STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315427	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	**535 N OAK AVE PITMAN, NJ 08071**

(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 Standard Survey 09/27/2024 Census: 60 Sample Size: 16 + 2 closed records C/O NJ 165834, 166215, 166218, 168252, 169039, 170242, 170553, 175579 The facility was in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities.	F 000		

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

Electronically Signed | 10/11/2024

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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H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H5730	8:43E-13.4(a) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall use the Universal Transfer Form, HFEL-7, provided as N.J.A.C. 8:43E-13 Appendix, incorporated herein by reference, and available on the Department's website at http://web.doh.state.nLus/apps2/forms/, in either paper or electronic version, whenever a patient is transferred to another licensed healthcare facility or program. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to use the required New Jersey Universal Transfer Form (NJ UTF) (HFEL-7) as required. This deficient practice was identified for 1 of 2 residents reviewed for hospitalizations (Resident #47) and was evidenced by the following: Reference: New Jersey Hospital Association "Provider Resources" Section 6: The NJ Universal Transfer Form (UTF) must be used by all licensed healthcare facilities and programs when the patient is transferred from one care	H5730	1. Corrective actions accomplished for affected residents: Resident #47 was identified as being affected by the deficient practice. In-services on the following will be provided to the licensed nurses by the Director of Nursing or designee: Discharge and Transfer (RS-39) Policy and Procedure; purpose, importance of, and instructions for completing all sections of the NJ Universal Transfer Form (UTF)/HFEL-07; process of sending the NJ UTF and retaining a copy in the	10/27/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/11/24

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H5730	Continued From page 1 setting to another. A review of the Electronic Medical Record (EMR) on 09/23/2024 at 11:28 AM and on 09/27/2024 at 09:18 AM, revealed the following: A review of the Admission Record revealed the resident was admitted with a diagnosis of [redacted]. A review of a Progress Note dated [redacted] timed at 13:23 (1:23 PM) revealed the following: Received resident in bed [redacted] and [redacted] needs known. Resident was having [redacted]. The note further indicated that the Nurse Practitioner was notified and stated that we needed to give the resident his/her PRN (as needed) [redacted] to keep him/her comfortable and to contact the [redacted] to ask if he wanted the resident to go to the hospital. [redacted] stated he wanted resident to be sent to the hospital. 911 was called and resident was sent to hospital with all necessary paperwork. A review of the New Jersey Universal Transfer Form-V1 revealed the form was not the HFEL-07 required form. During an interview with the surveyor on 09/26/2024 at 1:45 PM, the Director of Clinical Services said she spoke to a person at the Health	H5730	electronic medical record. 2. Residents identified having the potential to be affected: All residents have the potential to be affected. 3. Measures will be put in place or systemic changes to ensure the deficient practice will not recur: All sections of the NJ UTF will be completed by a licensed nurse to the best of their ability. The licensed nurse will send a completed, paper copy of the NJ UTF with the resident when they are transferred to a healthcare facility or program. The licensed nurse will retain a completed copy of the NJ UTF sent with the resident when they are transferred and ensure it is part of the resident's electronic medical record. The licensed nurses will be provided an in-service by the Director of Nursing or designee on the Discharge and Transfer (RS-39) Policy and Procedure, purpose of and instructions for completing the NJ UTF, and the importance of completing all sections of the form. The licensed nurses will also be provided an in-service by the Director of Nursing or designee on the process of sending the NJ UTF and retaining a copy in the electronic medical record. As part of the onboarding process, newly hired licensed nurses will be provided an in-service by the Staff Educator or designee on the Discharge and Transfer (RS-39) Policy and Procedure, purpose,	

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H5730	Continued From page 2 Department and was told it was okay to create a fillable UTF that contained the same information as the required form. On 09/27/2024 at 09:04 AM, the Director of Clinical Services came to the survey team and said we were given the incorrect information regarding the use of the required NJ UTF. During an interview with the surveyor on 09/27/2024 at 09:40 AM, the Registered Nurse (RN #1) was asked what the process is for transferring a resident to the hospital. RN #1 said we page the physician and call 911 if needed. We print the face sheet and print the Medication Administration Record. We have different options for the UTF. It is personal preference which one we use. We were never instructed to use one or the other. Under profile tab there is NJ UTF (HFEL-7) and pull it up, print it out and fill it out by hand. We make a copy to keep here and scan under the document tab so we have proof it was filled out. We give a copy for ambulance squad and the original is sent to the hospital. RN #1 went on to say the clerk is responsible to scan documents into the EMR. RN #1 said there is another way to do the transfer form. There is one under the assessment tab and it attaches to that tab. RN #1 replied, "*NJ Ex Order 26. 4B1* [redacted] " During an interview with the surveyor on 09/27/2024 at 10:05 AM, the Executive director/Licensed Nursing Home Administrator (ED/LNHA) told the surveyor said the that what the Director of Clinical Services was saying to the	H5730	and instructions for completing the NJ UTF, and the importance of completing all sections of the form. The newly hired nurses will also be provided an in-service by the Staff Educator or designee on the process of sending the NJ UTF and retaining a copy in the electronic medical record. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing or designee will review all residents who are transferred to a healthcare facility or program during the clinical meetings to ensure there is a copy of the NJ UTF in the electronic medical record, and all sections of the NJ UTF are completed. The Director of Nursing or designee will audit 100% of all transfers to a healthcare facility or program weekly x 4 weeks, monthly x 3 months, and then quarterly. Results will be reported to the Nursing Home Administrator or designee and reviewed at the quarterly Quality Assurance Performance Improvement (QAPI) Committee meetings. This will continue until substantial compliance is met.	

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H5730	Continued From page 3 survey team on 09/26/2024 was that is the one, meaning the facility created UTF, the nurses are supposed to use as it automatically saves into the EMR. A review of a facility policy on 09/27/2024 at 11:57 AM, titled Discharge & Transfer (RS-39) with a last revised date of 12/5/2023 revealed under Discharges and Transfer section: If the resident is being transferred to the hospital or another healthcare provider or setting within in the same community: The following information must be conveyed to the receiving provider along with the NJ Universal Transfer Form....	H5730		
H5750	8:43E-13.4(b) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall complete all sections of the Universal Transfer Form, to the best of the licensed healthcare facility or program's ability. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of the Medical Record (MR), as well as other facility documentation, it was determined that the facility failed to complete in it's entirety, the New Jersey Universal Transfer Form (NJUTF) when a resident was transferred to the hospital for 1 of 2 residents reviewed for hospitalization. This deficient practice was evidenced by the following:	H5750	1. Corrective actions accomplished for affected residents: Resident #63 who was affected by the deficient practice NJ Ex Order 26.4b1 [redacted] 2. Residents identified having the potential to be affected:	10/27/24

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H5750	Continued From page 4 Reference: New Jersey Hospital Association "Provider Resources" Section 6: The NJ Universal Transfer Form (UTF) must be used by all licensed healthcare facilities and programs when the patient is transferred from one care setting to another. According to the Admission Record Resident #63 was admitted to the facility with the following but not limited to diagnoses: *NJ Ex Order 26. 4B1* [redacted]. A review of a progress note, dated NJ Ex Order 26.4b1 timed at 05:28, signed by the Licensed Practical Nurse, revealed that Resident #63 was found *NJ Ex Order 26. 4B1* [redacted] ordered Resident #63 to be transferred to hospital. Resident #63 was transported to hospital at 8:15 AM. A review of the electronic medical record revealed an incomplete NJUTF for Resident #63 dated NJ Ex Order 26.4b1. Only sections 1 - 7 and section 8 had been completed on the NJUTF. On 9/27/2024 at approximately 11:10 AM the Executive Director presented an additional copy of Resident #63's NJUTF that had been provided to the acute care hospital. Review of the NJUTF provided via the hospital revealed that the following sections were not completed on the NJUTF: 6, 9, 11, 12, 13, 16, 17, 18, 19, 22, 23, and 25-29. A review of the NJUTF (form HFEL-7) revealed the following at the top of the form: "Items 1-29 must be completed." During an interview with facility administration on	H5750	All residents transferred out to another licensed healthcare facility have the potential to be affected by this practice. 3. Measures will be put in place or systemic changes to ensure the deficient practice will not recur: All transfers and discharges within the last 2 weeks have been reviewed to ensure the NJ Universal Transfer Form (UTF)/HFEL-07 was utilized and fully completed and no issues have been identified. The current license nurses will be provided in-service education by the community staff educator on proper use and full completion of the original NJ Universal Transfer Form (UTF)/HFEL-07. A duplicated version of NJ Universal Transfer form has been removed from the electronic medical record to prevent any further confusion as to the correct form to use. To ensure compliance, the Director of Nursing will review all resident transfers and discharges in the daily morning meeting Monday thru Friday to ensure that a completed copy of the NJ Universal Transfer Form (UTF)/HFEL-07 was sent to the receiving healthcare setting and a copy of completed form has been maintained and scanned into the EMR. Ongoing education will be provided during onboarding of new license nurses by the staff educator. Corrective disciplinary action will be taken as warranted for any continual non-compliance identified. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing will audit all	

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H5750	Continued From page 5 09/27/2024 at 10:04 AM, the facility Executive Director (ED) was asked if every section of the NJUTF needed to be completed prior to transfer. The ED reviewed Resident #63's NJUTF and stated, "*NJ Ex Order 26. 4B1* [redacted]." A review of the facility policy titled Discharge & Transfer, last revised 12/5/2023, did not address completion of the NJUTF.	H5750	resident transfers and discharges weekly x 6 months for full completion of the NJ Universal Transfer Form and that it has been sent to the receiving healthcare setting. Weekly audits will remain an ongoing practice to ensure compliance. All results will be reported to the Nursing Home Administrator and reviewed at the quarterly Quality Assurance Performance Improvement (QAPI) Committee meetings. This will continue until substantial compliance is met.	
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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by:	S 560		10/27/24

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S 560	Continued From page 6 Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for the week of Complaint staffing from 06/25/2023 to 07/01/2023, the facility was deficient in CNA staffing for residents on1 of 7 day shifts; For the week of Complaint staffing from 10/08/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts; For the week of Complaint staffing from 10/22/2023 to 10/28/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts; For the week of Complaint staffing from11/26/2023 to 12/02/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts; For the week of Complaint staffing from 12/17/2023 to 12/23/2023, the facility was deficient in CNA staffing on 1 of 7 day shifts; For the week of Complaint staffing from 07/07/2024 to 07/13/2024, the facility was deficient in CNA staffing for residents on 3 of 7-day shifts and deficient in total staff for 1 of 7 evening shifts; For the 2 weeks of staffing prior to survey from 09/08/2024 to 09/21/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "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, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	1. Corrective actions accomplished for affected residents: Efforts to hire licensed nurses and CNAs will continue until there is adequate staff to serve all residents. Concurrently, we will continue to offer overtime to current staff and utilize staffing agencies to fill any open spots in the schedule. 2. Residents identified having the potential to be affected: All residents have the potential to be affected by this practice due to the nature of the deficiency. 3. Measures will be put in place or systemic changes to ensure the deficient practice will not recur: Contracts with additional staffing agencies have been approved to supplement facility staff. Hiring, recruitment and retention efforts including wage and compensation analysis and adjustments, on-line job listings, job fairs, shift differentials, and referral bonuses are being utilized to ensure we stay competitive in the healthcare marketplace. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The Nursing Home Administrator or designee and Director of Nursing will review staffing schedules daily to ensure there is adequate staffing for all shifts. If adequate staffing levels are not met, a variance report will continue to be completed by the Household/Staffing Coordinator and sent to the Nursing Home Administrator or designee and Director of Nursing for review. The Nursing Home	

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S 560	Continued From page 7 effective on 02/01/2021: 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. 1. For the week of Complaint staffing from 06/25/2023 to 07/01/2023. The facility was deficient in CNA staffing for residents on1 of 7 day shifts as follows: -07/01/23 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. 2. For the week of Complaint staffing from 10/08/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -10/14/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. 3. For the week of Complaint staffing from 10/22/2023 to 10/28/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -10/22/23 had 5 CNAs for 62 residents on the day	S 560	Administrator or designee and Director of Nursing will audit 100% of variance reports for accuracy and completeness each time they receive them. Results will be reported at the quarterly Quality Assurance Performance Improvement (QAPI) Committee meetings. This will continue until substantial compliance is met.	

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S 560	Continued From page 8 shift, required at least 8 CNAs. -10/23/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -10/27/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -10/28/23 had 4 CNAs for 61 residents on the day shift, required at least 8 CNAs. 4. For the week of Complaint staffing from11/26/2023 to 12/02/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -11/26/23 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs. 5. For the week of Complaint staffing from 12/17/2023 to 12/23/2023, the facility was deficient in CNA staffing on 1 of 7 day shifts as follows: -12/17/23 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs. 6. For the week of Complaint staffing from 07/07/2024 to 07/13/2024, the facility was deficient in CNA staffing for residents on 3 of 7-day shifts and deficient in total staff for 1 of 7 evening shifts as follows: -07/08/24 had 5 CNAs for 59 residents on the day shift, required at least 7 CNAs. -07/10/24 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -07/10/24 had 4 total staff for 69 residents on the evening shift, required at least 6 total staff. -07/11/24 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. 7. For the 2 weeks of staffing prior to survey	S 560		

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S 560	Continued From page 9 from 09/08/2024 to 09/21/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -09/10/24 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -09/11/24 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs. -09/12/24 had 4 CNAs for 57 residents on the day shift, required at least 7 CNAs. -09/13 24 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. -09/14/24 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs. -09/15/24 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -09/17/24 had 5 CNAs for 62 residents on the day shift, required at least 8 CNAs. -09/18/24 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -09/19/24 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -09/21/24 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs. During an interview with the surveyor on 09/26/2024 at10:45 AM, the Director of Nursing (DON), said that the staffing coordinator (SC) works remotely, and that the DON and the SC work closely together to assure the required staffing is met. The DON went on to say unfortunately call outs at the last-minute make staffing a challenge. The facility offers many incentives to maintain staffing and are in a collaboration with a local school and their CNA program. We know the requirements and we exhaust all means to meet them. A review of a facility policy provided on	S 560		

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S 560	Continued From page 10 09/27/2024, titled, "Healthcare Staffing Guidelines (RS-73)," with a revised date of 05/15/24; indicated directed, "UMC healthcare will comply with all lawful staffing guidelines and evaluate effectiveness of staffing based on established and recognized criteria provided by NJ state agencies. Under the Procedure section: The following direct care staff to resident ratios will apply for all UMC healthcare communities: -One (1) CNA to every eight (8) residents on day shift -One (1) direct care staff members to every ten (10) residents for evening shift provided no fewer than half of all staff members are certified nursing aides and each direct staff member that are scheduled to work as certified nursing assistant (CNA) shall perform certified nursing aide duties. -One (1) direct care staff member to every fourteen (14) residents for night shift provided each direct care staff member that are scheduled to work as a certified nursing aide (CNA) shall perform certified nursing aide duties.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030801 Y1	A. Building B. Wing Y2	10/28/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	535 N OAK AVE PITMAN, NJ 08071

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H5730	Correction	ID Prefix H5750	Correction	ID Prefix	Correction
Reg. # 8:43E-13.4(a)	Completed	Reg. # 8:43E-13.4(b)	Completed	Reg. #	Completed
LSC	10/27/2024	LSC	10/27/2024	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/27/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030801 Y1	A. Building B. Wing Y2	10/28/2024 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H5750	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43E-13.4(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/27/2024	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/27/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030801 Y1	A. Building B. Wing Y2	10/28/2024 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/27/2024	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	
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 9/27/2024

☐ 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
	315427	A. BUILDING **01** B. WING _____	**09/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	**535 N OAK AVE** **PITMAN, NJ 08071**

(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 United Methodist Communities Pitman was in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/24/2024 and 09/25/24. United Methodist Communities at Pitman 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. United Methodist at Pitman is a 3 story building that was built in 1970's. It is composed of Type 1 construction. The facility is divided into 6 smoke zones. The facility has a 125 KW natural gas generator and a 150 KW diesel generator for emergency electrical power. There is a 125 KW diesel generator for designated emergency power to the electric fire pump, according to the U.S. FOIA (b) (6) [redacted].	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance	K 211		10/27/24

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

Electronically Signed | 10/11/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315427	A. BUILDING 01 B. WING _____	09/27/2024

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K 211	Continued From page 1 with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/25/24 in the presence of the U.S. FOIA (b) (6), it was determined the facility failed to ensure means of egress were continuously maintained free of all obstructions or impediments to full instant use in case of fire and protection from hazards by storage of combustible boxes in an exit access corridor in accordance with NFPA 101: 2012 Edition, Sections 7.1.10.1 and 19.3.2. This deficient practice had the potential to affect all 60 residents and was evidenced by the following: An observation at 1:12 PM of the first floor back hall, revealed the kitchen was storing combustible boxes of supplies on plastic racks along 24 feet of the exit access corridor wall. The corridor provided exit access to an exterior exit directly after the row of stored boxes. The exit access corridor was being used as a hazardous storage area. In an interview at the time, the U.S. FOIA (b) (6) confirmed the observation. The U.S. FOIA (b) (6) were informed of the findings at the Life Safety Code exit conference at 2:31 PM. NJAC 8:39 - 31.2(e)	K 211	1. Corrective actions accomplished for affected residents: Items stored in the identified area were relocated to another area to allow egress to be free of all obstructions to full use in case of emergency. 2. Residents identified having the potential to be affected: All residents have the potential to be affected by the deficient practice. 3. Measures will be put in place or systemic changes to ensure the deficient practice will not recur: Items blocking the egress in on the first floor back hall have been removed. No items will be stored in this area to ensure proper egress. Current staff will be educated to not place any items in this area. Newly onboarded staff will also be educated to keep this area free of all obstructions. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Dietary Director will conduct spot checks of area once a week for four weeks then two times per month for three months, and monthly for the following eight months to ensure no items are stored in this area. Results will be reported to the Quality	

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	315427	A. BUILDING **01** B. WING _____	**09/27/2024**

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K 211	Continued From page 2	K 211	Assurance Performance Improvement (QA) committee at the quarterly meeting. A determination for further action will be assessed at the QA meeting.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/25/24 in the presence of the *U.S. FOIA (b) (6)* [redacted]	K 324	1. Corrective actions accomplished for affected residents: The kitchen range-hood fire suppression	10/27/24

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K 324	Continued From page 3 it was a determined that the facility failed to perform monthly inspections of the range-hood fire suppression system in accordance with NFPA 17A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect all 60 residents and was evidenced by the following: An observation of the kitchen range-hood fire suppression system pull station and 2 wet chemical tank inspection tags, revealed the semi-annual inspection was performed in April of 2024 and the monthly inspection documentation spaces on the back of the tags were blank indicating the monthly inspection had not been performed for the months of: May, June, July and August 2024. In an interview at the time, the [redacted] confirmed the observation. The *U.S. FOIA (b) (6)* [redacted] were informed of the findings at the Life Safety Code exit conference at 2:31 PM. NJAC 8:39-31.2(e) NFPA 17A, 96	K 324	system pull-station and 2 wet chemical tanks were inspected immediately. Completed inspections were documented on the tags as well as the fire extinguisher inspection sheet. 2. Residents identified having the potential to be affected: All residents have the potential to be affected by the deficient practice. 3. Measures will be put in place or systemic changes to ensure the deficient practice will not recur: The kitchen range-hood fire suppression system pull- station and 2 wet chemical tanks will be inspected, and inspections will be documented monthly. Extinguisher check list updated for October inspections and moving forward to include ansul system. Corporate Director of Building Services educated *U.S. FOIA (b) (6)* [redacted] on documentation of monthly inspections. Security and maintenance staff will be educated on the process, timeliness, and documentation of the monthly inspections. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Building Services Director will conduct spot checks each month to ensure the inspections are completed. Corporate Director of Building Services will conduct spot checks quarterly to ensure the inspections are completed. Results will be reported to the Quality Assurance Performance Improvement (QA)	

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K 324	Continued From page 4	K 324	committee at the quarterly meeting. A determination for further action will be assessed at the QA meeting.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/25/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was a determined that the facility failed to provide instructional placards near 2 of 2 Class K portable fire extinguishers in accordance with NFPA 10: 2010 Edition, Section 5.5.5.3(a). This deficient practice had the potential to affect all 60 residents and was evidenced by the following: An observation of the kitchen at 1:17 PM, revealed 2 K-Type fire extinguishers that did not have the required instructional placard indicating the range-hood fire protection system must be activated prior to using the fire extinguisher. One of the K-type extinguishers was located at the kitchen entrance and the other was by the stairwell #4 entrance. In an interview at the time, the U.S. FOIA (b) (6) confirmed the observation and stated they were unaware of the requirement. The U.S. FOIA (b) (6) [redacted] and	K 355	1. Corrective actions accomplished for affected residents: Instructional signage was immediately created and placed over the two Class K fire extinguishers with instructions to initiate range-hood fire protection system prior to using the fire extinguishers. 2. Residents identified having the potential to be affected: All residents have the potential to be affected by the deficient practice. 3. Measures will be put in place or systemic changes to ensure the deficient practice will not recur: Instructional placards will be placed near 2 Class K portable fire extinguishers in the kitchen. The instructions will indicate the range-hood fire protection system must be activated prior to using the fire extinguisher. Dietary staff will be educated by the building service director on the order of use of firefighting equipment.	10/27/24

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K 355	Continued From page 5 *U.S. FOIA (b) (6)* were informed of the findings at the Life Safety Code exit conference at 2:31 PM. NJAC 8:39-31.2(e) NFPA 10	K 355	Findings will be reviewed in the monthly safety meeting with corrective action as warranted. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Dietary Director will conduct spot checks each month to ensure the placards are in place and in good condition. Results will be reported to the Quality Assurance Performance Improvement committee at the quarterly meeting. A determination for further action will be assessed at the meeting.	
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, 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	K 531		10/27/24

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K 531	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/25/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to maintain elevator emergency communication telephones for 1 elevator telephone tested in accordance with ASME/ANSI A17.3. This deficient practice had the potential to affect all 60 residents and was evidenced by the following: An observation at 12:03 PM revealed, a test of the emergency communication telephone for elevator #4 the emergency telephone did not function. There was no answer and a busy signal. The test was repeated 4 additional times by the U.S. FOIA [redacted] with the same results. In an interview at that time, the U.S. FOIA [redacted] confirmed the emergency communication telephone in elevator #4 was not answered when tested. The U.S. FOIA (b) (6) [redacted] were informed of the findings at the Life Safety Code exit conference at 2:31 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	1. Corrective actions accomplished for affected residents: Immediate further testing of the emergency button in elevator #4 indicated a user error by the U.S. FOIA (b) (6) [redacted] on duty at the time. Test performed on 4 separate occasions with a maintenance worker on the receiving end indicated the communication was received. U.S. FOIA (b) (6) [redacted] on duty at the time received immediate education on procedure for receiving a call from the elevator emergency call button. 2. Residents identified having the potential to be affected: All residents have the potential to be affected by the deficient practice. 3. Measures will be put in place or systemic changes to ensure the deficient practice will not recur: All staff in the role of Receptionists will be provided inservice education on the proper receiving of communication from the emergency elevator button and procedures thereafter. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Building Services Director will conduct audits of emergency elevator button weekly for four weeks, twice per month for three months, then monthly thereafter to ensure the emergency elevator buttons are working and communication is received appropriately at the front desk.	

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K 531	Continued From page 7	K 531	Results will be reported to the Quality Assurance Performance Improvement (QAPI) committee at the quarterly meeting. A determination for further action will be assessed at the meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review on 09/24/24 in the presence of the *U.S. FOIA (b) (6)* [redacted], it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for	K 914	1. Corrective actions accomplished for affected residents: Maintenance team immediately began using receptacle tester on non-hospital grade electrical outlets for grounding, plurality, and blade tension. Completed	10/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315427	A. BUILDING **01** B. WING _____	**09/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	**535 N OAK AVE** **PITMAN, NJ 08071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 8 grounding, polarity, and blade tension in accordance with NFPA 99: 2012 Edition and NFPA 70: 2011 Edition. This deficient practice had the potential to affect all 60 resident and was evidenced by the following: Record review between 9:00 AM and 2:30 PM revealed the facility's annual electrical inspection report, dated 08/07/24, from the facility's licensed vendor only documented that a visual electrical inspection was performed and did not indicated that the rooms with non-hospital grade electrical outlets were annually inspected for grounding, polarity, and blade tension. In an interview at 2:30 PM, the [redacted] confirmed the record review and stated that the facility was not currently documenting the outlet testing for grounding, polarity and tension. The [redacted] were informed of the findings at the Life Safety Code exit conference on 9/25/24 at 2:31 PM. NJAC 8:39-31.2(e) NFPA 99. 70	K 914	inspections are indicated by a sticker on the receptacle. All non-hospital grade electrical outlets will be inspected by 10/27/24 and annually thereafter. 2. Residents identified having the potential to be affected: All residents have the potential to be affected by the deficient practice. 3. Measures will be put in place or systemic changes to ensure the deficient practice will not recur: All non-hospital grade electrical outlets will be inspected by 10.27.2024 for grounding, polarity, and blade tension in addition to the visual inspection. Annual testing of all non-hospital grade electrical outlets for grounding, polarity and blade tension will be added to the community preventive maintenance tasks to be performed by the maintenance team and will include a pass/fail for each item. The annual inspection results will be submitted to the Quality Assurance Performance improvement committee team for review. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Building Services Director or designee will conduct audits and review records to ensure inspections, both visual as well as grounding, polarity, and blade tension, are within compliance monthly. Results will be reported to the Quality Assurance Performance Improvement (QAPI) committee at the quarterly meeting. A determination for further action will be	

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K 914	Continued From page 9	K 914	assessed at the meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918		10/27/24

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UNITED METHODIST COMMUNITIES AT PITMAN	**535 N OAK AVE** **PITMAN, NJ 08071**

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K 918	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and record review on 09/24/24 in the presence of the [U.S. FOIA (b) (6)] [redacted], it was determined that the facility failed to provide a letter of reliability from the natural gas supplier for their one natural gas generator and failed to certify the time needed by their generators to transfer power to the building was within the required 10-second time frame in accordance with NFPA 99: 2012 Edition and NFPA 110: 2010 Edition. This deficient practice was evidenced for 2 of 3 generators, had the potential to affect all 60 residents and was evidenced by the following: In an interview at 9:30 AM, the [U.S. FOIA (b)] [redacted] stated the facility has 3 emergency power generators. Two generators were diesel and 1 was natural gas fueled. A 150 Kilo Watt (KW) diesel and a 125 KW natural gas generators were for emergency electrical power to the facility and a 125 KW diesel generator was for dedicated emergency power to the electric fire pump. A record review between 9:00 AM and 2:30 PM revealed there was no letter of reliability to supply natural gas to the facility's generator from the natural gas supply company. In an interview at the time the [U.S. FOIA (b)] [redacted] confirmed the finding and stated he did not have a letter of reliability from the natural gas supplier. A record review at 1:39 PM of the 150 KW generator logs for the previous twelve months revealed the transfer times from primary to secondary power were not recorded on the following log dates: 8/19/24, 7/18/24, 6/18/24,	K 918	1. Corrective actions accomplished for affected residents: Gas company immediately contacted to initiate process to receive a letter of reliability. Follow up email sent. Maintenance staff educated on documenting transfer times during load tests for generators. 2. Residents identified having the potential to be affected: All residents have the potential to be affected by the deficient practice. 3. Measures will be put in place or systemic changes to ensure the deficient practice will not recur: Received a letter of reliability from the natural gas company. Logs will be updated to include transfer times. Maintenance staff will be educated to include transfer times during load tests. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: Building Services Director will conduct a monthly audit and review records to ensure generator logs are completed and include transfer times. Results will be reported to the Quality Assurance Performance Improvement (QAPI) committee at the quarterly meeting. Building Services Director will also report quarterly the letter of reliability to supply natural gas is current. A determination for further action will be assessed at the QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315427	A. BUILDING **01** B. WING _____	**09/27/2024**

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UNITED METHODIST COMMUNITIES AT PITMAN	**535 N OAK AVE** **PITMAN, NJ 08071**

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K 918	Continued From page 11 5/17/24, 4/18/24, 3/19/24, 12/5/23, 11/17/23, and October 2023 and September 2023 there was no load test indicated. A record review at 2:18 PM of the 125 KW natural gas generator logs for the previous twelve months revealed the transfer times from primary to secondary power were not recorded on the following log dates: 8/19/24, 5/17/24, 3/19/24, 2/12/24, and October 2023 and September 2023 there was no load test indicated. An interview at the time the [redacted] confirmed the findings and stated the maintenance staff were not filling out the test log properly. The [redacted] were informed of the findings at the Life Safety Code exit conference on 09/25/24 at 2:31 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	4. Corrective actions will be monitored to ensure the deficient practice will not recur: Building Services Director will conduct a monthly audit and review records to ensure logs are completed on a timely basis. Results will be reported to the Quality Assurance Performance Improvement (QAPI) committee at the quarterly meeting. Building Services Director will also report quarterly the letter of reliability to supply natural gas is current. A determination for further action will be assessed at the QA meeting.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	K 923		10/27/24

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	315427	A. BUILDING **01** B. WING _____	**09/27/2024**

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K 923	Continued From page 12 sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/25/24 in the presence of the *U.S. FOIA (b) (6)* [redacted], it was determined the facility failed to provide storage of oxygen cylinders so empty cylinders are segregated from full cylinders and appropriately labeled full and empty in accordance with NFPA 99: 2012 Edition, Sections 11.6.5.2 and 11.6.5.3. This deficient practice had the potential to affect all 60 residents and was evidenced by the following: An observation of the oxygen storage room at 12:10 PM revealed 26 compressed Oxygen	K 923	1. Corrective actions accomplished for affected residents: "Full" and "Empty" signs were immediately created and posted indicating the separation of full and empty oxygen tanks. 2. Residents identified having the potential to be affected: All residents have the potential to be affected by the deficient practice. 3. Measures will be put in place or systemic changes to ensure the deficient	

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K 923	Continued From page 13 cylinders. It could not be determined what cylinders were full or empty as they were not segregated and not marked to identify which were full or empty. In an interview at the time the [redacted] confirmed the observation. The *U.S. FOIA (b) (6)* [redacted] were informed of the findings at the life safety code exit conference at 2:31 PM. NJAC 8:39-31.2(e) NFPA 99	K 923	practice will not recur: Current nursing and maintenance staff will be provided inservice education on proper storage of oxygen. The oxygen tanks have been separated into two carts and split apart into two groups: “Empty” and “Full”. A sign has been added above the carts designating one for empty tanks and one for full tanks. Building service director will add oxygen storage check to monthly preventive maintenance tasks to ensure compliance. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The building service director will conduct an oxygen storage inspection weekly for four weeks. Inspections will continue to be completed twice per month for three months, then monthly thereafter to ensure compliance. Results will be reported to the Quality Assurance Performance Improvement (QAPI) committee at the quarterly meeting. A determination for further action will be assessed at the meeting.	

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
315427 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/28/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT PITMAN	535 N OAK AVE PITMAN, NJ 08071

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 K0211	10/27/2024	LSC K0324	10/27/2024	LSC K0355	10/27/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	10/27/2024	LSC K0914	10/27/2024	LSC K0918	10/27/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	10/27/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/27/2024	☐ YES ☐ NO