STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315439	A. BUILDING _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT BRISTOL GLEN	200 BRISTOL GLEN DRIVE NEWTON, NJ 07860

(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: 3/17/22 Census: 35 Sample Size: 14 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 582		5/19/22

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

Electronically Signed | 03/31/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 582	Continued From page 1 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to issue the required Medicare Beneficiary Protection Notification. This deficient practice was identified for 3 out of 3 residents reviewed, Resident #13, Resident #282, and Resident #283. The deficient practice was evidenced by the following:	F 582	F582 Preparation and/or execution of this plan of corrections does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law.	

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F 582	Continued From page 2 On 3/14/22 at 12:25 PM, the facility presented the surveyor with a list of residents who were discharged from a [redacted] in the last 6 months. These residents should have received Beneficiary Notices. The surveyor reviewed three residents selected from the list. Resident #283 was discharged from the facility. Resident #282 and Resident #13 remained at the facility. On 3/15/22 at 1:15 PM, the surveyor received the beneficiary notifications for 2 of the 3 residents to review. At that time, the Administrator (LNHA) stated the notification forms for Resident #283 could not be located. The LNHA did not know where the previous social worker placed the forms. According to the SNF Beneficiary Protection Notification Review form, Resident # 282 was admitted to the facility on [redacted] and the last documented covered day for [redacted] service was [redacted]. The facility did not present the resident with the required Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form. According to the SNF Beneficiary Protection Notification Review form, Resident #13 was admitted to the facility on [redacted] and the last documented covered day for [redacted] service was [redacted] The facility did not present the resident with the required SNFABN form. On 3/16/22 at 10:55 AM, the surveyor interviewed the Social Worker (SW) about the beneficiary notices for Resident #282 and #13. The SW stated Resident #282, and Resident #13	F 582	1. Resident #283 is no longer in the community. Resident#282 remains in the community but is no longer on [redacted] The social worker at the time of the cited practice is no longer at the community. Current social worker was provided in-service education by the corporate Medicare reimbursement specialist immediately upon the time of discovery to ensure compliance. 2. All resident residents on Medicare Part A have the potential to be affected by this cited practice. All residents admitted in last 30 days EMR will be reviewed by the corporate Medicare reimbursement specialist to ensure the Medicare Non-coverage (NOMNC) is completed as required. 3. The Interdisciplinary team will be provided in-service education on the timeline guidelines for completing the SNFABN and NOMNC forms. To ensure compliance with proper completion of the forms, the interdisciplinary team will review the status in the weekly UR meeting. The Social will be responsible for reporting the status of each form in the weekly utilization review meeting. 4. A random audit will be completed by the corporate Medicare reimbursement specialist weekly to x 4 weeks and then monthly thereafter on all residents admitted on Medicare A to ensure timely completion of the (Skilled Nursing Facility Beneficiary Protection Notification Review) SNFABN and (notice of Medicare Non-coverage)NOMNC forms	

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UNITED METHODIST COMMUNITIES AT BRISTOL GLEN	**200 BRISTOL GLEN DRIVE NEWTON, NJ 07860**

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F 582	Continued From page 3 received the Notification of Medicare Non-Coverage (NOMNC) form. The surveyor asked if the residents should have received the SNFABN form. The SW said she didn't know and would have to follow up with the Administrator. The SW looked up the SNFABN form and confirmed she had not given it to any residents. On 3/16/22 at 11:00 AM, the surveyor asked the SW about the beneficiary notifications for Resident #283. The SW stated she looked in the electronic and paper files of the previous SW and could not find any notification forms for that resident. On 3/16/22 at 1:09 PM, the surveyor informed the LNHA and the Director of Nursing (DON) of the concern with the residents not receiving the proper notification of potential liability for payment. On 3/17/22, 9:10 AM, the surveyor received the Beneficiary Notification for Resident #283 from the LNHA. According to the SNF Beneficiary Protection Notification Review form, Resident #283 was admitted to the facility on [redacted] and the last documented covered day for [redacted] service was [redacted] The facility provided a copy of the ABN form that had been given to the resident. There was no evidence that the resident received the required NOMNC form. On 3/17/22 at 11:41 AM, the surveyor informed the LNHA and the DON of the above concern. No further information was provided. NJAC 8:39-5.1	F 582	until 100% compliance is maintained for three consecutive months. Any identified trends will be corrected upon discovery, documented on community□s QAPI Data tracking log, and reported during monthly and quarterly QAPI (quality assurance performance and improvement) committee meetings overseen by the administrator.	

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F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, and b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 3/13/22 at 10:06 AM, in the presence of the Chef Manager and Operations Manager (OM), the surveyor observed the following:	F 812	1. No residents were identified in this cited practice.. Immediately upon the surveyor reporting of the discovery of findings, the 2 sprinkler caps and fire suppression poles identified with a grease like substance and particles were immediately cleaned. The cook and the utility worker responsible for cleaning were provided immediate on spot education. The Dining Director and Executive Chef were also provided on spot education on food storage and proper dating of food. The half sheet steam table pans, and the undated full	5/19/22

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F 812	Continued From page 5 1.. The surveyor observed two of five red sprinkler caps and fire suppression poles above the cook top area, which were soiled with a black grease-like substance and white colored particles. 2. In the standing refrigerator number 5, the surveyor observed two wrapped and undated 1/2 sheet sized steam table pans which contained a corn and lima bean salad and a wrapped and undated full sized sheet pan containing a green colored gelatin. 3. In walk in refrigerator, the surveyor observed a 1/2 of a slab of provolone cheese wrapped and with a use by date of 2/27/22 still on shelf. The surveyor also observed a container of rice pudding wrapped with a use by of 3/12/22. 4. At 11:44 AM, in the presence of the OM, on the [redacted] floor the surveyor inspected three standing refrigerators. In the first standing refrigerator, the surveyor observed 21 separately wrapped slices of pumpkin pie which were undated. In the second refrigerator on the floor, the surveyor also observed three wrapped and undated containers of bean salad, and 6 separately wrapped slices of pumpkin pie which were undated. On 3/13/22 at 11:37 AM, the surveyor discussed the above concerns with the Administrator and Director of Nursing. The surveyor reviewed the facility's policy with a revised date of 1/12/17 titled, "Food Product Shelf Life Guidelines." The policy indicated that the pumpkin pie should only be refrigerated for 2	F 812	size sheet pan of gelatin in the standing refrigerator was immediately discarded. The provolone cheese and rice pudding in the walk-in refrigerator was immediately discarded. The 21 undated wrapped pumpkin pies and 6 wrapped pumpkins with no dates were all discarded. 2. All residents residing in the community that consume food have the potential to be affected by the cited practice. The Dining Director and Executive Chef inspected food storage to ensure proper labeling and dating and compliance with policy standards. Issues identified were immediately corrected. 3. 3. All dining will be provided in-service education on proper on dating, labeling and discarding of food with emphasis on the importance of labeling and dating of all food items and the cleaning procedures for sprinkler caps and poles. The executive chef will audit food storage compliance and monitor pull date compliance daily. Any problem areas identified from the kitchen safety audits will be shared with the food service director immediately with corrective action. -Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated appropriate staff. The food service director will develop and implement a competency checklist with all staff and new hires to ensure staff compliance and understanding of food storage including labeling. 4. A random daily kitchen inspection will be completed by the dietitian, food	

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F 812	Continued From page 6 to 3 days after opening and the pudding should be refrigerated for 2 days after opening. The facility did not provide the surveyor with any additional requested policy and procedure. NJAC 8:39-17.2(g)	F 812	service director on food labeling and expiration dates of food items x 4 weeks, then weekly x 4 weeks and then will continue with a monthly inspection to ensure ongoing compliance. Findings will be immediately corrected and reviewed with the NHA(nursing home administrator) and at the monthly and quarterly QAPI (quality assurance performance and improvement) meetings. The frequency of the rounds will be adjusted according to the outcomes and will continue until substantial compliance is met.	

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	031901	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT BRIST	200 BRISTOL GLEN DRIVE NEWTON, NJ 07860

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H 000	Initials Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. 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 THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	H 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: Based on observation, interview and review of facility provided documentation, the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New	S 560	1. No residents were identified or affected by this cited practice. Efforts to hire community staff will continue until there is adequate staff to serve all residents. Until that time, facility will utilize staffing agencies, offer overtime to community staff to fill any open spots in the schedule. 2. All residents have the potential to be affected by this cited practice. 3. Contracts with additional staffing agencies have been secured to supplement facility staff. Hiring and	5/19/22

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

Electronically Signed | 03/31/22

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S 560	Continued From page 1 Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in	S 560	recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. In addition, CNA (certified nursing assistant) NATCEP (nursing aide training and competency evaluation program)classes have been initiated in the community and remain ongoing with the director of CNA training and development who has been certified as an instructor. A traveling CNA program has also been implemented with active recruitment and employment. Weekly recruitment meetings are ongoing with the home office, executive director, nursing home administrator and the associate resource director. Education will be provided to the staff regarding call offs and how it affects the community, the residents', and their peers by the staff educator as needed. Managers to provide assist as applicable based on job training and qualifications to support nursing until staffing requirements are met. Staffing patterns will be reviewed in the daily stand up and shift report to ensure staffing patterns are at acceptable level. NHA will communicate with families monthly to make them aware of staffing patterns and recruitment efforts until staffing stabilizes. License staff and certified nurse aides will be provided in-service education on the importance of communication and notifying the DON or NHA if they are unable document or to meet the needs of the residents related to staffing. The community census will be adjusted by	

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S 560	Continued From page 2 subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of the facility provided Nursing Home Resident Care Staffing Reports from 2/27/22 to 3/12/22 which included the following staff to resident ratio for each shift: The facility was deficient in CNA staffing for residents on 1 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: 2/28/22 had 3 CNAs for 31 residents on the day shift, required 4 CNAs. 3/4/22 had 2 total staff for 31 residents on the overnight shift, required 3 total staff. 3/10/22 had 2 total staff for 31 residents on the overnight shift, required 3 total staff.	S 560	temporarily suspending admissions to meet staffing requirements as needed. 4. The Administrator and the DON (director of nursing) will review staffing schedules daily as part of the daily standup meeting to ensure adequate staffing for all shifts. The administrator and the Associate Resource Director (HR) will continue to review recruitment and staffing weekly. This will remain an ongoing practice until staffing requirements are maintained. The social worker will conduct a random resident satisfaction survey of care monthly x 3 months and then quarterly as it relates to staffing challenges to ensure resident care needs continue to be maintained. The results of the daily staffing reviews and resident satisfaction surveys will be submitted to the monthly and quarterly QAPI committee through the remainder of 2022 with a supportive corrective action plan. All findings from the daily staffing and resident satisfaction reviews will continue to be reviewed with the QAPI (Quality assurance performance and improvement) committee until staffing requirements meet state requirements consistently.	

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S 560	Continued From page 3 On 3/17/22 at 10:33 AM the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) about staffing strategies. The DON explained that the Certified Nursing Assistant (CNA) certification course was taught at the facility and the students were paid to take the course. The LNHA said the facility contracted with 15 agencies and that the facility advertised, offered referral bonuses and sign on bonuses. The LNHA said they had social media accounts with incentives for referrals. The LNHA said the department heads were certified CNAs and would fill in as needed with feeding and other tasks. N.J.A.C. 8:39-5.1(a)	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
031901 Y1	Y2	5/27/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT BRISTOL GLEN	200 BRISTOL GLEN DRIVE NEWTON, NJ 07860

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/19/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/17/2022	☐ 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
	315439	A. BUILDING **01** B. WING _____	**03/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT BRISTOL GLEN	**200 BRISTOL GLEN DRIVE** **NEWTON, NJ 07860**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is 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 03/16/22, 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 Occupancy The facility is a one-story building that was built in 90's, It is composed of Type V protected. The facility is divided into 4- smoke zones. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The 350 KW generator does approximately 80% of the building.	K 000		

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

Electronically Signed | 03/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 The facility has 60 certified beds. At the time of the survey the census was 35.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	K 222		5/19/22

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K 222	Continued From page 2 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 03/16/22, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that the delayed egress feature provided on 4 of 4 exit discharge doors did not exceed 15-seconds. This deficient practice was evidenced by the following: while touring the facility the surveyor and	K 222	Preparation and/or execution of this plan of corrections does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. 1. No residents were identified in this	

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K 222	Continued From page 3 Maintenance Director observed that exit discharge doors were provided with a delayed egress feature to unlock the doors in the event of a non-fire emergency requiring evacuation. When tested, these doors released in 30-seconds, not the required maximum of 15-seconds. Release time above 15 seconds would require approval by the Authority Having Jurisdiction (AHJ). The Centers for Medicare and Medicaid Services, who is the AHJ, has not approved delayed egress to exceed 15-seconds. The doors observed were: # [redacted] the door opened in 30 seconds and was not provided with a sign # [redacted] the door opened in 30 seconds and was not provided with a sign # [redacted] was provided with a 30 second sign and opened in 30 seconds # [redacted] the door opened in 30 seconds and was not provided with a sign In an interview with the Maintenance Director during the observations, he stated that he was not aware of the 15 second limit on these doors. The Administrator was informed of the findings, at the life safety code exit conference on 03/16/22. NJAC 8:39-31.2(e)	K 222	cited practice. Upon the life safety surveyor□s observations and discovery, the 4 egressed doors identified with excess delayed time were immediately reset to the required 15 seconds on 3/17/2022.Signs have since been placed on all the egress doors. 2. All residents have the potential to be affected by this cited practice. 3. All maintenance staff was provided in-service education on the importance of maintaining the egress doors at the required maximum of 15 seconds. All egress doors will be checked daily by the maintenance staff as part of the daily maintenance rounds and the egress door closure time recorded on the daily round egress checklist inspection form. 4. The building service director will conduct a random inspection on the egress door weekly x4 weeks and then 2x per week x 3 months to ensure compliance. Findings will be corrected immediately and reported to the NHA (nursing home administrator) and reviewed in the monthly and quarterly quality assurance performance and improvement (QAPI) meeting with prompt corrective action. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101	K 291		4/30/22

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K 291	Continued From page 4 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/16/22, it was determined that the facility failed to provide an operational battery backup emergency light above A. The emergency generator's transfer switch, B. The electric fire pump transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was observed for 2 of 2 transfer switches and was evidenced by the following: A. At 1:10 PM, the Surveyor and Maintenance Director, observed in the basement fire pump transfer switch room, that no emergency lighting was provided. B. At 1:30 PM, the Surveyor and Maintenance Director, observed outside the facility where the emergency generator and transfer switch was located, that no emergency lighting was provided where the transfer switch was located. This finding was verified by the Maintenance Director and Administrator at the time of the observation's. The Administrator was notified of the above findings at the Life Safety Code exit conference on 3/16/22.	K 291	1. No residents were identified or affected in this cited practice. Battery operated back up lighting has been installed on 3/29/2022 to basement pump switch room and the outside the facility where the emergency generator and transfer switch is located. 2. All residents have the potential to be affected. 3. Maintenance staff will be provided in-service education on the battery backup lighting system and the process of checking the battery backup lighting system for operation has been placed on the maintenance schedule with routine replacement of batteries as per manufacture recommendation. 4. A random inspection of the battery backup lighting system will be conducted by the building service director monthly x 3months then quarterly to ensure compliance. Findings will be reviewed in the monthly and quarterly QAPI (quality assurance performance and improvement) meeting to ensure compliance with immediate corrective action as war	

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K 291	Continued From page 5 NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		5/19/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT BRISTOL GLEN	200 BRISTOL GLEN DRIVE NEWTON, NJ 07860

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K 363	Continued From page 6 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/16/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 5 of 30 resident room door's and was evidenced by the following: On 3/16/22, during the building tour from 9:00 AM to 2:00 PM, the Surveyor and Maintenance Director, observed that the doors to resident rooms, did not latch into the door frame in the following room numbers: #[redacted]- hardware issue #[redacted]- hardware issue #[redacted]- hardware issue #[redacted] hardware issue #[redacted]- hardware issue An interview was conducted with the Maintenance Director, who stated and confirmed that the above resident room doors, had hardware issues that prevented the doors from	K 363	1. Resident rooms #[redacted], [redacted] were directly affected by this cited practice. The repairs to the door frames were made immediately completed. The door frames to each individual room identified were immediately readjusted at the hinges and latch strikes filled enabling the doors to close appropriately. 2. All residents have the potential to be affected by this cited practice. Maintenance rounds were completed on all resident room doors to ensure compliance and no other issues were identified. 3. Maintenance staff will be provided inservice education on importance checking room door to ensure positive latching occurs when room doors close. Clinical associates will be provided with education on reporting room doors that fail close completely and the need for a work order for evaluation of the identified problem. A monitoring system check will be implemented by the building service director. The monitoring check system will be completed by the maintenance staff weekly to ensure compliance and will be reviewed by the building service weekly upon completion with corrective action implemented as warranted. 4. The building service director will	

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K 363	Continued From page 7 latching properly. The Administrator was informed of the finding at the Life Safety Code exit conference on 3/16/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	conduct random inspection checks to 2 doors 3X per week for 4 weeks in each household unit. Then 1 door 3X per week for 3 months in each household unit. Any issues will be addressed immediately. The findings from the inspection audits will be discussed with the NHA and reviewed in monthly and quarterly QAPI (quality assurance performance improvement plan) meeting. The inspection audits will remain in place until it has been determined that a 100% compliance threshold has been achieved for two consecutive months. This plan to be amended when indicated.	
K 918 SS=E	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	K 918		4/30/22

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K 918	Continued From page 8 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) This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not ensure a remote manual stop station for 1 of 1 generators. that was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents. On 3/16/22, the Surveyor and Maintenance Director observed that the 350 KW facility generator was outside and encased. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. An interview was conducted during the observation with the Maintenance Director, where he stated that at the time of observation, the area was observed not to have a remote manual stop station. The Administrator was informed of the finding at the Life Safety Code exit conference on 3/16/22.	K 918	1. No residents were directly affected by this cited practice. Upon the life safety surveyor observation, the generator service company was immediately contacted to install a manual stop station. Stop station installed 4/ 30/2022. 2. All residents have the potential to be affected by this cited practice. 3. Maintenance staff were provided education on the testing procedure for the stop station. The assigned maintenance staff will check the stop station monthly during the generator check and annual load test and as warranted to ensure in compliance. The building service director will be responsible for ongoing compliance by creating a re-occurring preventive maintenance task in the maintenance work order system. 4. A random system check report will be completed monthly by the building service director to demonstrate compliance with	

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K 918	Continued From page 9 NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	the required station stop to ensure proper function and the report will be submitted to the QAPI (quality assurance performance improvement) committee. Findings will be reviewed with the administrator and in the monthly and quarterly QAPI meeting with immediate corrective action as warranted.	

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
315439 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/27/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT BRISTOL GLEN	200 BRISTOL GLEN DRIVE NEWTON, NJ 07860

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 K0222	05/19/2022	LSC K0291	04/30/2022	LSC K0363	05/19/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	04/30/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/17/2022	☐ YES ☐ NO