

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER OUR HOME ADULT DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 475 GRAND AVENUE ENGLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments Type of Survey: Monitoring / Follow-up Census: AM Session : 142 Capacity: 165 On 9/3/2025, the Department of Health conducted a follow-up survey regarding the Office of Inspector General's audit that was conducted on 8/27/2024. The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 421	8:43F-6.3(e)(1)(i) General Services (e) The facility shall develop and implement a staff orientation plan and a staff training and education plan, including plans for each service and designation of person(s) responsible for ongoing training. 1. All staff shall receive orientation at the time of employment and ongoing in-service training regarding, at a minimum, emergency plans and procedures, the infection prevention and control services, participant rights, and elder abuse. i. The facility shall document ongoing	M 421		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/15/25

New Jersey Department of Health

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M 421	Continued From page 1 in-service training of all staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that all employees received ongoing annual in-services which included emergency plan and procedures, infection prevention and control, participant rights and NJ Ex Order 26.4(b)(1) for 3 of 4 employees, Employee #'s 2, 3 and 4. This deficient practice was evidenced by the following: On 8/27/24, the Office of the Inspector General (OIG), conducted an audit at the facility. During the visit, the auditor was provided with only one (1) training conducted by the facility, which was dated 1/8, without documentation of a year. The training document was titled, "annual training", but did not have any details of what topics were covered. The auditor additionally found that one (1) of the seven (7) employees selected for review, did not have evidence of attending new employee orientation in their employee personnel files. On 9/3/25 at 11:45 a.m., the Social Worker, who stated she was also the Assistant Administrator (AA), provided the surveyor with a list of employees. The surveyor selected a sample of four (4) employees on the list and requested their	M 421		

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M 421	Continued From page 2 personnel files. At 12:40 p.m., the surveyor reviewed four (4) employee personnel files which revealed the following: Employee #1 had the title, "Director of Nursing", and was employed on [REDACTED] NJ Ex Order 26.4 Employee #2 had the title, "Driver", and was employed on [REDACTED] NJ Ex Order 26.4(b). Employee #3 had the title, "Social Worker", and was employed on [REDACTED] NJ Ex Order 26.4(b) Employee #4 had the title, "Activity Director", and was employed on [REDACTED] NJ Ex Order 26.4 The surveyor observed that each of the 4 personnel files contained a document titled, "New Hired Employee Check List", which revealed that in-services were completed upon hire and included the following topics: "New Employee Orientation, Participant Rights, Abuse and Neglect, Fire and Safety, Pain Management and Infection Control." However, further review of the 4 employees personnel files revealed no documentation of ongoing in-services after the start of employment for Employee #'s 2, 3 and 4. During interview with the AA, the surveyor inquired about whether there was documentation of any ongoing in-servicing for the employees. The AA provided the surveyor with two in-service sheets dated 11/18/24, titled, "Major Disaster/Flood", and a "Fire Drill" dated 12/20/2019. The AA was unable to provide any further documentation of on going in-services for the	M 421		

If continuation sheet 4 of 8

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M 689	Continued From page 4 times a year with at least one of the four drills for emergencies due to fire. Additionally, the facility failed to ensure that all staff participated in at least one annual drill for emergencies due to another type of disaster such a storm or flood. This deficient practice was evidenced by the following: On 9/3/25 at 11:45 a.m., the Social Worker who stated she was also the Assistant Administrator (AA), provided the surveyor with a list of employees. The surveyor selected a sample of four (4) employees on the list and requested their personnel files. At 12:40 p.m., the surveyor reviewed a sample of four (4) employee personnel files which revealed the following: Employee #1 had the title, "Director of Nursing", and was employed on [REDACTED] NJ Ex Order 26.4(b). Employee #2 had the title, "Driver", and was employed on [REDACTED] NJ Ex Order 26.4(b). Employee #3 had the title, "Social Worker", and was employed on [REDACTED] NJ Ex Order 26.4(b). Employee #4 had the title, "Activity Director", and was employed on [REDACTED] NJ Ex Order 26.4(b). The surveyor observed that the 4 personnel files contained a document titled, "New Hired Employee Check List", which reflected that in-services were completed upon hire that included following topics: "New Employee Orientation, Participant Rights, Abuse and Neglect, Fire and Safety, Pain Management and Infection Control.	M 689		

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M 689	Continued From page 5 However, further review of the personnel files, revealed no documentation of ongoing in-services after the start of employment for Employee #'s 2, 3 or 4. During interview with the Assistant Administrator, the surveyor inquired about whether there was documentation of any ongoing in-servicing for the employees. The AA was able to provide one (1) in-service dated 11/18/24, titled, "Major Disaster/ Flood", and another in-service dated 12/20/2019 titled, "Fire Drill." The surveyor inquired again about documentation of fire drills or disaster drills and the AA was unable to provide any further documentation to reflect that fire drills or emergency drills were conducted. The surveyor reviewed an undated facility policy and procedure titled, "Emergency Procedures Emergency Due to Fire and Other Type of Disaster",...4. All staff is required and responsible for knowing the location of and how to use the nearest fire alarm box and fire extinguishers. 5. At least 4 drills shall be conducted, which shall include at least one drill due to fire emergency. 6. At least one drill should include another type of disaster as mentioned in this chapter. 7. All staff members should at least conduct one drill annually. 8. Participants may take part in fire drill."	M 689		
M 805	8:43F-16.5(a)(b)(c) Infection Control, Santation, Housekeeping (a) The facility shall provide and maintain a sanitary and safe environment for participants. (b) The facility shall provide housekeeping and	M 805		

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M 805	Continued From page 6 pest control services. (c) Written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for housekeeping, sanitation, and safety services shall be developed and implemented. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure a safe environment for the participants. This deficient practice was evidenced by the following: On 8/27/25 the Office of the Inspector General (OIG) conducted an audit at the facility. During the visit the auditor observed an exposed electrical outlet, unsecured long extension cords and network cables. The auditor additionally observed that two of the facility vehicles had expired inspection stickers. On 9/3/25 at 9:45 a.m., the surveyor went on a tour of the facility accompanied by an employee who had the title, "Social Worker", who stated that she was also the Assistant Administrator (AA). While on the tour, the surveyor observed a small office which the AA identified as one of the Social Worker's offices. The surveyor observed a large group of network cables and various long cords which were not secured within the office.	M 805		

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M 805	Continued From page 7 At 11:15 a.m., the surveyor accompanied the AA on an additional tour of the facility, and the surveyor observed a closet next to the main dining/activity room where participants were engaged in activities. The surveyor observed that the closet was unlocked and upon entering the closet in the presence of the AA, the surveyor observed the following chemicals: 1. A value refill sized container of (NJ Ex Order 26.4) bleach 2. A bottle of (NJ Ex Order 26.4)(b)(1) disinfectant with the cautionary warning, "Keep out of reach of children." 3. (NJ Ex Order 26.4)(b)(1) "All-Natural fruit and drain fly killer. Additionally during the tour, the surveyor observed an exposed electrical receptacle, in the far-left corner of the main dining/ activity room. During surveyor interview with the AA, she acknowledged and stated that the closet should have been locked and that all chemicals should be locked up. The AA additionally stated that the electrical outlet should have had a cover on it. At 1:30 p.m., the surveyor interviewed the AA and inquired about the facility vehicles and how the facility kept track of the registration dates. The AA stated that there was a list of vehicles which included registration dates which the AA provided to the surveyor. The surveyor reviewed the vehicle list and observed that there were no expired registration dates listed for the list of thirteen vehicles (13) which included seven (7) buses and (6) cars. The surveyor toured the parking lot of the facility and observed three parked buses which had registration stickers that reflected registration through July of 2026.	M 805		



Plan of Correction – OUR HOME ADULT DAY CARE

License #: 02028

Survey Date: 09/03/2025

Acting Administrator: NJ Ex Order 26.4(b)(1)

Address: 475 Grand Avenue, Englewood, NJ 07631

Deficiency M421 – N.J.A.C. 8:43F-6.3(e)(1)(i)

Staff Orientation and Ongoing In-Service Training

1. Corrective action for participants affected

The deficiency involved three employees—Employee #2 (Driver), #3 (Social Worker), and #4 (Activity Director)—whose training documentation was incomplete. Although no participants were harmed, incomplete annual in-service training could have limited staff readiness in emergency preparedness, infection control, or protection of participant rights.

By **10/10/2025**, the facility completed the **revision of staff training policies** and the **development of bilingual** NJ Ex Order 26.4(b)(1) **training materials**. However, as of the date of this Plan of Correction submission (**10/15/2025**), the staff re-education sessions have not yet been implemented. The facility will conduct a comprehensive re-education program for **all employees**, covering all **ten core training topics**, and anticipates full completion by **11/30/2025**. Until full completion, staff are closely supervised by the Administrator and/or their respective department directors and are assigned duties only within verified competency areas.

2. Identification of other participants potentially affected

Because all participants depend on trained staff, the entire active census was considered potentially affected. A facility-wide review of all personnel files was completed from **09/08/2025 through 09/12/2025**, identifying any additional employees due for renewal. All staff will complete their annual training requirements by **11/30/2025**.

3. Systemic changes to prevent recurrence

- By **10/10/2025**, the facility developed bilingual in-service training materials and launched a structured annual education program with the following ten core topics:
 1. Orientation Overview (mission, vision, core values, code of conduct)
 2. Participant Rights and Responsibilities
 3. Abuse, Neglect & Exploitation (prevention and mandatory reporting)
 4. Infection Prevention and Control
 5. Emergency Plans and Procedures (fire and disaster response)
 6. HIPAA and Confidentiality
 7. Workplace Safety and Incident Reporting
 8. Transportation/Bus Safety
 9. Sexual Harassment and Professional Conduct



10. Pain Management and Comfort Care

- The main designated trainers include the Administrator, Director of Nursing, and Social Work Director; however, under specific subjects, appropriate alternate trainers may be assigned.
- Topic-specific sign-in sheets and individual in-service logs are maintained in each HR file.
- The **Staff Orientation and In-Service Education Policy** was revised on **09/20/2025** to require completion of all topics annually and to restrict scheduling of staff with expired training.
- A **Quality Assurance (QA) Committee**—comprising the Administrator, Activity Director, Director of Nursing, Social Work Director, and Food Program Director—was established to oversee training compliance and review progress quarterly.

4. Monitoring for continued compliance

- The **Administrator** conducts a **Quarterly Training Audit** (March, June, September, December) to monitor staff completion.
- The **QA Committee** reviews results quarterly to verify progress and ensure all employees complete all required training by **11/30/2025**.
- During the interim, weekly supervisory reviews ensure compliance with core safety and care standards.
- All training records are retained on-site for at least three years and made available for DOH review.

Date of correction: 11/30/2025

Responsible persons: Administrator and aligned directors

Deficiency M689 – N.J.A.C. 8:43F-14.17(f)(g)

Emergency Drills

1. Corrective action for participants affected

On **10/08/2025**, the facility conducted a staff fire-safety drill led by the Administrator in coordination with department heads. The drill reinforced emergency preparedness and fire-response procedures for all employees.

Training contents included:

- Review of the facility's **Emergency Preparedness and Fire Drill Policy** (revised in September 2025).
- Identification of the **two primary exits** located on opposite sides of the second floor and discussion of safe evacuation routes through both exits.
- Demonstration of **fire extinguisher locations** and instruction in the **PASS** method (Pull, Aim, Squeeze, Sweep).
- Review of staff responsibilities for assisting participants with limited mobility during evacuations.



- Explanation of **alarm activation procedures**, communication flow, and chain of command during emergencies.
- Designation of the **assembly area** in the open parking lot on the first floor, including headcount and reporting procedures to the Administrator.
- Review of procedures for contacting **911** and ensuring all participants are accounted for.

This drill focused on staff readiness and was not participant-involved, as it served to strengthen internal response skills prior to the next scheduled participant-inclusive evacuation drill.

Attendance was documented and filed in the Emergency Drill Log.

No participants were affected or placed at risk.

2. Identification of other participants potentially affected

Because all participants depend on staff readiness during emergencies, the entire participant population was considered potentially affected. A participant-involved fire drill is scheduled for **01/28/2026** to meet the annual requirement.

3. Systemic changes to prevent recurrence

- The **Emergency Preparedness Plan** was reviewed and updated by **09/30/2025**.
- A **2025–2026 Annual Drill Calendar** was created to ensure one drill per quarter, including at least one fire and one disaster-type drill annually.
- Department heads are now responsible for ensuring all staff participate in at least one drill annually.
- A **standardized Emergency Drill Report Form** documents the date, time, type, participants, results, and Administrator signature.

4. Monitoring for continued compliance

- The Administrator reviews the **Emergency Drill Log monthly** to ensure drills are completed and documented.
- The QA Committee reviews drill records quarterly and monitors scheduling of the participant-inclusive evacuation drill.
- Any missed or delayed drill is rescheduled within the same quarter.

Date of correction: 10/08/2025 (a staff drill completed); 01/28/2026 (participant-inclusive drill scheduled)

Responsible person: Administrator

Deficiency M805 – N.J.A.C. 8:43F-16.5(a)(b)(c)

Infection Control, Sanitation, and Safety

1. Corrective action for participants affected



All environmental and electrical safety issues identified during the survey were corrected promptly to ensure participant safety and compliance with physical-plant standards.

- The **exposed electrical outlet** in the activity/dining area was fitted with a protective cover on **09/10/2025**.
- All **unsecured long extension cords** were safely covered or removed on **09/10/2025**.
- In the **Social Worker's office**, a **large group of network cables** was enclosed in a **wooden cable box** on **09/19/2025**, and all additional loose cords were organized and secured the same day.
- All **hazardous cleaning chemicals** were relocated to locked storage cabinets labeled "*Keep Out of Reach of Members*" on **09/05/2025**.
- **Keypad door locks** were installed on the janitor, mechanical, pantry, storage, and staff rooms by **09/26/2025** to restrict unauthorized access.
- All **facility vehicles** were inspected, and any expired inspection stickers were renewed by **10/06/2025**. The **vehicle-fleet management records**, including the **Vehicle Registration and Inspection Log**, were reviewed and updated by the same date.
- No participants were harmed or exposed to unsafe conditions during or after corrections.

2. Identification of other participants potentially affected

Because the cited hazards were located in shared participant and staff areas, all participants were considered potentially affected. The **Administrator** conducted a **facility-wide environmental inspection** on **09/29/2025**, confirming that all areas met safety and sanitation requirements and were compliant with **N.J.A.C. 8:43F-16.5**.

3. Systemic changes to prevent recurrence

- The **Infection Control and Sanitation Policy** was revised by **09/30/2025**, requiring:
 - Monthly inspection of all outlets, cords, and cabling, with documentation.
 - Locked and labeled storage for all cleaning and other chemicals.
 - Immediate correction or reporting of any identified safety hazard.
- A new **Environmental Safety and Infection Control Checklist** was implemented for daily housekeeping use and weekly Administrator review.
- A **Vehicle Registration and Inspection Log** was added to the monthly administrative calendar to ensure timely registration renewals and inspection compliance.
- All staff will receive re-training on infection prevention, environmental safety, and safe equipment use as part of the annual in-service education program.

4. Monitoring for continued compliance

- The **Administrator** conducts **monthly environmental-safety rounds** using the standardized checklist to verify compliance.
- The **Quality Assurance (QA) Committee** reviews inspection findings quarterly and ensures immediate corrective action for any noted deficiencies.
- All safety and inspection records are maintained on-site for a minimum of three years and are available for DOH review upon request.



OUR HOME ADULT DAYCARE

475 GRAND AVE ENGLEWOOD, NJ 07631 TEL: 201-731-3636 FAX: 201-431-9762

Date of correction: 09/30/2025 (environmental corrections completed); 10/06/2025 (vehicle inspections and the update of vehicle registration and inspection log completed)

Responsible person: Administrator

Administrator Certification

I certify that the Plan of Correction above addresses each cited deficiency from the 09/03/2025 survey and that all immediate hazards have been corrected. Systems, policies, and monitoring processes have been established to ensure ongoing compliance and prevent recurrence.

NJ Ex Order 26.4(b)(1)

Acting Administrator (effective 10/01/25), Our Home Adult Day Care

NJ Ex Order 26.4(b)(1)

Signature: _____ **Date:** 10/15/2025

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 02028	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/16/2025
NAME OF FACILITY OUR HOME ADULT DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 475 GRAND AVENUE ENGLEWOOD, NJ 07631

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 M0421	Correction	ID Prefix M0689	Correction	ID Prefix M0805	Correction
Reg. # 8:43F-6.3(e)(1)(i)	Completed	Reg. # 8:43F-14.17(f)(g)	Completed	Reg. # 8:43F-16.5(a)(b)(c)	Completed
LSC	11/30/2025	LSC	10/08/2025	LSC	10/06/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐		REVIEWED BY (INITIALS)		DATE	
REVIEWED BY CMS RO ☐		REVIEWED BY (INITIALS)		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/3/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			