STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	708116	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
2ND HOME PASSAIC, LLC	63 GROVE STREET PASSAIC, NJ 07055

(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) COMPLETE DATE
M 000	Initial Comments Type of Survey: Monitoring/Follow-up to the 8/21/24 survey conducted by the Office of Inspector General. Census: Two Morning Sessions: 121 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 203	8:43F-2.6(g) Licensure Procedures A facility shall not exceed its licensed capacity. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility exceeded its licensed capacity of 120 slots for one day on 9/3/25 when 121 participants attended the program. This deficient practice was evidenced by the following: On 9/3/25 at 10:17 a.m., during entrance conference with the Administrator, she stated that the facility's capacity was 120. At this time, the surveyor requested the census. At 11:08 a.m., the Administrator provided the	M 203		

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

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M 203	Continued From page 1 surveyor with the daily participant sign-in sheets and stated that the census was 120. The surveyor reviewed the previously mentioned sign-in sheets titled, "Daily Check In for 9/3/2025," which revealed 121 participant signatures. At 12:11 p.m., the surveyor showed the Administrator the sign-in sheets dated 9/3/25 and informed the Administrator that there were 121 participant signatures. At this time, the Administrator counted the participant signatures and confirmed that the census was 121. The surveyor then inquired the reason the facility went over its licensed capacity, and the Administrator stated that too many participants attended and that it was the first time the facility ever went over capacity. The Administrator explained that since she started at the facility, the census increased, and more participants wanted to attend. The surveyor inquired how the Administrator knew how many participants were expected to attend each day, and the Administrator stated that she did not know because some participants would walk to the facility.	M 203		
M 481	8:43F-8.2 Medical Services A physician shall be designated to serve as the facility's medical consultant. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility	M 481		

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M 481	Continued From page 2 documents, it was determined that the facility failed to ensure that a physician was designated to serve as the facility's medical consultant. This deficient practice was evidenced by the following: 1. On 9/3/25 at 3:44 p.m., the surveyor interviewed the Executive Director (ED) to inquire if the facility had a medical consultant when she started at the NJ Ex Order 26. 4B1, and the ED stated that the facility had a medical consultant and that she previously provided an auditor from the Department of Human Services Office of Inspector General with the contract. The surveyor reviewed a medical consultant contract provided by the ED, which revealed that the contract was dated NJ Ex Order 26. 4B1. The ED was not able to provide the surveyor with a medical consultant contract dated prior to NJ Ex Order 26. 4B1. 2. On 8/21/24, an Auditor from the Department of Human Services Office of Inspector General reviewed a medical consultant contract provided by the ED, which revealed that the contract was expired. The surveyor reviewed the facility's policy titled, "Designation and Responsibilities of Medical Consultant," which indicated, "Policy: A physician shall be designated to serve as a medical consultant ..."	M 481		
M 651	8:43F-14.10(a)(1)(i) Physical Plant Requirements (a) Each adult facility shall provide a quiet room or a separate, quiet area for participants who wish to rest or recline. The quiet room/area shall not be counted as activity or dining space.	M 651		

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M 651	Continued From page 3 1. The facility shall provide at least one item of comfortable furniture, such as a bed, lounge, recliner, or equivalent, selected in accordance with assessments of participants' needs to rest or recline, for every 10 adult day health services participant equivalents, calculated on the basis of the licensed capacity. This comfortable furniture shall be available for use in the quiet room/area. i. A minimum of 40 square feet shall be provided for each bed, lounge, recliner, or equivalent. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide one recliner/comfortable furniture for each ten participants and the facility was licensed for 120 participants, so there should be twelve recliners/comfortable furniture per participant. This deficient practice was evidenced by the following: 1. On 9/3/25 at 10:17 a.m., during entrance conference with the Administrator, she stated that the facility's capacity was 120.	M 651		

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M 651	Continued From page 4 At 10:42 a.m., the surveyor observed five recliners in a room with an open layout and no doors. The room was also occupied by a billiards pool table and two dominoes tables, which were all in use by multiple participants. At 10:50 a.m., the surveyor observed one recliner in the hallway next to the nursing office. At 11:08 a.m., the Administrator provided the surveyor with the daily participant sign-in sheets and stated that the census was 120. The surveyor reviewed the previously mentioned sign-in sheets titled, "Daily Check In for 9/3/2025," which revealed 121 participant signatures. At 12:52 p.m., the surveyor asked the Director of Nursing (DON) if the facility had a quiet room, and the DON directed the surveyor to the quiet room. At this time, the surveyor observed four recliners in the quiet room and one office chair with wheels. At 2:29 p.m., the surveyor toured the facility a second time with the Administrator. At this time, the surveyor inquired the reason the quiet room only had four recliners, and the Administrator stated that there were four recliners in the quiet room and six recliners on the other side of the facility. The surveyor asked the Administrator if she knew that the facility was supposed to have one recliner/comfortable furniture per 10 participants, and the Administrator stated, "I wasn't sure about the ratio, I'm short two recliners." The surveyor inquired the reason the facility did not have enough recliners/comfortable furniture, and the Administrator stated that the census was lower prior to her employment at the	M 651		

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M 651	Continued From page 5 facility and that the facility likely had enough recliners/comfortable furniture for the number of participants they had before she was employed. 2. Additionally, the surveyor reviewed a photograph taken by an Auditor from the Department of Human Services Office of Inspector General on 8/21/24, which revealed six recliners in the previously mentioned room with the open layout, no doors, and dominoes table. The photo revealed a participant who appeared to be resting while five other participants played dominoes close by. At the time of the 8/21/24, OIG survey, there was not a separate quiet area for the participants to rest and there was not a sufficient number of comfortable furniture provided for the participants for a census of 104. The surveyor reviewed the facility's policy titled, "Provision of beds, lounges or recliners," which indicated, "Policy: The facility shall provide at least one item of comfortable furniture, such as a bed, lounge, recliner, or equivalent ... for every ten adult day health care participant equivalents, calculated on the basis of the licensed capacity ..."	M 651		
M 689	8:43F-14.17(f)(g) Physical Plant Requirements (f) Drills of emergency plans shall be conducted at least four times a year and documented, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The four drills shall include at least one drill for emergencies due to fire. (g) The facility shall conduct at least one drill per	M 689		

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M 689	Continued From page 6 year for emergencies due to another type of disaster, such as storm, flood, other natural disaster, bomb threat, or nuclear accident. All staff shall participate in at least one drill annually, and program participants may take part in drills. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to conduct and document at least four emergency drills annually, including a fire drill and at least one disaster drill for all staff in 2023 and 2024. This deficient practice was evidenced by the following: 1. On 9/3/25 at 3:44 p.m., the surveyor interviewed the Executive Director (ED) to inquire about emergency drills. The ED stated that she completed three emergency drills for 2025 and that she had one disaster drill left to complete. At this time, the surveyor requested the emergency drills from 2023-2025, and the ED stated that she could only provide the emergency drills that she completed and that she did not know if emergency drills were completed prior to her employment at the facility in March of 2024. The surveyor reviewed the emergency drills provided by the ED, which revealed that the ED completed three fire drills and one disaster drill in 2024, and three fire drills in 2025.	M 689		

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M 689	Continued From page 7 2. On 8/21/24, an Auditor from the Department of Human Services Office of Inspector General reviewed emergency drills, which revealed that the facility completed two fire emergency drills in 2024 and none in 2023. The surveyor reviewed the facility's policy titled, "Emergency Plans and Procedures," dated 5/1/06, which indicated, "The administrator will be responsible to ensure that center specific protocols are written that outline emergency plans, policies, and procedures. These protocols shall include plans and procedures to be followed in case of medical, emergency equipment breakdown, fire or other disaster ... 9. Drills of emergency plans shall be conducted at least four times a year. The four drills shall include at least one drill for emergencies due to fire and one dure to another type of disaster ..."	M 689		
M 691	8:43F-14.17(h) Physical Plant Requirements Fire extinguishers shall be examined annually and maintained in accordance with manufacturers' and National Fire Protection Association (NFPA) requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	M 691		

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M 691	Continued From page 8	M 691		

pertinent facility documents, it was determined that the facility failed to inspect and maintain 5 fire extinguishers annually as required by the National Fire Protection Association (NFPA) and failed to comply with the Department of Transportation rules and ensured vehicles were maintained in safe operating order for 121 of 121 participants. This deficient practice was evidenced by the following:

1. On 9/3/25 at 10:28 a.m., the surveyor toured the facility and observed a fire extinguisher near the front concierge desk and administrative offices with a label that indicated the fire extinguisher was last inspected in 2022. At this time, the Administrator stated that a fire inspection company came to the center on 9/2/25, to inspect the facility's fire extinguishers. The Administrator explained that the fire inspection company had to return later to inspect four of the facility's carbon dioxide fire extinguishers.

The surveyor continued the tour and observed three additional carbon dioxide fire extinguishers without labels to show the date of such inspection and maintenance.

At 12:55 p.m., the surveyor in the presence of the Director of Transportation (DOT) observed a fire extinguisher inside of one of the facility's buses (License Plate [redacted]), with a label that indicated that the fire extinguisher was last inspected in September of 2024. At this time, the DOT stated that the label for the fire extinguisher was inside of the facility.

At 1:05 p.m., the Administrator stated that when the fire inspection company inspected the fire extinguishers on the facility's buses, the

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M 691	Continued From page 9 previously mentioned bus was not at the facility. The Administrator stated that the fire inspector left a label for the facility to apply to the fire extinguisher. 2. Additionally, the surveyor reviewed photographs taken by an Auditor from the Department of Human Services Office of Inspector General on 8/21/24, which revealed that a fire extinguisher inside of the facility was last inspected in September of 2022, and a fire extinguisher in one of the facility's buses was last inspected in January of 2020. The surveyor reviewed the 5/1/06 facility policy titled, "Transportation Services," which indicated, "Policy: The Administrator shall be responsible for ensuring the provision of safe transportation services, either directly or through contractual agreements, to all participants who require transportation ... The surveyor reviewed the 5/1/06 facility policy titled, "Emergency Plans and Procedures," which indicated, "Policy: The Administrator will be responsible to ensure that center specific protocols are written that outline emergency plans, policies, and procedures. These protocols shall include plans and procedures to be followed in case of medical, emergency equipment breakdown, fire or other disaster. Procedure ... 6. Fire extinguishers will be examined annually and labeled ..."	M 691		
M 767	8:43F-16.2(a)(1-4) Infection Control, Santation, Housekeeping (a) The facility shall develop, implement, and review, at least annually, written policies and	M 767		

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M 767	Continued From page 10 procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications, incorporated herein by reference: 1. Guideline for Hand Hygiene in Health-Care Settings, PB85-923404, as amended or supplemented; 2. OSHA Standards 29 CFR--1910.1030, Bloodborne pathogens, as amended and supplemented; 3. Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly, and contained in MMWR 39(RR-10), as amended or supplemented; and 4. Prevention of Nosocomial Pneumonia, PB95-176970, January 3, 1997, 46(RR-1), as amended or supplemented. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documents it was determined that the facility failed to review, at least annually, its infection prevention and control policies and procedures. This deficient practice was evidenced by the following: 1. On 9/3/25, the surveyor reviewed policies and	M 767		

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M 767	Continued From page 11 procedures on Infection Prevention and Control and annual staff in-services were completed by the Director of Nursing on infection control for 2024 and 2025. 2. On 8/21/24, an Auditor from the Department of Human Services Office of Inspector General reviewed policies and procedures for infection control, which revealed that the policies and procedures were not updated annually.	M 767		
M 805	8:43F-16.5(a)(b)(c) Infection Control, Santation, Housekeeping (a) The facility shall provide and maintain a sanitary and safe environment for participants. (b) The facility shall provide housekeeping and pest control services. (c) Written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for housekeeping, sanitation, and safety services shall be developed and implemented. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide a safe and sanitary environment and failed to ensure	M 805		

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M 805	Continued From page 12 housekeeping and sanitation conditions were met for 121 of 121 participants. This deficient practice was evidenced by the following: 1. On 9/3/25 at 10:26 a.m., the surveyor toured the facility and observed the following: a) 15 white ceiling tiles with brown marks on them b) two missing ceiling tiles c) blue and white cords on the floor without protection in the nursing station. d) two broken water dispensers, one of which was in the main common area with stagnant brown water and brown particles in the water tray e) a broken baseboard heater with a piece of metal that appeared to be sharp sticking out in a common area and another baseboard heater without a cover f) At 10:32 a.m., the surveyor toured the facility and observed a broken water dispenser near the front concierge desk. At this time, the surveyor interviewed the Director of Transportation (DOT) to inquire about the water dispenser. The DOT stated that the water dispenser was out of order and that they called to have the water dispenser removed but no one came yet. g) At 10:42 a.m., the surveyor observed another broken water dispenser in the main common area with stagnant brown water and brown particles in the water tray. In addition, the surveyor observed a broken baseboard heater with a piece of metal that appeared to be sharp sticking out in a common area and another baseboard heater without a cover, a hole in a wall of the main	M 805		

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M 805	Continued From page 13	M 805		

common area near the janitor's closet and exposed wires at the nursing station and "Door A, two gallons of multipurpose cleaner, two quarts of Clorox disinfectant cleaner with bleach, and one 21-ounce container of Comet disinfectant cleaner with bleach sitting out on the floor in the corner of the kitchen.

h) during continued tour of the facility, the surveyor observed a paint can and a box of apples sitting on the floor in the kitchen's storage area. The surveyor then observed two kitchen staff enter the storage area and place the box of apples on top of the paint can.

i) At 10:52 a.m., the surveyor opened an activity storage closet and observed multiple storage bins stacked close to the ceiling and leaning over.

j) At 10:59 a.m., the surveyor observed three pairs of shoes on the kitchen floor outside of the dry food storage closet.

k) At 11:08 a.m., the Administrator stated that the facility had new ceiling tiles and that a roofing company had to come out to fix leaks before the facility could change the tiles. The Administrator explained that the facility left the ceiling tiles with brown marks in place so that the roofing company could identify where the leaks were.

l) At 1:04 p.m., the surveyor observed full bags of garbage outside on the ground in the walkway behind the facility instead of in the designated garbage area. At this time, the DOT stated that the garbage bags were placed there until the end of the day and later placed in the dumpster.

m) At 2:29 p.m., during the tour, in the presence of the Administrator, the surveyor observed wires

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M 805	Continued From page 14	M 805		

on the floor without protection and an extension cord in the Administrator's office. The surveyor inquired the reason the Administrator had an extension cord plugged in, and the Administrator stated, "I don't know why it's there." In the same interview, the surveyor asked about the shoes in the kitchen, the broken water dispensers and the baseboard heaters, the Administrator stated that some staff had been at the facility for years and had gotten too comfortable. In addition, the Administrator stated that she had to call someone to come fix the water dispensers and that the baseboard heater cover was missing since she started in March of 2024. The surveyor inquired if the Administrator called anyone to fix the baseboard heaters, and the Administrator stated, "I did not call maintenance because it was like that when I came".

n) During the same interview, the surveyor inquired about the hole in the wall, and the exposed wires, the Administrator stated that "Door A" was that way when she started at the facility in March of 2024 and that she could ask maintenance to come fix it. The Administrator continued to say that she requested for maintenance to fix the holes in the walls. When the surveyor inquired about the apples and the paint can, the Administrator stated that the apples should not be sitting on top of the paint can and that the paint can should be stored away.

2) At the time of the Office of Inspector General (OIG) survey on 8/21/24, the Auditors provided photographs of their observations which were reviewed by the surveyor which revealed the following: four white ceiling tiles with brown marks, wires on the floor without protection in the Administrator's office, a wire hanging from a broken wall near an exit, what appeared to be the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	708116	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
2ND HOME PASSAIC, LLC	63 GROVE STREET PASSAIC, NJ 07055

(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) COMPLETE DATE
M 805	Continued From page 15 same broken water dispensers, a baseboard heater without a cover, exposed wires, prescribed medication stored in an unlocked drawer in the front desk reception area, a full garbage bag and boxes inside the janitor's closet, which made the floor sink inaccessible to the janitor, an emergency exit that was blocked by boxes, multiple instances where alarms for the doors were hanging off the torn walls, a cluttered storage area with a blocked aisle, bleach and other chemicals, including a paint can that were not properly stored and garbage bags outside on the ground in the walkway behind the facility. The surveyor reviewed the 1/1/14 facility policy titled, "Housekeeping Services," which indicated, "Policy: The facility shall provide and maintain a sanitary and safe environment for participants ... f. All furnishings shall be clean and in good repair and mechanical equipment shall be in working order ... Broken or worn items shall be repaired, replaced or removed promptly ... c. All poisonous and toxic materials shall be identified, labeled and stored in a locked cabinet or room that is used for no other purposes ...e. Paints, varnishes, lacquers, thinners and all other flammable materials shall be stored in closed metal cabinets or containers ... i. All solid or liquid waste that is not regulated medical waste; garbage and trash shall be collected, stored and disposed of in accordance with the rules of the New Jersey Department of Senior Services ..." Reference 8:43F-16.5(a)(b)(c)	M 805		

Received POC #2 11/18/25
Accepted

[redacted]
NJ Ex Order 26, 4B1

2nd HOME
Adult Medical Day Care

Plan of Correction for Survey Completed: 9/3/2025

M203 8:43F-2.6(g) Licensure Procedures

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

    - No participant was harmed by the presence of one additional member at the center on any of the identified days. All services were provided as required.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

    - All the participants had the potential to be affected by the deficient practice.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.

    - On 9/4/2025, the Administrator implemented a policy requiring the front desk staff to call each member that didn't attend that day to verify if they plan to attend the next day . Members will also be asked before leaving for the day to confirm whether they will attend the next day to ensure census will not exceed 120 participants.

    - 9/4/2025 The Administrator reinforce existing center policy by reminding members routinely that they are not permitted to attend programs at the center using their own transportation without first contacting the center to ensure that a slot is available on that date.

    - On 9/4/2025 Administrator instituted a policy that will be implemented by the Director of Transportation ensuring that no patient is to be pick up without the front desk or the director of transportation's approval.

    - Administrator in service all staff regarding calling the members the day before and on the same day on the new policy.

    - The front staff and the administrator will monitor the census does not go over .

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The Administrator will check the attendance records daily at the end of any shift and review anticipated absentees to make sure that census the following day does not exceed 120 members.

Completion date:9/4/2025

2nd HOME
Adult Medical Day Care

M481 8:43F-8.2 Medical Services

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- No residents were affected by the expiration of the medical consultant's contract in April 2024. The medical consultant remained available to serve the clients of the facility as needed and to advise the center on clinical issues. The rules at NJAC 8:43F-8.2 do not specify that a contract is required, the physician remained "designated" to serve the center.
- The facility update contract on 11/26/2024.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

- All the participants had the potential to be affected by the deficient practice.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.

- On 9/15, the Administrator prepared an Excel sheet listing all required consultant services and included contract initiation and termination dates. The administrator will verify every month whether any contracts are due to expire and initiate renewals of the agreements as needed.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The Administrator will check monthly the excel sheet to make sure on compliance.

- The completion date is : 9/15/2025

2nd HOME
Adult Medical Day Care

M651 8:43F-14. 10(a)(1)(i) Physical Plant Requirements

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- No Residents were affected.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

- All the participants had the potential to be affected by the deficient practice.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.

- On 9/4/2025, The Administrator informed the 2nd Home corporate office that the center was short on recliners.
- On 9/4/2025, at 9:58am the Administrator received approval and ordered two additional recliners.
- On 9/4/2025, The Administrator redesignated a conference room, which was not a required space, to a quiet room.
- On 9/8/2025 the Administrator received the two new recliners that were missing and had them put in the quiet room. The quiet room has been permanently designated to hold at least 12 recliners, which will be available at all times the facility is open.
- On 9/8/2025 the Administrator made patients and staff aware of the new quiet room .

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The Administrator will routinely monitor the Quiet Room to ensure that there is sufficient space and that 12 recliners are operable and available for participant use.

- The Completion date:9/8/2025

2nd HOME
Adult Medical Day Care

M689 8:43F-14.17(f) (g) Physical Plant Requirements

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- The correction plan to ensure routine implementation of quarterly Emergency drills has been put in place.
- 9/4/2025 it was implemented that the administrator signs off on the drills.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

- All the participants had the potential to be affected by the deficient practice.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.

- The administrator will schedule Emergency drills quarterly and sign off on them when completed .

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The administrator will make sure drills are done quarterly and sign off on them .
- The Quality Assurance Committee will evaluate compliance on a quarterly basis.

- The Completion date:9/4/2025

2nd HOME
Adult Medical Day Care

M 691 8:43F-14.17 (h) Physical Plant Requirements

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- No resident was affected by the deficient practice.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

- All the participants had the potential to be affected by the deficient practice.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.

- The Administrator contacted the fire inspection company on 9/2/25 and required them to return to the facility as soon as possible to complete the 2025 inspection.

- On 9/4/2025, the fire inspection company came to the facility and completed the inspection initiated on 9/2/2025 and also inspected the fire extinguisher on bus plate 024554 bus.

- The Administrator reviewed the policy with supervisors, including the Director of Transportation, to remind them of the importance of verifying fire extinguisher and alarm system performance.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The Administrator prepared and will utilize an Excel spread sheet to monitor inspections

and will verify every month that all fire extinguisher and system inspections are completed at the scheduled times.

- The Administrator will verify after the fire extinguisher company concludes their inspection that all extinguishers, including those on buses, were inspected.

The completion date is : 9/5/2025

2nd HOME
Adult Medical Day Care

M 767 8:43F-16.2(a)(1-4) Infection Control, Sanitation, Housekeeping

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

    - No resident was affected by the deficient practice cited related to annual updates to the infection control policies.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

    - All the participants had the potential to be affected by the deficient practice.

2. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.

    - All infection control policies were reviewed on 9/5/25 to ensure that they had been updated as needed for 2025. Any changes were incorporated into the policy and procedure manual binder.
    - On 9/5/2025 the DON was in service regarding the checklist .
    - All updates will be met and follow though in infection control manual and by infection control preventionist .
    - The Administrator and the Director of Nursing will ensure that current policy and procedures will be followed by facility,

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued

effectiveness of the systemic changes.

- The infection control preventionist will be review the infection control policies quarterly.
- The quality assurance committee will review the status of annual updates to the infection control policies and procedures.

- The completion date is : 10/1/2025

M805 8:43F-16.5(a)(b)(c) Infection Control, Sanitation, Housekeeping

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

   - (a) and (b)9/5/2025 and 9/8/2025 The 2nd Home maintenance personnel came to change or clean the 15 tiles and to repair the two missing ceiling tiles and repair holes in the walls identified.
   - (c) 9/5/2025 The Administrator had the maintenance personnel add protection to the identified cords.
   - (d), (f) and (g) 9/4/2025 The Administrator had the two identified water dispensers cleaned to ensure water dispensed to participants was clear. On 10/8/2025 the water company came out to maintenance .
   - (e) 9/4/2025 The 2nd Home maintenance personal inspected the baseboard heaters and ordered 2 new replacement heaters. 9/8/2025 the baseboard heater were installed and patient were kept away from that area on 9/5/2025.
   - (g) and (h) 9/4/2025 The Administrator had all cleaning supplies removed from the kitchen floor and put in the janitor closet. Janitor closet is lock at all times. Inservice was done to all staff regarding the closet must be lock at all times. Also paint was thrown out by the administrator . The center will ensure that the janitor floor sink is accessible at all times.
   - (i) 9/4/25 The Administrator had the activities aid clean out the activities closet and store everything in a safe manner.
   - (j) 9/5/2025 The Administrator will give a memo to the kitchen director regarding no food is to be on the floor. All staff was in service on personal belongings, food on the floor , toxic chemicals was in the kitchen .

- (l) 9/4/2024 The Administrator issued a memo to the personnel in charge of cleaning the kitchen as well as all staff informing them that the garbage is not to be left in the alley or in front of any exit door .
- 9/3/2025 the administrator removed the extension cord .

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

   - All the participants had the potential to be affected by the deficient practice.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.

- The administrator will do a walk though daily throughout the center to make sure that everything is in good condition, and that all exits are clear at all times .
- In service all staff regarding medication to go straight to nursing and personal to be in their purse not on the desk .

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The quality assurance committee will address physical plant safety status and review any reported issues on a quarterly basis.

- The completion date is : 9/12/2025

Sincerely,

NJ Ex Order 26.4(b)(1) CALA/ Administrator

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
708116 Y1	A. Building B. Wing Y2	11/18/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
2ND HOME PASSAIC, LLC	63 GROVE STREET PASSAIC, NJ 07055

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 M0203	Correction	ID Prefix M0481	Correction	ID Prefix M0651	Correction
Reg. # 8:43F-2.6(g)	Completed	Reg. # 8:43F-8.2	Completed	Reg. # 8:43F-14.10(a)(1)(i)	Completed
LSC	11/18/2025	LSC	11/18/2025	LSC	11/18/2025
ID Prefix M0689	Correction	ID Prefix M0691	Correction	ID Prefix M0767	Correction
Reg. # 8:43F-14.17(f)(g)	Completed	Reg. # 8:43F-14.17(h)	Completed	Reg. # 8:43F-16.2(a)(1-4)	Completed
LSC	11/18/2025	LSC	11/18/2025	LSC	11/18/2025
ID Prefix M0805	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-16.5(a)(b)(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/18/2025	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	
9/3/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO