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 _____	C 05/22/2024

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		
F 000	INITIAL COMMENTS Complaint #: NJ172491, NJ172492 Survey Date: 5/15/24 through 5/22/24 Census: 49 Sample: 13 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to consistently follow standards of clinical practice with regards to: a.) following a physician's order as written for 1 of 15 residents (Resident # 1), and b.) completing NJ Ex Order 26.4b1 (an assessment	F 658	1. No immediate action could be taken for resident #14 related the NJ Exec Order 26.4b1 assessment. Resident #14 NJ ex order 26.4b1 NJ ex order 26.4b1 and had NJ Exec Order 26.4b1 from the cited practice. Resident #1 NJ ex order 26.4b1 and had NJ Ex	6/24/24

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

Electronically Signed | 06/13/2024

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F 658	Continued From page 1 of NJ Exec Order 26.4b1 status that must be done when a resident NJ Exec Order 26.4b1 or if it is NJ Exec Order 26.4b if they NJ Exec Order 26.4b1) after a resident had a history of NJ Ex for 1 of 1 resident (Resident #14) NJ ex order 26.4b1 NJ ex order 26.4 . The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 5/15/24 at 11:34 AM, the surveyor observed Resident #1 seated in a wheelchair in their room. The resident NJ ex order 26.4b1	F 658	NJ Exec Order 26.4b1 from the cited practice and no immediate action could be taken related to NJ Ex Order 26.4b1 . Resident #1 NJ Exec Order 26.4 was NJ Exec Order 26.4 that evening as per orders. RN#2 was provided immediate retraining on the community's NJ Exec Order 26.4b1 assessment policy and procedure. RN#1 was provided in-service training on the correct instruction for the NJ Exec Order treatment with use of NJ Exec Order 26.4b1 with emphasis on following physician orders. 2. All residents with falls unwitnessed or that may have hit their head post a fall, or other injury, and need a neurological assessment have the potential to be affected. All residents that have orders for Dakin's solution have the potential to be affected by this cited practice. 3. All current license nursing staff will be provided in-service education by the staff educator on the community's Fall Prevention and Management Policy that includes emphasis of the neurological assessment completion process post fall for residents that cannot communicate that they may have hit their head due to cognitive impairment or for those oriented residents who can communicate that they may have hit their head post a fall, or other injuries requiring a neurological assessment to be completed as per policy and as indicated by a physician orders. A competency will be completed with each nurse to ensure the nurse can verbalize and demonstrate how to enter neurological checks within the electronic medical record system. Nurses not in attendance of training will be educated upon their return. Ongoing neurological	

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F 658	Continued From page 2 Resident #1 stated they NJ ex order 26.4b1 that was being treated by the nursing staff and verbalized no concerns. The surveyor reviewed the electronic medical records (EMR) of Resident #1 which revealed the following: The Admission Record (a summary of important resident information) documented Resident #1 had diagnoses that included, but were not limited to, NJ ex order 26.4b1 A Quarterly Minimum Data Set (MDS) assessment, dated NJ ex order 26, indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). Resident #1 scored a NJ ex out of 15 which indicated that the resident had NJ ex order 26.4b1 A review of the Order Summary Report documented Resident #1 had a physician order (PO), dated NJ ex order 26.4b1, which read: "NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 A review of the NJ ex order 26.4b1 electronic Treatment Administration Record (eTAR) for Resident #1 documented the above PO for the NJ ex order 26.4b1 treatment and it was signed by the nursing staff as administered twice a day in the morning and evening shifts.	F 658	competency will be provided to newly hired nurses during their onboarding process. Residents requiring neurological assessments post a fall or other injury will be reviewed in the daily clinical meeting by the Director of Nursing or the Nurse Mentor in her absence Monday through Friday to ensure neurological assessment completion as per physician orders and policy. Review will include: the fall note and incident, physician orders for the neurological assessment, and to determine timely completion of the neurological assessment as per policy and orders. All current license staff will be provided in-service education on providing wound care with Dakin's solution by the staff educator in collaboration with the wound nurse consultant with emphasis on the importance of following physician orders when providing wound care. Any nurse who fails to comply with the points of the in-servicing provided will be provided further education and /or progressive discipline as indicated. 4. The Director of Nursing will complete an audit weekly for 4 weeks all falls or injuries that require a neurological assessment completion and then monthly for 6 months to ensure compliance. Wound observation for wounds requiring Dakin's solution will be completed weekly x 4 weeks then monthly x 2 months to ensure compliance. All findings will be reviewed with the nursing home administrator and in the quarterly quality assurance performance improvement (QAPI) committee meeting with immediate progressive disciplinary	

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F 658	Continued From page 3 A review of the resident's care plans included a care plan with a focus that read NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 An intervention for the care plan dated NJ ex order 26.4b1 read, NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 On 5/21/24 at 9:50 AM, the surveyor observed Registered Nurse #1 (RN #1) perform the NJ ex order 26.4b1 for Resident #1. RN #1 reviewed the NJ ex order 26.4b1 PO with the surveyor prior to starting the NJ ex order 26.4b1. On 5/21/24 at 10:07 AM, during the NJ ex order 26 NJ ex order 26.4b1 the surveyor observed RN #1 wash her hands appropriately for 35 seconds at the bathroom sink and don gloves. RN #1 took NJ Exec Orde NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1, NJ Exec Order 26.4b Resident #1's NJ ex order 26.4b1, and dispose the used NJ Exec Orde in the garbage bin. RN #1 took a clean, dry NJ Exec Order 2 and patted the NJ Exec Order 26.4b1. RN #1 took a NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 cleansed the NJ ex order 26.4b1, and then dispose of the NJ Exec Orde in the garbage bin. RN #1 took a [redacted] with NJ Exec Order 26.4b1 and applied the medication to the NJ ex order 26.4b1. RN #1 then disposed of the NJ Exec Orde in the garbage and applied a NJ Exec Order 26.4b1. On 5/21/24 at 10:32 AM, the surveyor observed RN #1 sign for the NJ ex order 26.4b1 being administered to Resident #1. RN #1 confirmed she had completed the resident's NJ ex order 26 NJ ex order 26.4b1. On 5/21/24 at 10:35 AM, the surveyor reviewed	F 658	corrective action as warranted. The frequency of the audits for the neurological assessment process post a fall or a injury requiring an assessment and Dakin's wound care observations will be adjusted according to the outcomes.	

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F 658	Continued From page 4 with RN #1 the NJ ex order 26.4b1 and the NJ ex order 26.4b1 of NJ ex order 26.4b1 RN #1 acknowledged she did not perform the NJ ex order 26 NJ ex order 26.4b1 as written in the physician order and she NJ ex order 26.4b1 the NJ ex order 26.4b1 On 5/21/24 at 12:50 PM, the surveyor informed the US FOIA (B) (6) US FOIA (B) (6), US FOIA (B) (6) US FOIA (B) (6) and the US FOIA (B) (6) of US FOIA (B) (6) about the concern observed during the NJ Ex Order 26.4b1 of the physician's order not being followed as written. There was no additional information provided by the facility. A review of the facility's policy titled, "Pressure Injury Prevention & Managing Skin Integrity" with a last revised date of 2/14/2024 read under Policy, "Any resident with a wound shall receive treatment and services consistent with the resident's goals of treatment." The policy did not further address following written physicians' orders for wound treatments. A review of the facility's provided wound treatment competency titled, "UMC-Wound Treatment Observation Utilizing Clean technique" read under Quality of Care, " ...Physician order is checked before starting treatment ...Physician Order includes location of wound, frequency of treatment, method for cleaning wound, medication to be applied if any and type of dressing to be utilized ..." 2. On 5/15/24 at 12:20 PM, the surveyor observed Resident #14 seated in their wheelchair in the dayroom of the unit. Resident #14 NJ ex order 26.4b1 and NJ ex order 26.4b1 NJ ex order 26.4b1.	F 658		

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F 658	Continued From page 5 On 5/20/24 at 9:47 AM, the surveyor reviewed a NJ ex order 26.4b1, dated NJ ex order 26 for Resident #14. The resident NJ ex order 26.4b1 at approximately 6:45 pm in which Resident #14 NJ ex order 26.4b1 NJ ex order 26.4b1 . Resident #14 NJ ex order 26.4b1 There NJ ex order 26.4b1, an NJ Exec Order 26.4b1 was provided and NJ Exec Order 26.4b1 were initiated. The surveyor reviewed the EMR of Resident #14 which revealed the following: The Admission Record documented Resident #14 had diagnoses that included, but were not limited to, NJ ex order 26.4b1 A Quarterly MDS assessment, dated NJ ex order 26, indicated the facility assessed the resident's cognitive status using a BIMS. Resident #14 scored a NJ out of 15 which indicated that the resident NJ ex order 26.4b1 . A nurse progress note dated NJ ex order 26 at 20:17 [8:17 pm], documented Resident #14 NJ ex order 26.4b1 and NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 in the dining room area. The note further detailed the resident NJ ex order 26.4b1 of NJ ex order 26.4b1 on the NJ ex order and NJ ex order 26.4b1 for the resident were NJ ex order 26.4b1 A nurse progress note dated NJ ex order 26 at 23:05 [11:05 pm], detailed a NJ ex order 26.4b1 completed for Resident #14 which included, NJ ex order 26.4b1 NJ ex order 26.4b1 and NJ ex order 26.4b1.	F 658		

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F 658	Continued From page 6	F 658		

There were no other progress notes found that documented any additional [NJ Exec Order 26.4b1] being completed after the resident's [NJ ex ord]

A review of the Order Summary Report for [NJ ex order 26] [NJ ex order] revealed, there were no PO to account for [NJ Exec Order 26.4b1] being completed after the resident's [NJ ex order 26.4b1].

A review of the [NJ ex order 26.4b1] electronic Medication Administration Record (eMAR) and eTAR revealed that there were [NJ ex order 26.4b1] [NJ ex order 26.4b1] after the resident's [NJ ex order 26.4b1].

A review of the [NJ ex order 26.4b1] list of vital signs (VS) revealed that there were no VS documented to account for the [NJ Exec Order 26.4b1] being completed after the resident's [NJ ex order 26.4b1].

On 5/20/24 at 11:20 AM, the surveyor requested from the [US FOIA (6] for further documentation of the [NJ Exec Order 26.4b1] related to the [NJ ex order 26.4b1] of Resident #14. The [US FOIA (6] stated she would review and provide further information.

On 5/20/24 at 12:40 PM, the [US FOIA (6] provided the surveyor a document titled "[NJ Exec Or] [NJ Exec Order 26.4b1] LIST" dated [NJ Exec Orde] and timed 19:41 [7:41 pm], which was found in the resident's EMR.

A review of the document revealed under the section titled, "Vital Signs", the VS documented were dated [NJ ex order 26]. The other sections of the document which included [NJ Exec Order 26.4b1]

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F 658		F 658		

Continued From page 7

were completed. There was no additional documentation to indicate additional [redacted] being performed after the resident's [redacted].

On 5/21/24 at 12:40 PM, the surveyor informed the US FOIA (B) (6) and US FOIA (B) (6) of US FOIA (b)(6) about the concern that there was no documentation to indicate [redacted] for the resident were completed after their [redacted] on [redacted]. The [redacted] and the [redacted] acknowledged it would be expected for [redacted] to be completed and documented for an [redacted] NJ ex order 26.4b1 .

On 5/22/24 at 9:58 AM, the surveyor interviewed the [redacted] who stated there was no additional information found for completion of the [redacted]. The [redacted] stated the facility protocol for [redacted] once initiated was that it would be done every 2 hours for 12 hours, then every 3 hours for 24 hours, and every 4 hours for another 24 hours. The [redacted] further stated a physician order should have been written and the facility's policy was for [redacted] to be initiated when a resident had an [redacted] a [redacted] or if a [redacted] could not be ruled out.

On 5/22/24 at 10:13 AM, the surveyor interviewed over the phone Registered Nurse #2 (RN #2) who was the assigned nurse for Resident #14 at the time of the [redacted]. RN #2 stated for [redacted] or [redacted] with [redacted] were to be initiated. RN#2 could not explain the facility's protocol on how often [redacted] were to be performed and stated the facility policy was different from what she was used to. RN #2 further stated [redacted] were entered as physician's orders and

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F 658	Continued From page 8 would be triggered for nurses to assess the resident's vital signs at a certain frequency. RN #2 was not sure where the triggered [redacted] documentation would be found in the EMR and stated she would write her [redacted] assessments in her progress notes instead. RN #2 could not recall the details of the [redacted] for the resident. The surveyor discussed with RN #2 the concern that there were [redacted] for the resident other than the two progress notes and the [redacted] documentation provided by the [redacted]. RN #2 could not speak to why there was not further documentation of the [redacted] and no physician order found. A review of the facility's policy titled, "Fall Prevention and Management" with a last reviewed date of 7/6/2023 read under Post Fall Management, B. Minor Head Trauma or Impact, it read: " ...performs neuro-checks every two hours for the first 12 hours, every three hours for the next 24 hours, every four hours for the following 24 hours ...2. Neuro-checks shall be implemented if a resident cannot communicate that they may have hit their head due to cognitive impairment ..." NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		6/24/24

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F 695	Continued From page 9 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to clarify a Physician's Order (PO) in accordance with professional standards of practice for 1 of 16 residents (Resident #16) reviewed. The deficient practice was evidenced by the following: 1. On 5/15/24 at 11:15 AM, the surveyor observed Resident #16 in a NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 The surveyor reviewed the medical records of Resident #16, who was admitted to the facility with diagnoses that included but not limited to NJ ex order 26.4b1 [redacted] A review of the Minimum Data Set Assessment (MDS), an assessment tool, used to facilitate the management of care, dated NJ ex order 26.4b1 revealed that the resident had a score of [redacted] out of 15 on the Brief Interview for Mental Status, which indicated that the resident was NJ ex order 26.4b1 Further review of the MDS under Section [redacted] also revealed that the resident NJ ex order 26.4b1	F 695	1. Resident #16 NJ ex order 26.4b1 NJ ex order 26.4b1 and the NJ ex order 26.4b1 NJ ex order 26.4b1 . The US FOIA (b)(6) [redacted] was provided inservice education on the importance of transcribing NJ Exec Order 2 orders at an exact rate and not range. 2. All resident with oxygen orders has the potential to be affected. All oxygen orders were immediately audited upon notification by the surveyor. No further need for clarification of orders was identified. 3. All license staff will be provided inservice education by the staff educator on the importance of ensuring oxygen orders are clear and state the exact amount of oxygen to be administered and if a range is provided in the order, then the prescriber must provide clarification. All new oxygen orders will be reviewed in the daily clinical meeting by the director of nurses or the nurse mentor in her absence Monday through Friday to ensure accuracy of order. Any issues identified will be immediately clarified. 4. A Daily review of new oxygen orders will be completed the Director of Nursing for 4 weeks then weekly for 1 month and monthly for 2 months. At the quarterly quality assurance performance improvement meeting, the results of the monitoring of oxygen orders will be	

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F 695	Continued From page 10 NJ ex order 26.4b1. A review of the PO for Resident #16 revealed a PO, dated NJ ex order 26.4, for NJ ex order 26.4b1 On 5/17/24 at 9:18 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1), who was assigned to Resident #16, and stated that Resident #16's NJ ex order 26.4 was set at NJ ex order 26 but NJ ex order 26.4b1 NJ Exec Order 26.4b1 NJ ex order 26.4b1 LPN#1 further stated that the PO for NJ Exec Order 26 must be at a specific rate and not in a range. On 5/17/24 at 10:05 AM, the surveyor interviewed the Registered Nurse/Nurse Mentor (RN/NM #1), who stated "NJ Exec Order 2 orders should not be written with a range but a NJ Exec Order 26.4b1, like NJ E ." On 5/17/24 at 12:35 PM, the surveyor interviewed the US FOIA (B) (6) , who acknowledged that the PO for the NJ Exec Order 26 should have been at a specific rate and not in a range. On 5/17/24 at 1:00 PM, the US FOIA (B) (6) US FOIA (B) (6) provided the surveyor with a facility policy titled, "Oxygen Management Clinical Practice Guideline", with a revised date of 4/22/22. The facility policy does not specifically address the O2 rate order administration. On 5/20/24 at 01:18 PM, they survey team met	F 695	submitted by the director of nursing. Any patterns identified, will result in the implementation of an action plan by the director of nursing and will be monitored by the nursing home administrator until resolution.	

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	315439	A. BUILDING _____ B. WING _____	C 05/22/2024

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 695	Continued From page 11 US FOIA (B) (6)), US FOIA (B) (6) and US FOIA (B) (6) US FOIA (B) (6) to review concerns. The US FOIA (B) stated the O2 orders should be clearer and not have a range. The facility did not provide any further information. NJAC 8:39- 27.1 (a)	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031901	A. BUILDING: _____ B. WING _____	C 05/22/2024

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

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (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 pertinent facility documentation, it was determined 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 Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing	S 560	1. No residents were identified or affected by this practice. Efforts to hire community staff will continue until there is adequate staff to serve all residents. Until that time, staff working overtime shifts and contracted agency staff will be used to fill open shifts and open positions. 2. All residents have the potential to be affected by this practice. 3. Contracts with additional staffing agencies have been renewed and/or approved. Hiring and recruitment efforts including wage analysis and adjustments, online job listings, job fairs, shift differentials, special compensation programs, referral bonuses and sign on bonuses are being utilized to	6/24/24

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

Electronically Signed | 06/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031901	A. BUILDING: _____ B. WING _____	C 05/22/2024

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S 560	Continued From page 1 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 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	S 560	become more competitive in the market. Weekly recruitment meetings are ongoings with an external recruiter, human resource, the Director of Nursing, and the administrator. Managers, working within their scope of practice, will continue to help and support to residents until staffing requirements are met. Staffing patterns will be reviewed in daily stand up and at shift report to ensure staffing patterns are at an acceptable level. 4. A staffing variance report will be completed for each shift that does not meet required care ratios. The Social Worker will conduct a random satisfaction survey of ten residents per month for 3 months. The data collected from the staffing variance report and resident satisfaction surveys will be documented and reported to the quality assurance performance improvement (QAPI)Committee monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 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 "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for 7 segment dates that related to the standard survey and complaints revealing the following: 1. For the 2 weeks of staffing prior to survey from 04/28/2024 to 05/11/2024 the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -04/28/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -04/30/24 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. On 05/20/24 1:20 PM, the surveyor discussed the staffing ratio concerns with the facility's Licensed Nursing Home Administrator, Corporate Director of Clinical Services, Executive Director, and Nursing Director. No further information was provided.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315439	A. Building B. Wing	6/27/2024

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 06/24/2024	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 06/24/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	
5/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
031901		6/27/2024

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 06/24/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315439	A. BUILDING **01** B. WING _____	**05/22/2024**

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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/15/2024 and 05/16/2024, 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 in a three-story building with a basement that was built in 2001, It is composed of Type II protected construction. The facility is divided into 4- smoke zones. The 350 KW generator does approximately 80% of the building. The building is fully sprinklered and utilizes city water. The facility has 60 certified beds. At the time of the survey the census was 49. The building has three separate facilities ALR, SNF/NF (LTC) and independent living. The Long Term Care facility is located on the second floor and is composed of three units: Highland, Sawmill Pond and Paulenskill. There are common areas to LTC residents on the First floor (rehab gym, salon and Kitchen).	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING	K 293		6/24/24

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

Electronically Signed | 06/13/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 293	Continued From page 1 Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 05/16/2024 in the presence of facility management, it was determined that the facility failed to ensure exit and directional exit signs were provided and marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants in accordance with NFPA 101, 2012 Edition, Section 19.2.10.1 and 7.10. This deficient practice had the potential to affect approximately 6 of 49 residents and was evidenced by: An observation on 05/16/2024 at approximately 12:50 PM, in Sawmill Pond unit corridor by rooms 34 and 35 revealed two exit access paths. One path was to a stairwell and was to a stairwell down the corridor. There was no visible exit sign and the exit was not readily apparent to the occupants showing the direction of travel to reach one of the exit paths. There was no exit sign on one side above the double doors by room 32 leading to an alternative evacuation route if the stairwell exit at the end of the hall by room 35 was not passable. In an interview, at the time of observation, the US FOIA (b)(6) verified the findings. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit	K 293	1. No Residents were affected by the alleged deficient practice. An additional exit sign has been installed opposite the double doors by room 32 identified by the surveyor to ensure exit and directional exit. 2. All residents have the potential to be affected by the cited practice. Maintenance rounds were completed to ensure compliance with the direction and location of exit signs and no other issues were identified. 3. Maintenance staff will be provided in-service education on the importance of visible and applied exit signage. 4. The Building Services Director will complete “Weekly Walk-through rounds” for 1 month then monthly for 2 months and then quarterly to ensure compliance. Findings will be reported to the quality assurance performance improvement committee quarterly with immediate corrective action as warranted.	

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K 293	Continued From page 2 conference on 5/16/2024. NJAC 8:39-31.1 (c), 31.2(e).	K 293		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 05/16/2024 in the presence of facility Management, it was determined that the facility failed to ensure that 1 of 2 exit access stairwell doors were capable of maintaining the 1-1/2 hour fire rated construction in accordance with NFPA 101(1012 edition) Section 19.3.1. This deficient practice was evidenced by the following, An observation on 05/16/2024 at approximately 1:58 PM, revealed during a closure test of the Tower North first floor corridor stairway exit access door, the door was opened to a 90 degree opening to the door frame and allowed to self-close but the door did not positive latch into its frame. The surveyor observed that the 1-1/2 hour fire rated door's latching mechanism was	K 311	1. No residents were affected by the cited practice. The latching mechanism will be installed. 2. All residents have the potential to be affected by the cited practice. A maintenance audit was conducted of all fire exit doors and all the latching mechanisms are in place. 3. Maintenance staff will be provided in-service education on the importance of presence of latching mechanism on fire exit doors. Weekly walk-through rounds will be assigned to a maintenance team member to check all exit doors to ensure compliance with latching. Findings will be reviewed with building service director for	6/24/24

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K 311	Continued From page 3 missing. This test was performed two additional times with the same results. In an interview at the time of observation, the US FOIA (B) (6) US FOIA (B) (6) confirmed the findings. The facility's US FOIA (B) (6) and US FOIA (B) were informed of the deficient practice on 05/16/2024 at approximately 3:15 PM during the Life Safety Code exit conference. NJAC 8:39- 31.2(e)	K 311	immediate correction. 4. The Building Services Director will report the completion of the repair to the quality assurance performance improvement Committee. The quarterly quality assurance performance improvement committee will identify any trends or patterns and make immediate recommendations to revise the plan of correction as warranted.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		6/24/24

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 353	Continued From page 4 Based on observations and interviews on 05/16/2024 in the presence of facility management, it was determined that the facility failed to maintain the sprinkler system and ensure the ceiling level was smoke resistant in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7, 9.7.8, NFPA 25:2011 Edition. These deficient practices had the potential to affect all 49 residents and was evidenced by: An observation on 05/16/2024 at 12:04 PM revealed there was a red plastic protective cap on the sprinkler head in resident room 26 in the Highland Unit room 26. This cap would prevent the sprinkler head from operating as designed. In an interview, at the time, the US FOIA (B) (6) US FOIA (B) (6) explained the cap must have been left from recent repair. An observation on 05/16/2024 at 12:49 PM in an alcove by the Sawmill Pond Unit Spa, open to the corridor, revealed a ceiling tile that was held up by a wire, leaving an opening. This condition would allow for hot gasses and smoke to pass the sprinkler head into the concealed space without activating the fire sprinkler system. In an interview at the time, the US FOIA (B stated that it was a wall mounted nurse call box wire that was using the ceiling grid to hold the wire (lifting the ceiling tile). The wire traveled down from the ceiling grid to a receptacle. An observation on 05/16/24 at 1:01 PM in the presence of the US FOIA (B, revealed there was no sprinkler escutcheon fitting to the drywall ceiling at the sprinkler head in the Paulenskill unit storage closet. This condition would allow hot	K 353	1. No resident was identified in this cited practice. The red cap covering over the sprinkler system in room 26 has been removed. The exposed wire has been hard-wired so there is no longer a penetration at the ceiling tile. The sprinkler escutcheon identified on the Paulinskill unit has been fitted to the drywall ceiling. 2. All residents have the potential to be affected by this cited practice. An audit was conducted on all sprinkler heads of the health care unit and no other missing escutcheons or red caps were noted. An audit was done of all ceiling tiles for voids in common areas and no issues were identified. The maintenance staff checked all ceiling tile integrity throughout the facility. No openings were found that would allow hot gases or smoke past the sprinkler into the space above. 3. Maintenance staff will be provided in-service education on the importance of the absence of voids in ceiling tiles and on caps and escutcheon placement on sprinkler heads. This will include monitoring private contractors at job completion to ensure compliance is met. The sprinkler check log that is part of the Preventative Maintenance Manual will be reviewed monthly by the director of building services to ensure compliance. 4. The Corporate Director of Building services will monitor sprinkler heads monthly for 6 months to assure all are adequate and functioning properly. Any negative findings will be immediately addressed and reported to the administrator and reviewed in the	

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 _____	**05/22/2024**

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
K 353	Continued From page 5 gasses and smoke past the sprinkler into the concealed space above. These findings were verified by US FOIA (b)(6) [redacted] at the times of the observation. The facility's US FOIA (b)(6) was informed of the deficient practices during the Life Safety Code exit conference on 5/16/2024. NJAC 8:39-31.2 NFPA 25	K 353	quarterly quality assurance performance improvement committee meeting with action plan implemented as indicated.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 5/16/2024 in the presence of Plant Operations Director (POD), it was determined that the facility failed to conduct the annual portable fire extinguisher inspection on 6 of 15 fire extinguishers in accordance with NFPA 10:2010 edition Section 7.2. This deficient practice had the potential to effect all residents and was evidenced by the following: Observations of the fire extinguishers located in the corridors of the second floor starting at 11:15 AM revealed 6 of the 15 fire extinguishers lacked an annual inspection. A review of the inspection tag revealed that the last annual inspection was	K 355	1. No residents were identified in this cited practice. The six fire extinguishers identified by the surveyor were inspected and dated. 2. All residents have the potential to be affected by this cited practice. 3. Maintenance staff will be provided in-service education by the corporate director of building services on the timely inspection of all fire extinguishers inspection tags. The established Preventive Maintenance & Scheduling will be followed reflecting the monthly and annual inspection of the fire extinguishers. The maintenance team will complete	6/24/24

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	315439	A. BUILDING **01** B. WING _____	**05/22/2024**

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 355	Continued From page 6 conducted August 2022. In an interview at 11:15 AM , the US FOIA (B) (6) confirmed that the fire extinguishers had not been inspected as they were due for servicing. The facility's US FOIA (B) (6) was made aware of the deficient practice on 5/16/2024 during the exit conference. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355	walk-through rounding weekly each month to ensure fire extinguishers are inspected timely. 4. On a weekly basis for 1 month and then monthly for 3 months, the building service director will perform a walk-through audit of fire extinguishers to ensure they have been visually inspected and documentation on the tag indicates completion is evident. Monthly rounds will remain ongoing to ensure that the extinguishers are not expired and are working properly. Should any extinguisher be found non-compliant the vendor will be notified immediately to come and exchange the extinguisher. Findings will be reviewed in the quarterly quality assurance performance improvement committee meeting. If 100 % compliance or greater has not been achieved by the end of the 4 months, then the monitoring will continue until this threshold has been reached	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372		6/24/24

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K 372	Continued From page 7 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 05/16/2024 in the presence of facility management, the facility failed to ensure penetrations in smoke and fire barriers were protected by a system or material capable of restricting the transfer of smoke and fire in accordance with NFPA 101 Life Safety Code (2012 edition) Sections 8.3, 8.5, 8.5.2.2. This deficient practice had the potential to affect all 49 residents and was evidenced by the following: An observation on 5/16/24 at 11:10 AM in the presence of the US FOIA (B) (6) and US FOIA (B) (6) revealed the fire barrier located on the second floor above the fire barrier doors adjacent to the care coordinators office, had two pipe penetrations each approximately 7 inches by 7 inches. These penetrations were not protected by a system or material capable of restricting the transfer of fire. An observation at the same time in the corridor by the care coordinators office, revealed a 10 by 15 inch hole in the drywall ceiling above the drop ceiling and in front of the fire barrier door. In an interview at the time, the US FOIA (B and US FOIA confirmed the opening. An observation on 5/16/24 at approximately 12:30 US FOIA in the presence of the US FOIA (B revealed the fire barrier located in Sawmill unit above the sliding fire barrier doors adjacent to the dining room, had three wire and one pipe penetrations. These	K 372	1. No residents were affected by the cited practice. All penetrations identified will be filled with the proper rated sealant and reference material will be maintained on -site to ensure product is available for any needed repair. 2. All residents have the potential to be affected by the cited practice. A maintenance audit was conducted above the fire barrier walls and surrounding drywall and no other penetrations were found. 3. Maintenance staff will be provided in-service education on the importance of the absence of penetrations and the proper sealant to be used for filling penetrations. This will include monitoring private contractors at job completion to ensure compliance is met. Outside contractors will be educated, prior to completing services on the building, about proper fire wall penetrations. The Maintenance Director will inspect for penetrations prior to job completion to ensure compliance. 4. The Building Services Director will conduct audits monthly for 6 months to ensure work of outside contractors meets compliance and the plan will be amended when compliance is indicated after results are discussed in the quarterly quality assurance performance improvement committee. The quality assurance	

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K 372	Continued From page 8 penetrations were not sealed to prevent the passage of smoke and hot gasses. An observation on 5/16/24 at 2:00 PM of an electrical closet located in the begriming of the Paulenskill unit, revealed: A. Four 4-inch pipes penetrating the drywall were sealed with orange foam sealant. In an interview at the time, the US FOIA (B) stated he did not know the fire rating and had no documents on the fire rating of the orange sealant. B. Multiple BX wire penetrations running along the wall to ceiling junction across 3 of the 4 walls were sealed with a blue sealant. The sealant product was not available for inspection. In an interview at the time, the US FOIA (B) stated he did not know the fire rating and had no documents on the fire rating of the blue sealant. The sealant product was not available for inspection. The US FOIA (B) (6) was made aware of the deficient practices during the Life Safety Code exit conference on 5/16/2024.	K 372	performance improvement committee will identify any trends or patterns and make recommendations to revise the action plan as warranted.	
K 531 SS=D	NJAC 8:39-31.1(c). 31.2(e) Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and	K 531		6/24/24

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K 531	Continued From page 9 Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 5/16/2024, in the presence of the US FOIA (B) (6) it was determined that: A. the facility failed to test and inspect elevators annually with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division and/or AHJ. B. The facility failed to perform the monthly Firefighters Service operation with a written record in accordance with NFPA 101 (2012 Edition) Section 19.5.3, 9.4, 9.4.2, 9.4.3. These deficient practices had the potential to affect all 49 residents and were evidenced by the following: A. A review of the facility's elevator inspection certificate at 02:13 PM, revealed that elevator #4 was last inspected on 4/20/2022. The annual elevator inspection was conducted by the authority having jurisdiction (AHJ) and was 1 year overdue. No further documentation was provided.	K 531	1. No residents were affected by the cited practice. The annual inspection was performed and passed. The firefighters service function was performed successfully and recorded. 2. All residents have the potential to be affected by the cited practice. 3. The Building Services Director or designee will pre-schedule the annual elevator test to remain in compliance. The firefighters service function will be assessed monthly and recorded. The Maintenance staff will be provided in-service education on the above and this education remain ongoing with newly hired maintenance staff. 4. The Building Services Director will audit the record sheet randomly for compliance for 6 months and until 100%	

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K 531	Continued From page 10 In an interview, at 2:13 PM, the facility's [US FOIA (b)(6)] confirmed the elevator had not been inspected when required and stated he will communicate with elevator inspector AHJ to schedule an inspection. B. In an interview , at 2:13 PM, the facility [US FOIA (b)(6)] explained he was not aware of the requirement to operate the Firefighters Service function monthly keeping a record and that no such test was performed and recorded. The facility's [US FOIA (b)(6)] was informed of the deficient practices at the Life Safety Code exit conference on 5/16/2024. NJAC 8:39-31.2(e) ASME A17.1(2007)	K 531	compliance is met for 3 months. The results will be reviewed with the LNHA. The plan will be amended when compliance is indicated after results are discussed in the quarterly quality assurance performance improvement committee.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 05/16/2024 in the presence of facility management, it was determined that the facility failed to ensure that 1 of 6 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 (National Electrical	K 911	1. No residents were affected by the cited practice. The duplex electrical outlet has been replaced with a GFCI outlet. 2. All residents have the potential to be affected by the cited practice.	6/24/24

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K 911	Continued From page 11 Code) Section 210.8. This deficient practice had the potential to affect any resident using the salon and was evidenced by the following: During the tour of the facility starting at approximately 11:08 AM on 05/16/2024 in the presence of the US FOIA (B) (6) US FOIA (B) (6) the surveyor observed and tested six (6) electrical outlets in wet (with-in 6 feet of a sink) locations with one (1) electrical outlet that failed to de-energize when tested. At approximately 11:56 AM, the surveyor observed, measured and recorded in the inside Resident Salon, one (1) Duplex electrical outlet located 4 feet to the right of the hair washing sinks edge. When tested with a Ground Fault Circuit Interrupter tester, the Duplex electrical outlet did not de-energize as required by Code. The US FOIA (confirmed the findings at the time of observations. The facility's US FOIA (B) (6) and US FOIA (were informed of the deficient practice during the Life Safety Code survey exit on 05/16/2024 at approximately 3:15 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	3. An audit of outlets less than 6 ft from a water source in common areas was conducted and GFCI outlets were installed where necessary. The Maintenance staff will be provided in-service by the building service director education on the regulatory requirement of the above. All newly hired maintenance staff will be provided education on this required practice. 4. The Building Services Director will report the completion of the replacements to the QAPI Committee.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		6/24/24

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K 918	Continued From page 12 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 05/16/24 in the presence of facility management, it was determined that the facility failed to ensure the emergency generator resumed power to the facility within 10 seconds in accordance with NFPA 110 (2010). This deficient practice had the	K 918	1. No residents were affected by the cited practice. 2. All residents have the potential to be affected by the cited practice.	

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K 918	Continued From page 13 potential to affect all 49 residents and was evidenced by the following: A review of the facilities generator operating documentation for the previous 12 months revealed that there was no documented time for the power transfer located in the log or generator inspection report. In an interview on 5/16/24 at 10:10 AM, the facilities US FOIA (B) (6) confirmed the lack of documentation and stated that the transfer time was not recorded during their monthly generator testing. The US FOIA (B) stated that he would add a space to the generator log to record the transfer time and begin recording it. The facility's US FOIA (B) (6) was made aware of this deficient practice on 05/16/24 during the Life Safety Code exit conference. 8;39-31.2(e), 31.2(g) NFPA 99, 110	K 918	3. The Building Services Director updated the generator testing log sheet to include a spot for the transfer time to be documented. The Maintenance staff will be provided in-service education on the above. All new hired maintenance staff will be provided education on accurate compliance of the log. This practice will be ongoing. 4. The Building Services Director will audit the log randomly for compliance for 6 months and until 100% compliance is maintained for 3 months. The results will be reviewed with the administrator in the quarterly quality assurance performance improvement committee meeting. The plan will be amended when compliance is indicated after results are discussed with the committee.	

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	6/27/2024 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 K0293	06/24/2024	LSC K0311	06/24/2024	LSC K0353	06/24/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	06/24/2024	LSC K0372	06/24/2024	LSC K0531	06/24/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0911	06/24/2024	LSC K0918	06/24/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
5/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO