life Safety Code survey exit on 12/09/2024 at approximately 1:29 PM. NJAC 8:39-31.2 (e)	K 321	Immediate Corrective Action: Inspection of all self-closing doors: A comprehensive inspection of all self-closing doors in hazardous areas (boiler rooms, electrical rooms, storage rooms, etc.) was conducted immediately by our maintenance team. Repairs or replacements: Any self-closing doors that are not functioning properly will be repaired or replaced immediately. This includes ensuring that the doors close automatically without obstruction and maintain the required fire-resistance rating. Basement activity storage door new closure was placed. See photo for reference. Identification of Non-Compliant Doors: We will identify and tag any doors that are not compliant and make necessary repairs, ensuring all doors in hazardous areas meet the required standards for self-closing and fire resistance. Systematic Changes to Prevent Recurrence: Routine Inspections and Testing: An annual inspection and testing program will be implemented for all self-closing fire-rated doors in hazardous areas. The program will include: Verifying the proper operation of the door-closing mechanism. Ensuring that doors are not obstructed and can close fully. Checking that fire-rated doors are not damaged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING **01** B. WING _____	**12/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	**1990 ROUTE 18 NORTH** **OLD BRIDGE, NJ 08857**

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K 321	Continued From page 3	K 321	The results of each inspection will be documented and kept on file for review. Long-Term Sustainability: Documentation and Tracking: A detailed log of all self-closing doors will be created, listing the location of each door, its inspection dates, and any repair or maintenance actions taken. Monitoring and Follow-Up: Ongoing Compliance: The facility will schedule annual internal inspections of self-closing doors in hazardous areas to ensure continued compliance. Reports will be reviewed by the facility's fire safety officer and any identified issues will be addressed promptly. The results of the findings will be addressed at the first quarter safety committee meeting and the first quarter QA meeting. Responsible Party: Maintenance Director: Oversees the inspection, repair, and ongoing monitoring of self-closing doors.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where	K 372		12/27/24

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	315417	A. BUILDING **01** B. WING _____	**12/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 372	Continued From page 4 an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations on 12/05/2024 and 12/09/2024 in the presence of Facility Management, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for three (3) of twelve (12) smoke barriers in accordance with NFPA 101:2012 Edition, Sections 19.3.6.2.3, 8.5.6, 8.5.6.2 and 8.5.6.3. This deficient practice had the potential to affect all 88 residents and was evidenced by the following: A review of the facility provided lay-out on 12/05/2024 identified the facility as a three-story (3) building with twelve (12) smoke barrier walls. The facility was also connected to a Assisted Living facility. Observations starting at approximately 8:56 AM on 12/05/2024 and continuing on 12/09/2024 in the presence of the U.S. FOIA (b) (6) revealed the following above the ceiling tiles of the corridor double fire rated barrier doors: 1) On 12/05/2024 at approximately 10:01 AM, the surveyor observed on the 3rd. floor above the ceiling tiles by the 1-1/2 hour fire rated double corridor doors leading into the "A-Wing", two (2) approximately 1-inch diameter holes with wires running through the smoke barrier wall.	K 372	Immediate Corrective Action: Inspection of Fire-Rated Barriers and Doors: A comprehensive inspection of all fire-rated barriers, including walls and ceilings around fire doors, will be conducted immediately to identify any penetrations that lack proper fire blocking. Areas of focus will include penetrations above fire doors, walls with ducts, pipes, cables, or conduits passing through, and other vulnerable areas in the building. Sealing Penetrations: All identified penetrations that lack appropriate fire-blocking will be immediately sealed using approved fire-resistant materials. These materials will include fire-rated caulk, intumescent sealants, or other materials that meet NFPA 101 and NFPA 80 requirements for fire blocking. The materials used will be selected based on NFPA guidelines to ensure that they provide an effective barrier against fire and smoke.	

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	315417	A. BUILDING **01** B. WING _____	**12/11/2024**

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K 372	Continued From page 5 2) On 12/05/2024 at approximately 11:06 AM, the surveyor observed on the 2nd floor above the ceiling tiles by the 1-1/2 fire rated double corridor doors leading into the "A-Wing", one (1) approximately 1-1/2 inch in diameter hole with 9 black wires running through the smoke barrier wall. 3) On 12/09/2024 at approximately 9:48 AM, the surveyor observed on the 1st floor above the ceiling tiles by the 1-1/2 fire rated double corridor doors next to the Social Services office, two (2) approximately 1-1/2 inch in diameter holes with one BX electrical cable and an approximately 1/2-inch in diameter white plastic tubing running through one penetration through the smoke barrier wall. The U.S. F[redacted] confirmed the findings at the time of observations. The U.S. FOIA (b) (6) and U.S. F[redacted] were informed of the deficient practice during the Life Safety Code survey exit on 12/09/2024 at approximately 1:29 PM. N.J.A.C 8:39-31.2(e)	K 372	Verification of Fire Blocking: Once penetrations have been sealed, the Maintenance Director will perform a follow-up inspection to verify that all fire-blocking measures are properly implemented and meet required safety standards. Any issues found during this inspection will be corrected immediately. Shape Systematic Changes to Prevent Recurrence: Contractor Instructions and Oversight: Moving forward, any contractors who perform work involving penetrations in fire-rated walls, ceilings, or around fire doors will be instructed as follows: Contractors will be required to ensure that all penetrations made during their work are properly fire-blocked in accordance with NFPA 101 and NFPA 80 standards. Contractor contracts will include a clause requiring compliance with all fire safety and building code regulations, including sealing all penetrations with fire-resistant materials. A checklist for contractors will be developed to ensure they have followed fire-blocking protocols before finalizing	

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	315417	A. BUILDING **01** B. WING _____	**12/11/2024**

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K 372	Continued From page 6	K 372	any work that involves penetrations in fire-rated barriers. Maintenance Staff Oversight: Maintenance staff will be tasked with monitoring and inspecting any penetrations made by contractors during construction, repair, or maintenance projects. Maintenance staff will perform follow-up inspections to ensure that any penetrations made by contractors are sealed correctly and fire-blocked immediately. If any deficiencies are found, the Maintenance Director will ensure that the issue is addressed before the area is considered fully operational or before the contractor leaves the job site. Ongoing Inspections of Fire-Barriers: The facility's maintenance team will develop a schedule for quarterly inspections of all fire-rated barriers, including doors, walls, and ceilings, to ensure that no unsealed penetrations have been made. Any new penetrations, whether by contractors or facility staff, will be immediately sealed with appropriate fire-blocking materials, and will be included in the inspection schedule for verification.	

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K 372	Continued From page 7	K 372	Fire Safety Training for Staff and Contractors: Maintenance staff will receive additional training to ensure they are fully knowledgeable about the proper methods for sealing penetrations in fire-rated barriers and identifying potential fire-blocking deficiencies. Contractors will receive orientation or written instructions regarding the facility's fire safety protocols related to penetrations and fire-blocking. This will be reinforced during contractor onboarding before starting any project that involves fire-rated walls. Shape Follow-Up Monitoring and Compliance: Follow-Up Inspections: A follow-up inspection will be performed within 30 days of completing the immediate corrective actions to verify that all fire-blocking has been implemented properly and that the facility remains in compliance with K372. The inspection will be performed by the Maintenance Director to confirm that all fire-rated barriers are intact and that all penetrations are properly sealed. Quarterly Audits: A quarterly fire-safety audit will be	

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K 372	Continued From page 8	K 372	conducted to ensure continued compliance. This will include: A review of all areas where penetrations have occurred. Verification that all penetrations are properly fire-blocked and meet fire-safety codes. Auditing the contractor checklist and documentation to ensure that all work completed by contractors adheres to fire safety regulations. Ongoing Documentation: Documentation will be maintained for all inspections, corrections, and training sessions. This includes: Logs of contractor instructions regarding fire-blocking requirements. Maintenance inspection records and follow-up reports. Audit results and corrective actions taken. Shape Responsible Parties: Maintenance Director: Oversees inspections, repairs, and ensures all penetrations are properly sealed. Also responsible for ensuring maintenance staff follow procedures.	

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	315417	A. BUILDING **01** B. WING _____	**12/11/2024**

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K 372	Continued From page 9	K 372	Contractors: Responsible for ensuring compliance with fire safety regulations and properly sealing penetrations made during work. Shape Completion Date for Corrective Action: All immediate corrective actions, including sealing penetrations and inspecting fire-rated barriers, will be completed by 12/27/24. Ongoing monitoring and quarterly audits will begin immediately and continue per the established schedule. The results will be discussed the the facility's quarterly safety committee meetings.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall,	K 531		12/23/24

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K 531	Continued From page 10 firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 12/05/2024 and 12/09/2024 in the presence of facility management, it was determined that the facility failed to maintain emergency communications in proper working condition for 2 of 2 elevators tested of 4 total elevators, in accordance with ASME/ANSI A17.3 and NFPA 101: 2012 Edition, Section 19.5.3, 9.4.2 and 9.4.3. This deficient practice had the potential to affect the 88 Residents and was evidenced by the following: In an interview on 12/05/2024 at approximately 8:19 AM, a request was made to the facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) how many elevators are in the building. The U.S. FO told the surveyor that there are four (4) elevators. Observations starting at approximately 8:56 AM on 12/05/2024 in the presence of the U.S. FO revealed the following: 1) At approximately 8:58 AM, a test of elevator #1 emergency communication telephone was performed. When the surveyor pressed the button for the emergency communication phone, the operator answered, then no words. With-in approximately 20 seconds the phone automatically disconnected. A second test was performed and the phone did not function properly. The emergency communication phone did not have a pre-recorded message.	K 531	The facility must ensure that all elevator systems, including emergency communication devices (e.g., emergency phones in elevators), are properly maintained and functioning to ensure the safety and well-being of residents and staff. Immediate Corrective Action: Inspection of All Elevators: An immediate inspection of all elevator emergency communication systems (phones) was conducted to assess functionality. This inspection was performed by the facility's maintenance team and qualified elevator service provider to ensure that all emergency phones are working. The inspection focused on: Ensuring each emergency phone connects to a 24-hour monitoring service or can directly communicate with emergency personnel. Verifying that phones are in working condition with clear audio and uninterrupted functionality. Immediate Repair or Replacement: Any non-functional or damaged emergency phones was repaired or replaced immediately to ensure they met	

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	315417	A. BUILDING **01** B. WING _____	**12/11/2024**

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K 531	Continued From page 11 2) At approximately 9:36 AM, a test of elevator #2 emergency communication telephone was performed. When the surveyor pressed the button for the emergency communication phone, the operator answered and said "Hold on, Thank you for waiting" and with-in approximately 20 seconds, the phone automatically disconnected. The U.S.F. confirmed the findings at the time of observations. The U.S. FOIA (b) (6) and U.S. F. were informed of the deficient practice during the Life Safety Code survey exit on 12/09/2024 at approximately 1:29 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	operational requirements. All phones that are out of service will be marked as "out of order" until repaired and will not be used until fully functional. Test All Emergency Phones: Once repairs or replacements were made, each elevator emergency phone was tested for connectivity to emergency services, ensuring they work properly in the event of an emergency. Systematic Changes to Prevent Recurrence: Scheduled Inspections and Preventive Maintenance: A monthly inspection will be established for all elevator emergency phones. The inspection will include: Functionality testing to ensure clear, immediate communication with emergency personnel. Visual inspection to check for physical damage or wear. These inspections will be documented, and the results will be reviewed by the Maintenance Director. Documentation and Record-Keeping: A logbook will be created and maintained to record each inspection and test result, including: Date and time of inspection. Description of any identified issues. Actions taken (repair, replacement, etc.). Confirmation that repairs have been completed and phones are operational. Training of Maintenance Staff:	

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K 531	Continued From page 12	K 531	Maintenance personnel will receive training on the proper testing and repair of elevator emergency phones, including how to ensure they are properly connected to emergency services. Follow-Up Monitoring and Compliance: Ongoing Monitoring: To ensure long-term compliance, the monthly inspection schedule will be adhered to and documented. Responsible Parties: Maintenance Director: Responsible for overseeing the inspection, repair, and maintenance of all elevator emergency communication systems. Oversees all safety systems, including elevator emergency phones, ensuring compliance with fire safety codes. Completion Date for Corrective Action: All immediate corrective actions, including repairs and testing of emergency phones, was completed. Monthly inspections and preventive maintenance will commence immediately after the corrective actions have been implemented and will continue regularly. The results of the inspections will be discussed at the quarterly safety committee meetings.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315417	A. Building 01 - MAIN BUILDING 01 B. Wing	1/10/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

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 Reg. # NFPA 101 LSC K0321	Correction Completed 12/31/2024	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 12/27/2024	ID Prefix Reg. # NFPA 101 LSC K0531	Correction Completed 12/23/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/11/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO