

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/02/2024</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
H5795	<p>8:43E-13.5 UNIVERSL TRANSFR FORM:P&amp;P REGARDG USE OF FORM</p> <p>A licensed healthcare facility or program shall develop and implement written policies and procedures addressing the required use of the Universal Transfer Form by a licensed healthcare facility or program's staff, method of transportation, procedures for security of the resident and all personal belongings or other items that accompany or immediately follow a transferred resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that a Universal Transfer Form (UTF) policy and procedure was developed, implemented, and enforced to address the proper utilization and completion of a UTF for 1 resident reviewed for transfer to the hospital, Resident #4. This deficient practice was evidenced by the following:</p> <p>On 3/18/2024 at 10:45 a.m., Surveyor #1 reviewed the medical record (MR) of Resident #4 and observed a document titled, [redacted] NJ ex order 26.4b1", which indicated that the resident moved into the facility on [redacted] NJ ex order 26.4b1 and had diagnoses which included [redacted] NJ ex order 26.4b1 and NJ ex order 26.4b1. Continued review of Resident #4 MR revealed a document titled, "Progress Notes (PN)," which revealed a PN dated [redacted] NJ ex order 26.4b1, timed 1:03 p.m., and indicated that the resident [redacted] NJ ex order 26.4b1 on. The PN also revealed an event note dated [redacted] NJ ex order 26.4b1, timed 11:41 p.m., which</p>	H5795		

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

TITLE

(X6) DATE

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/02/2024</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
--------------------	--	---------------	---	--------------------

H5795	<p>Continued From page 1</p> <p>indicated that Resident #4 <b>NJ ex order 26.4b1</b></p> <p><b>NJ ex order 26.4b1</b></p> <p>On 3/19/2024 at 10:15 a.m., Surveyor #1 conducted an interview with the facility's Director of Nursing (DON), the surveyor requested Resident #4 UTF for the <b>NJ ex order 26.4b1</b> on <b>NJ ex order 26.4b1</b>.</p> <p>At 12:45 p.m., Surveyor #2 interviewed the facility's DON, along with the facility's Licensed Practical Nurse (LPN), and both stated that they were unable to provide the surveyor with the requested UTF for <b>NJ ex order 26.4b1</b>. During continued Surveyor #2 interview, the DON and LPN stated that they were unable to provide the surveyor with Resident #4's UTF for <b>NJ ex order 26.4b1</b> because it was not retained in the resident's MR. At that time Surveyor #2 requested the facility UTF policy.</p> <p>At 12:58 p.m., Surveyor #1 interviewed the facility's DON who stated that the facility did not have a UTF policy.</p>	H5795		
A 000	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Revisit Survey for the Removal Plan on 4/2/24</p> <p>Census: 32</p> <p>A Life Safety Code Survey was conducted by the State Agency from 03/19/2024 to 04/02/2024. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living</p>	A 000		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK</b> <b>TEANECK, NJ 07666</b>
--	---

(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
A 000	<p>Continued From page 2</p> <p>Residences, Comprehensive Personal Care Homes, and Assisted Living Programs. Complaint #: NJ00161519, NJ00168083, NJ00171315</p> <p>Census: 31 (Standard Survey Visit - 3/19/24)</p> <p>Sample: 4</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 511	<p>8:36-5.5(a) General Requirements</p> <p>(a) The facility or program shall develop and implement written job descriptions to ensure that all personnel are assigned duties based upon their education, training, and competencies and in accordance with their job descriptions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined that the facility failed to ensure that written job descriptions were developed and implemented to ensure each employee</p>	A 511		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A 511	<p>Continued From page 3</p> <p>possessed the necessary education and competency to perform their assigned duties for 3 of 8 employees whose personnel files were reviewed: Employee #'s 1, #2, #3. This deficient practice was evidenced by the following:</p> <p>On 3/19/2024 at 12:08 p.m., the surveyor reviewed the personnel files for 8 employees. The surveyor observed that these files failed to contain a written job description for Employee #'s 1, 2 and 3. There was no documented evidence of a job description in each employees' personnel file to ensure that the employees received a copy of their job description and to confirm that each employees' assigned duties and responsibilities were in accordance with their education and competencies.</p> <p>On 3/19/2024 at 12:26 p.m., the surveyor interviewed the facility's Human Resource Manager (HRM), who was responsible for maintaining the Employee Personal Files. The HRM stated that she would retrieve the job description for Employee #'s 1,2 and 3.</p> <p>As of 2:15 p.m., the surveyor had not received a copy of the job description for Employee #1, #2, and #3 to ensure that each employee's assigned duties and responsibilities were in accordance with their education and competencies.</p> <p>The facility failed to provide the surveyor with written job descriptions for the 3 of 8 sampled employees.</p>	A 511		
A 517	<p>8:36-5.6(b)(1-7) General Requirements</p> <p>(b) The facility or program shall develop and implement a staff orientation and a staff</p>	A 517		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK</b> <b>TEANECK, NJ 07666</b>
--	---

(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
A 517	<p>Continued From page 4</p> <p>education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following:</p> <ol style="list-style-type: none"> <li>1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment;</li> <li>2. Emergency plans and procedures;</li> <li>3. The infection prevention and control program;</li> <li>4. Resident rights;</li> <li>5. Abuse and neglect;</li> <li>6. Pain management;</li> <li>7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19.</li> </ol>	A 517		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A 517	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00161519, NJ00168083, NJ00171315 Based on interview and review of personnel files, it was determined that the facility failed to provide documented evidence that 6 of 8 employees received the required in-service training of Pain Management, Dementia Training, Abuse and Neglect, Assisted Living Concepts, Resident Rights, Infection Control, and Emergency plans. These in-services were to be provided upon hire and annually thereafter. This deficient practice was evidenced based on the following:</p> <p>On 3/19/2024 at 12:08 p.m., the surveyor reviewed the employee personnel files and observed that the following employee files did not have documented evidence that the employees received the required in-services listed above:</p> <p>Employee #1 was hired on <span style="background-color: black; color: white; font-size: small;">NJ ex order 26.4b1</span> as a Certified Medication Aide. Upon review of the employee file there was no documented evidence that the employee received Pain Management training upon hire.</p> <p>Employee #2 was hired on <span style="background-color: black; color: white; font-size: small;">NJ ex order 26.4b1</span> as a Certified Medication Aide. Upon review of the employee file there was no documented evidence that the employee received Pain Management training upon hire.</p> <p>Employee #3 was hired on <span style="background-color: black; color: white; font-size: small;">NJ ex order 26.4b1</span> as a Certified Home Health Aide. Upon review of the employee file there was no documented evidence that the employee received Pain Management,</p>	A 517		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A 517	<p>Continued From page 6</p> <p>Dementia training nor Abuse and Neglect upon hire and annually thereafter.</p> <p>Employee #4 was hired on [NJ ex order 26.4b1] as a Waiter for the kitchen. Upon review of the employee file there was no documented evidence that the employee received training on Dementia training upon hire and annually thereafter.</p> <p>Employee #5 was hired on [NJ ex order 26.4b1] as a Waiter for the kitchen. Upon review of the employee file there was no documented evidence that the employee received training on Assisted Living Concepts, Resident Rights, Infection Control, and Emergency plans.</p> <p>Employee #6 was hired on [NJ ex order 26.4b1] as a Concierge. Upon review of the employee file there was no documented evidence that the employee received training on Dementia training upon hire.</p> <p>On 3/19/2024 at 12:26 p.m., the surveyor interviewed the Human Resource Manager who stated she would gather the information for the employees that were missing training and bring them to the surveyor. However, there was no documentation of training provided to the surveyor during the survey on 3/19/24.</p>	A 517		
A 647	<p>8:36-6.1(a)(3) Resident Care Policies</p> <p>(a) Written resident care policies and procedures shall be established, implemented, and reviewed at intervals specified in the policies and procedures. Each review of the policies and procedures shall be documented. Policies and procedures shall include, but not be limited to, the following:</p>	A 647		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A 647	<p>Continued From page 7</p> <p>3. The determination of staffing levels to ensure delivery of services and assistance as needed for each resident of the facility or program during each 24-hour period. Services may be provided directly by staff employed by the facility or program or in accordance with a written contract;</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility's Administrator failed to develop, implement, and enforce a staffing policy and procedure to ensure that each facility resident will be provided with adequate care and assistance they need. This deficient practice was evidenced by the following:</p> <p>On 3/18/2024 at 10:03 a.m., during the survey entrance conference, the surveyor requested the facility's staffing policy from the Operations Specialist (OS), who said that she would look for the policy.</p> <p>On 3/19/2024 at 12:08 p.m., the OS stated that there was no staffing policy for the facility. The OS revealed that she called the corporate office to confirm that there was no staffing policy.</p> <p>The facility's OS was unable to provide the surveyor team with a Staffing policy at the time of the survey on 3/19/2024.</p>	A 647		
A1097	8:36-16.6 Physical Plant	A1097		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK</b> <b>TEANECK, NJ 07666</b>
--	---

(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
A1097	<p>Continued From page 8</p> <p>All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a fire suppression system as required by New Jersey Administrative Code 8:36-16.6. The deficiency affected 1 of 1 smoke compartment and had the potential to affect all 32 residents residing in the facility.</p> <p>It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause, serious injury, harm, impairment, or death to residents.</p> <p>On 03/19/2024 at 2:00 PM, the New Jersey Department of Health determined the failed practice represented an immediate threat to residents' health and safety. The facility's Administrator was informed of the immediacy of the situation involving the sprinkler heads being removed, and a Removal Plan was requested.</p> <p>Findings included:</p> <p>Observation on 03/19/2024 at 12:55 PM revealed Room 116 on the first floor of the facility was</p>	A1097		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/02/2024</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A1097	<p>Continued From page 9</p> <p>under renovation. The observation revealed that fire sprinkler heads in the area had been removed.</p> <p>During an interview on 03/19/2024 at 1:10 PM, the Director of Maintenance and Administrator stated they were not aware the sprinkler heads had been removed. They confirmed the facility lacked a policy or procedure regarding environmental surveillance rounds to ensure compliance with applicable codes.</p> <p>During a phone interview on 03/19/2024 at 1:31 PM, the facility's contracted construction company's Site Supervisor (SS) stated he was aware that fire sprinklers within the facility had been removed based on damage the sprinklers sustained during the demolition phase of a project that occurred three weeks prior.</p> <p>A Removal Plan to address the immediate threat was requested and provided to the surveyor on 03/19/2024. On 03/19/2024 at 7:25 PM, an updated Removal Plan was received and approved by the New Jersey Department of Health. The Plan included:</p> <p>"During the Life safety inspection 3/19/24 it was determined that the sprinkler heads and fire alarms were removed from the construction area in assisted living and the barrier walls were not up to code.</p> <ol style="list-style-type: none"> <li>1. Immediately met with contractors to stop working at around 4pm on 3/19/24</li> <li>2. Met with Fire Marshal and leadership team to discuss survey findings and remove immediate threat. Threat will be eliminated by approved fire watch until new sprinkler system is installed and verified operational by [facility's parent company] and [construction company].</li> </ol>	A1097		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A1097	<p>Continued From page 10</p> <p>3. We have a policy and procedure to address our environmental surveillance rounds called a FireWatch with Logs to ensure safety of our Residents.</p> <p>4. We installed a Smoke Wall immediately per the Inspectors [sic] requests.</p> <p>5. Assigned site supervisor and staff from [construction company] to fire watch until new sprinklers and smoke detectors are installed. Instructing them to be aware of any smoke or fire in the construction area. If detected pull the fire alarm in the community or call 911 directly. Training completed by community administrator. This started at 5pm on 3/19 and was signed off every hour while constantly patrolling the area. [Site Supervisor] from [construction company] did the first evening and two of our concierge [Concierge #1] and [Concierge #2].</p> <p>6. New sprinklers and smoke detectors will be installed on 3/20/24 per [construction company]. The [fire protection company] Cut and capped two copper lines feeding Unit 241 and installed a [sic] new black steel pipes with sprinkler heads.</p> <p>7. A [sic] 1 ¾ inch hollow core doors and penetrations in the smoke barriers. A [sic] 1 ¾ inch solid core doors were installed to replace the 1 ¾ inch hollow core doors. Sheet rock penetrations were repaired, taped, and mudded.</p> <p>8. The 1-hour fire walls and separation and 45-minute opening protectives. We installed a Metal stud with sheet rock taped, and mudded temporary walls were installed to replace the temporary plastic barrier.</p> <p>9. Administrator will be auditing the fire watch daily and assuring staff sign in and out. We will run a second Fire Watch on 3/20/24 to ensure system is working correctly, to be signed off every hour until 3/21/24.</p> <p>10. Immediate threat was removed on an interim basis on 3/19/24 until the sprinklers and smoke</p>	A1097		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A1097	<p>Continued From page 11</p> <p>detectors are installed.</p> <p>11. The 13 residents in this area were not affected due to the measures we put in place."</p> <p>On 03/20/2024 at 9:00 AM, the surveyor conducted an onsite revisit to verify the Removal Plan had been implemented. The fire watch was in place, door openings in the smoke barrier were replaced with rated drywall, and the fire sprinkler system installation had begun.</p> <p>On 04/02/2024 at 9:35 AM, a surveyor conducted another onsite revisit to verify the Removal Plan had been implemented. The surveyor observed that a fire sprinkler system was installed and in place. A construction barrier was in place and was compliant with all applicable codes. Observation of the fire barrier revealed no unsealed penetrations and also revealed the opening protectives were in compliance with applicable code. The surveyor verified fire watch training and a fire watch was implemented from 03/19/2024 to 03/20/2024.</p>	A1097		
A1179	<p>8:36-17.1(a) Housekeeping-Sanitation-Safety-Maintenance</p> <p>(a) The facility shall provide and maintain a sanitary and safe environment for residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe and secure environment for residents during a renovation. The deficiency affected 1 of 1 smoke compartment and had the</p>	A1179		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/02/2024</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A1179	<p>Continued From page 12</p> <p>potential to affect all 32 residents residing in the facility.</p> <p>It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause, serious injury, harm, impairment, or death to residents.</p> <p>On 03/19/2024 at 2:00 PM, the New Jersey Department of Health determined the failed practice represented an immediate threat to residents' health and safety. The facility's Administrator was informed of the immediacy of the situation involving sprinkler heads and smoke detectors being removed and deficiencies related to a smoke barrier and a fire barrier, and a Removal Plan was requested.</p> <p>Findings included:</p> <p>Observation on 03/19/2024 at 12:55 PM revealed Room 116 on the first floor of the facility was under renovation. The renovation scope included removing the demising walls between Room 116 and Room 118 to make it one room. Further observation revealed the fire sprinkler heads and smoke detectors in the space had been removed. The demising smoke barrier that separated the renovation space from the egress corridor had unsealed penetrations and voids, and doors in the smoke barrier were not one- and three-quarter inch thick solid core doors that would resist the passage of smoke. The entire area undergoing renovation lacked a required one-hour fire wall separation and fire rated 45-minute opening protectives in the required barriers separating the work area from occupied space, which failed to meet the requirements set forth by the National Fire Protection Association (NFPA) 241, Standard for Safeguarding</p>	A1179		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A1179	<p>Continued From page 13</p> <p>Construction, Alteration, and Demolition; and the New Jersey Administrative Code section 5:23.</p> <p>During an interview on 03/19/2024 at 1:10 PM, the Director of Maintenance and Administrator stated they were not aware devices had been removed and were not aware of the deficiency related to the smoke barrier. They confirmed the facility lacked a policy or procedure regarding environmental surveillance rounds to ensure compliance with applicable codes.</p> <p>During a phone interview on 03/19/2024 at 1:31 PM, the facility's contracted construction company's Site Supervisor (SS) stated he was aware that fire sprinklers and smoke detectors in the facility had been removed based on damage the sprinklers and detectors sustained during the demolition phase of a project that occurred three weeks prior.</p> <p>A Removal Plan was requested and provided to the surveyor on 03/19/2024. On 03/19/2024 at 7:25 PM, an updated Removal Plan was received and approved by the New Jersey Department of Health. The plan included:</p> <p>"During the Life safety inspection 3/19/24 it was determined that the sprinkler heads and fire alarms were removed from the construction area in assisted living and the barrier walls were not up to code.</p> <ol style="list-style-type: none"> <li>1. Immediately met with contractors to stop working at around 4pm on 3/19/24</li> <li>2. Met with Fire Marshal and leadership team to discuss survey findings and remove immediate threat. Threat will be eliminated by approved fire watch until new sprinkler system is installed and verified operational by [facility's parent company] and [construction company].</li> </ol>	A1179		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/02/2024</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A1179	<p>Continued From page 14</p> <p>3. We have a policy and procedure to address our environmental surveillance rounds called a FireWatch with Logs to ensure safety of our Residents.</p> <p>4. We installed a Smoke Wall immediately per the Inspectors [sic] requests.</p> <p>5. Assigned site supervisor and staff from [construction company] to fire watch until new sprinklers and smoke detectors are installed. Instructing them to be aware of any smoke or fire in the construction area. If detected pull the fire alarm in the community or call 911 directly. Training completed by community administrator. This started at 5pm on 3/19 and was signed off every hour while constantly patrolling the area. [Site Supervisor] from [construction company] did the first evening and two of our concierge [Concierge #1] and [Concierge #2].</p> <p>6. New sprinklers and smoke detectors will be installed on 3/20/24 per [construction company]. The [fire protection company] Cut and capped two copper lines feeding Unit 241 and installed a [sic] new black steel pipes with sprinkler heads.</p> <p>7. A [sic] 1 ¾ inch hollow core doors and penetrations in the smoke barriers. A [sic] 1 ¾ inch solid core doors were installed to replace the 1 ¾ inch hollow core doors. Sheet rock penetrations were repaired, taped, and mudded.</p> <p>8. The 1-hour fire walls and separation and 45-minute opening protectives. We installed a Metal stud with sheet rock taped, and mudded temporary walls were installed to replace the temporary plastic barrier.</p> <p>9. Administrator will be auditing the fire watch daily and assuring staff sign in and out. We will run a second Fire Watch on 3/20/24 to ensure system is working correctly, to be signed off every hour until 3/21/24.</p> <p>10. Immediate threat was removed on an interim basis on 3/19/24 until the sprinklers and smoke</p>	A1179		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR PREMIER RESIDENCES OF TEANECK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>655 POMANDER WALK TEANECK, NJ 07666</b>
--	---

(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
A1179	<p>Continued From page 15</p> <p>detectors are installed.</p> <p>11. The 13 residents in this area were not affected due to the measures we put in place."</p> <p>On 03/20/2024 at 9:00 AM, the surveyor conducted an onsite revisit to verify the Removal Plan had been implemented. The fire watch was in place, door openings in the smoke barrier were replaced with rated drywall, and the installation of the fire sprinkler system had begun.</p> <p>On 04/02/2024 at 9:35 AM, a surveyor conducted another onsite revisit to verify the Removal Plan had been implemented. The surveyor observed that a fire sprinkler system was installed and in place. A construction barrier was in place and was compliant with all applicable codes. Observation of the fire barrier revealed no unsealed penetrations and also revealed the opening protectives were in compliance with applicable code. The surveyor verified fire watch training and a fire watch was implemented from 03/19/2024 to 03/20/2024.</p>	A1179		



## PREMIER RESIDENCES

A FIVE STAR PREMIER SENIOR LIVING COMMUNITY

### Version #3

During the Life safety inspection 3/19/24 it was determined that the sprinkler heads and fire alarms were removed from the construction area in assisted living and the barrier walls were not up to code.

1. Met with Fire Marshal and leadership team to discuss survey findings and remove immediate threat. Threat will be eliminated by approved fire watch.
2. Assigned site supervisor and staff from **NJ Ex Order 26.4b1** to fire watch until new sprinklers and smoke detectors are installed. Instructing them to be aware of any smoke or fire in the construction area. If detected pull the fire alarm in the community or call 911 directly. Training completed by community administrator.
3. New sprinklers and smoke detectors will be installed on 3/20/24 per **NJ Ex Order 26.4b1**
4. Administrator will be auditing the fire watch daily and assuring staff sign in and out.
5. Immediate threat was removed on an interim basis on 3/19/24 until the sprinklers and smoke detectors are installed.

**NJ Exec Order 26.4b1**

3/19/24

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 02A001	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/26/2024
NAME OF FACILITY FIVE STAR PREMIER RESIDENCES OF TEANECK	STREET ADDRESS, CITY, STATE, ZIP CODE 655 POMANDER WALK TEANECK, NJ 07666	

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 H5795	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:43E-13.5	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	04/02/2024	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 _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/2/2024	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---	--

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 02A001	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/26/2024
Y1	Y2	Y3
NAME OF FACILITY FIVE STAR PREMIER RESIDENCES OF TEANECK		STREET ADDRESS, CITY, STATE, ZIP CODE 655 POMANDER WALK TEANECK, NJ 07666

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 A0511	Correction	ID Prefix A0517	Correction	ID Prefix A0647	Correction
Reg. # 8:36-5.5(a)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-6.1(a)(3)	Completed
LSC	04/02/2024	LSC	04/02/2024	LSC	04/02/2024
ID Prefix A1097	Correction	ID Prefix A1179	Correction	ID Prefix	Correction
Reg. # 8:36-16.6	Completed	Reg. # 8:36-17.1(a)	Completed	Reg. #	Completed
LSC	04/02/2024	LSC	04/02/2024	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	<input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO	<input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/2/2024	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
---	---	------------------------------	-----------------------------