STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE , WOODBRIDGE, New Jersey, 07095

(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
F0000	INITIAL COMMENTS Survey Date: 4/8/25 Census: 46 Sample: 12 + 1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		
F0640 SS = B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and	F0640	1. Immediate action(s) taken for the resident(s) found to have been affected include: The MDS discharge [redacted] assessment for Resident #22s was electronically completed and transmitted on [redacted]. The policy for MDS Assessments was revised to include the timeliness of MDS assessments. 2. Identification of other residents having the potential to be affected was accomplished by: A review of the discharge assessments was reviewed to ensure all MDS Assessments were electronically submitted to CMS. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Administrator and Director of Nursing conducted an educational in-service with the [redacted] and the IDC team. A. The MDS 3.0 RAI Manual, MDS Assessment specifically to Death in Facility Tracking Record (A0310F = 12)	04/27/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2025

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F0640 SS = B	Continued from page 1 data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to complete a [NJ Ex Orde] Minimum Data Set (MDS), an assessment tool, as required for 1 of 1 system selected for residents with MDS record over 120 days reviewed (Resident #22), and was evidenced by the following: On 4/2/25 at 9:45 AM, the surveyor reviewed the system selected MDS record over 120 days which revealed Resident #22 was overdue for a MDS assessment. A review of Resident #22's medical record (MR) revealed that the resident had [NJ Ex Order 28] in the facility on [NJ Ex Order 28]. A review of the resident's MDS assessments	F0640	Continued from page 1 " Must be completed when the resident dies in the facility or when on LOA. " Must be completed within 7 days after the residents death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days). " Must be submitted within 14 days after the residents death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days). " Consists of demographic and administrative items. " May not be combined with any type of assessment. B. Tracking will be conducted by the IDCP team at the weekly Utilization Review meetings to discuss all assessments timing, completion and submission in timely a manner. Audits will be conducted 1x a week for six months by the Administrator/DON and/or their designee, until consistent compliance has been achieved. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator/Director of Nursing and/or designee will conduct random weekly audits times one month and will continue monthly over the next six months to ensure MDS assessments timing, completion and submission in a timely manner. A quality assurance improvement performance has been implemented as a corrective improvement measure. The audit findings will be reported and reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the Committee. The QAPI committee meets quarterly and is attended by the Medical Director, DON, Administrator, department heads and nursing consultants where suggestions and recommendations are presented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2025

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F0640 SS = B	Continued from page 2 revealed the last MDS completed was a quarterly assessment dated [NJ Ex Order 26.4]. The was no assessment for the resident's [NJ Ex Order] On 4/3/25 at 12:08 PM, the surveyor interviewed the [U.S. FOIA] who confirmed Resident #22 had [NJ Ex Order 26.] in the facility on [NJ Ex Order 26.4] and there was no completed MDS assessment for [NJ Ex Order 26.4(]. The U.S. FOIA (b) (6) stated the facility had seven days after the resident's [NJ Ex Orde] to complete the assessment and an additional fourteen days to transmit it. The U.S. FOIA (b) (6) stated that the resident's assessment was missed. On 4/3/25 at 12:28 PM, the surveyor interviewed the U.S. FOIA (b) (6)), who confirmed that Resident #22's MDS should have been completed and then transmitted within 14 days. The [U.S. FOIA (] could not speak to why the MDS was missed. On 4/7/25 at 10:27 AM, the U.S. FOIA (b) (6)), in the presence of the survey team, acknowledged that the completion and transmission of [NJ Ex Order 26.4(] in facility MDS for Resident #22 was missed in error. A review of the facility's "MDS Assessments" policy dated revised January 2025, did not include MDS timing. A review of the facility's "MDS Comprehensive" policy dated revised 4/3/25, did not include MDS timing. NJAC 8:39 - 11.1	F0640	Continued from page 2 The plan of correction represents the facilitys allegation of compliance as of April 27, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2025

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F0000	INITIAL COMMENTS No Information	F0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ST JOSEPH SENIO.. B. WING	(X3) DATE SURVEY COMPLETED 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE , WOODBRIDGE, New Jersey, 07095

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/7/25 and 4/8/25 and St Joseph's Home AL & NC was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. St Joseph's Home AL & NC is a Two-story, Type I Fire Resistant building that was built in January 1992. The facility is divided into 5 smoke zones. The facility has a diesel generator. The facility had 51 licensed beds and occupied 46 at the time of survey.	K0000		
K0341 SS = F Bldg. 02	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 4/7/25 and 4/8/25 in the presence of the U.S. FOIA (b) (6) [redacted]) and the U.S. FOIA (b) (6) [redacted]), it was	K0341	1. Immediate action(s) taken for the 46 resident(s) found to have been affected include: A Smoke detector was installed, programmed and tested in the mechanical room where Fire Alarm Control Unit (FACU) is located, on April 14, 2025, by Johnson Controls Fire Protection. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all 46 residents had the potential to be affected. A smoke detector was installed in the mechanical room where FACU unit is maintained. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Life Safety Code National Fire Protection	04/14/2025

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		A. BUILDING 02 - ST JOSEPH SENIO.. B. WING	04/08/2025

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K0341 SS = F Bldg. 02	Continued from page 1 determined the facility failed to ensure in areas not continuously occupied automatic smoke detection shall be provided at all Fire Alarm Control Unit's (FACU), in accordance with NFPA 101: 2012 Edition, Sections 19.3.4.1, 9.6.1.8 and NFPA 72: 2010 Edition, Section 10.15. This deficient practice had the potential to affect 46 residents and was evidenced by the following: Observations on 4/7/25 at 11:06 AM of the FACU mechanical room revealed the room was not an occupied room and was not equipped with a smoke detector to protect the FACU. In an interview at the time, the [redacted] and the [redacted] confirmed the observation. In an interview on 4/8/25 at 9:45 AM, the [redacted] confirmed the FACU room did not have a smoke detector. The facility's [redacted] the [redacted] and the [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 4/8/25 at 1:45 PM. N.J.A.C 8:39-31.2 (e) NFPA 72	K0341	Continued from page 1 Association (NFPA) Life Safety Code of Chapter 19 existing Health care occupancies was reviewed by the Administrator and management team to minimize the risk of future occurrence. The smoke detector will be inspected bi-annually during the inspection conducted by the fire safety company and during routine monthly rounds to ensure it is in working order. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator and/or designee will conduct monthly audits times six months in addition to the bi-annually inspection by the fire company to ensure smoke detectors are located and in working operations as required by NFPA/Life Safety Code. A quality assurance improvement performance has been implemented as a corrective improvement measure. The audit findings will be reported and reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the Committee. The QAPI committee meets quarterly and is attended by the Medical Director, DON, Administrator, department heads and nursing consultants where suggestions and recommendations are presented. The QAPI committee meets quarterly and is attended by the Medical Director, DON, Administrator, department heads where suggestions and recommendations are presented. The plan of correction represents the facilitys allegation of compliance as of April 14, 2025.	

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/7/25 and 4/8/25. The facility was found to be in compliance with Appendix Z-Emergency Preparedness, 42 CFR 483.73, Requirements for Long Term Care Facilities.	E0000		

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K0000 Bldg. 02	INITIAL COMMENTS No Information	K0000		

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E0000	Initial Comments No Information	E0000		

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