STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING _____ B. WING _____	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	96 PARKWAY ROCHELLE PARK, NJ 07662

(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 Standard Survey: 12/21/22 Census: 203 Sample Size: 35 + 3 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days	F 640		1/10/23

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

Electronically Signed | 01/15/2023

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

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F 640	Continued From page 1 after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 21 of 38 residents	F 640	Corrective action of residents in sample list: Each late MDS submission was verified as late but found to be accepted into the MDS system by the MDS coordinator.	

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F 640	Continued From page 2 reviewed for resident assessment, Resident #187, #509, #178, #3, #191, #42, #208, #41, #124, #16, #5, #175, #97, #67, #66, #193, #110, #96, #196, #172, and #189). The MDS is a comprehensive tool that is federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must complete and electronically transmit the MDS up to 14 days of the assessment being completed. According to the latest version of the Center for Medicare/Medicaid Services (CMS) - Resident Assessment Instrument (RAI) 3.0 Manual (updated October 2019) page 2-33 ".....The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days)." On Page 2-17 indicated "Transmission Date no later than...MDS completion date +14 calendar days." This deficient practice was evidenced by the following: 1. Review of the Quarterly MDS with an Assessment Reference Date (ARD) of 4/15/22 for Resident #187 was due to be transmitted to Centers for Medicare and Medicaid Services (CMS) no later than 5/13/22. The MDS was not transmitted to CMS until 6/15/22. Review of another Quarterly MDS with an ARD of 7/15/22 for Resident #187 was due to be transmitted to CMS no later than 8/12/22. The MDS was not transmitted to CMS until 9/2/22. Review of a Significant Change in Status	F 640	Corrective action for all remaining residents: All residents that require an OBRA MDS assessment have the ability to be affected by this deficient practice. Systemic change: The MDS coordinators were re-inserviced on the policy and procedure for timing of MDS completion and submission timeframes according to the RAI manual by the regional MDS coordinator. Two alternate transmitters were trained by the regional MDS coordinator on how to transmit completed assessments timely should the need arise due to illness or absence. The facility MDS coordinators will distribute weekly a listing of all MDS due dates for the following week to all IDT members that complete the MDS, The MDS transmission report will be audited weekly by the Director of nursing for any late submissions. Any discrepancies will be discussed at the morning clinical meeting by the MDS Coordinators. QA: The results of said audit will be monitored by the regional MDS coordinator. The results of said audits will be reviewed by the administrator or designee at the bi monthly quality assurance performance improvement meetings for receomendations and comments for the next 6 months.	

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F 640	Continued From page 3 Assessment with an ARD of 9/25/22 for Resident #187 was due to be transmitted to CMS no later than 10/23/22. The MDS was not transmitted to CMS until 11/11/22. 2. Review of an Admission MDS with an ARD of 10/28/22 for Resident #509 was due to be transmitted to CMS no later than 11/25/22. The MDS was not transmitted to CMS until 11/30/22. 3. Review of an Annual MDS with an ARD of 4/12/22 for Resident #178 was due to be transmitted to CMS no later than 5/10/22. The MDS was not transmitted to CMS until 6/15/22. Review of a Quarterly MDS with an ARD of 7/13/22 for Resident #178 was due to be transmitted to CMS no later than 8/10/22. The MDS was not transmitted to CMS until 9/5/22. Review of a Significant Change in Status Assessment with an ARD of 10/13/22 for Resident #178 was due to be transmitted to CMS no later than 11/10/22. The MDS was not transmitted to CMS until 11/30/22. 4. Review of an Annual MDS with an ARD of 7/18/22 for Resident #3 was due to be transmitted to CMS no later than 5/10/22. The MDS was not transmitted to CMS until 9/26/22. 5. Review of a Quarterly MDS with an ARD of 10/16/22 for Resident #191 was due to be transmitted to CMS no later than 11/13/22. The MDS was not transmitted to CMS until 11/30/22. 6. Review of a Quarterly MDS with an ARD of 5/24/22 for Resident #42 was due to be	F 640		

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F 640	Continued From page 4	F 640		

transmitted to CMS no later than 6/21/22. The MDS was not transmitted to CMS until 6/27/22.
7. The surveyor reviewed the Discharge MDS 3.0 assessments, including all the completed MDS's for Resident #208 which revealed that the resident had a discharge MDS with an ARD of 9/5/22 and was due to be transmitted no later than 10/3/22. The MDS was not completed and transmitted until 10/4/22.
8. Review of a Quarterly MDS with an ARD of 8/28/22 for Resident #41 was due to be transmitted to CMS no later than 9/25/22. The MDS was not transmitted to CMS until 9/26/22.

9. Review of an Admission MDS with an ARD of 8/11/22 for Resident #124 was due to be transmitted to CMS no later than 9/8/22. The MDS was not transmitted to CMS until 9/21/22.

10. Review of a Quarterly MDS with an ARD of 7/10/22 for Resident #16 was due to be transmitted to CMS no later than 8/7/22. The MDS was not transmitted to CMS until 9/2/22.

11. Review of a Quarterly MDS with an ARD of 7/13/22 for Resident #5 was due to be transmitted to CMS no later than 8/10/22. The MDS was not transmitted to CMS until 9/2/22.
12. Review of an Admission MDS with an ARD of 7/1/22 for Resident #175 was due to be transmitted to CMS no later than 7/29/22. The MDS was not transmitted to CMS until 8/9/22.

Review of a Quarterly MDS with an ARD of 9/28/22 for Resident #175 was due to be transmitted to CMS no later than 10/26/22. The MDS was not transmitted to CMS until 11/1/22.

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F 640	Continued From page 5	F 640		

13. Resident #97 was observed to have a Quarterly MDS with an ARD date of 9/20/22 and was due to be transmitted no later than 10/18/22. The MDS was not transmitted to CMS until 10/24/22.

14. Review of an Admission MDS with an ARD of 7/2/22 for Resident #67 was due to be transmitted to CMS no later than 7/30/22. The MDS was not transmitted to CMS until 8/2/22.

Review of a Quarterly MDS with an ARD of 9/27/22 for Resident #67 was due to be transmitted to CMS no later than 10/25/22. The MDS was not transmitted to CMS until 11/1/22.

15. Review of a Quarterly MDS with an ARD of 6/12/22 for Resident #66 was due to be transmitted to CMS no later than 7/10/22. The MDS was not transmitted to CMS until 7/11/22.

Review of another Quarterly MDS with an ARD of 9/9/22 for Resident #66 was due to be transmitted to CMS no later than 10/7/22. The MDS was not transmitted to CMS until 10/13/22.
18. Review of a Significant Change in Status Assessment with an ARD of 6/3/22 for Resident #193 was due to be transmitted to CMS no later than 7/1/22. The MDS was not transmitted to CMS until 9/18/22.

19. Review of an Annual MDS with an ARD of 8/11/22 for Resident #110 was due to be transmitted to CMS no later than 9/7/22. The MDS was not transmitted to CMS until 9/18/22.

20. Review of a Quarterly MDS with an ARD of 10/28/22 for Resident #96 was due to be

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F 640	Continued From page 6	F 640		

transmitted to CMS no later than 11/24/22. The MDS was not transmitted to CMS until 12/1/22.

Review of a Significant Change in Status Assessment with an ARD of 7/28/22 for Resident #96 was due to be transmitted to CMS no later than 8/26/22. The MDS was not transmitted to CMS until 9/18/22.

21. Review of an Admission/Medicare 5 days MDS with an ARD of 7/17/22 for Resident #196 was due to be transmitted to CMS no later than 8/6/22. The MDS was not transmitted to CMS until 8/9/22

Review of a Discharge Return Not Anticipated /End of PPS Part A Stay with an ARD of 10/06/22 for Resident #196 was due to be transmitted to CMS no later than 11/1/22. The MDS was not transmitted to CMS until 11/30/22.

22. Review of a Discharged Return not Anticipated/End of PPS Part A Stay with an ARD of 10/16/22 for Resident #172 was due to be transmitted to CMS no later than 11/13/22. The MDS was not transmitted to CMS until 11/30/22.

23. Review of a Discharged Return not Anticipated/End of PPS Part A Stay with an ARD of 10/13/22 for Resident #189 was due to be transmitted to CMS no later than 11/10/22. The MDS was not transmitted until 11/30/22.

On 12/6/22 at 11:09 AM, the surveyor interviewed the Registered Nurse MDS Coordinator for the North Unit (RN/MDS Coordinator #1). RN/MDS Coordinator #1 stated that MDS Assessments should be submitted, "as soon as" they are

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F 640	Continued From page 7 completed and that there is a 14 day window from when they are completed to when they need to be submitted. RN/MDS Coordinator #1 stated that she did not know why several MDS Assessments were submitted late. On 12/12/22 at 12:25 PM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDS Coordinator #1) in the North Building. The surveyor and the RN/MDS Coordinator #1 reviewed the MDS for the following residents and she acknowledged that they were submitted late. On 12/6/22 at 11:24 PM, the surveyor interviewed the RN/ MDS Coordinator for the South Building. (RN/MDS Coordinator #2). RN/MDS Coordinator #2 stated that sometimes there are MDS Assessments ready to be exported but that she will forget to subit them right away. RN/MDS Coordinator #2 stated that MDS Assessments should be transmitted as soon as they are completed but that it is permissible to transmit them within 14 days of when they are completed. On 12/12/22 at 2:15 PM, the surveyor expressed their concerns regarding late MDS transmissions to the Executive Licensed Nursing Home Administrator (LNHA), Chief Nursing Officer, LNHA/ VP of Operations Associate Administrator, and Regional Quality Assurance RN. NJAC8:39-11.2 (e)	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		1/10/23

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F 641	Continued From page 8 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 1 of 38 residents (#207) reviewed. The deficient practice was evidenced by the following: The MDS is a comprehensive tool, that is a federal mandated process for clinical assessment of all residents. The MDS must be completed and transmitted to the Quality Measure System at Centers for Medicare & Medicaid Services (CMS). On 12/12/22 at 9:49 AM, the surveyor reviewed the discharge medical records for Resident #207. The resident was admitted to the facility on [NJAC 8 43E-2.1 and E] Further review of the medical records revealed that the resident was discharged to [NJAC 8 43E-2.1] on [NJAC 8 43E-2.1 an]. The surveyor reviewed the MDS 3.0 assessments, including all the completed MDS's for Resident #207. The review of the MDS 3.0 for Resident #207 revealed that the resident was discharged to [NJAC 8 43E-2.1 and Exec Order 26, 4. b. 1]. The surveyor reviewed the Interdisciplinary Progress Notes dated 9/17/22 which documented that Resident #207 was discharged [redacted] with family in [redacted].	F 641	Corrective action of residents in sample list: Resident #207 MDS was corrected and resubmitted by the MDS coordinator. Corrective action for all remaining residents: All residents who are discharged from the facility have the potential to have their discharged disposition coded incorrectly. The MDS coordinators performed an audit of all discharged residents within the last 60 days. Systemic change: The MDS coordinators were re-inserviced on the policy and procedures for coding the discharge disposition from the RAI manual by the Regional MDS coordinator. The MDS coordinator will audit 35 records per month for the residents with a discharge MDS for accuracy. QA: Results of said audit will be monitored by the director of nursing. The results of said audit will be reviewed by the administrator or designee at the bi monthly quality assurance performance improvement meetings for the next 6 months.	

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F 641	Continued From page 9 During an interview by the surveyor on 12/12/22 at 1:48 PM, the MDS Coordinator who was responsible for completing the MDS assessment stated that acute hospital discharge status was checked in error. The MDS Coordinator further stated that Resident #207 was discharged [redacted] NJAC 8:39-11.2(e)1	F 641		
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 that the facility failed to maintain professional standards of nursing practice by 1. failing to label and date an Enteral Feeding container, 2. not following a physician's order for 1 of 4 sampled residents, Resident #41. 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 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	F 658	Corrective action or residents in sample list: Resident #41 [redacted] was immediately discarded. Resident #41 [redacted] orders were immediately clarified with the MD by the unit manager. Corrective action for all remaining resident: All other residents that receive tube feedings have the potential to be affected by the deficient practice. All tube feeding orders were reviewed for transcription accuracy by the dietician. All tube feeding bottles were checked for proper labeling by the dietician. Systemic change	1/10/23

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F 658	Continued From page 10 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 11/30/22 at 11:32 AM, during the initial tour the surveyor observed on a [redacted] of [redacted] on Resident # 41's bedside table. The surveyor noted that the [redacted] container was half empty and did not have a resident information label. Review of the Admission Record revealed that Resident #41 was admitted to the facility with diagnosis that included but were not limited to: NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] A review of the most recent Quarterly Minimum Data (MDS), an assessment tool used to facilitate the management of care dated, [redacted] identified that Resident #41 was unable to participate with a Brief Interview for Mental Status (BIMS) and had cognition that was [redacted] A review of the resident's physician orders (PO) revealed two orders with a start date of 6/10/2022, that included an [redacted] one time a day, give [redacted] of [redacted]. Resident #41 had another PO with a start date of 11/24/2022, [redacted] type: [redacted] by [redacted]. Total volume to be administered: [redacted].	F 658	All RNs and LPNs were re-inserviced by the director of nursing on the transcription of tube feeding orders, labeling of tube feeding bottles, and signing the medical administration post administration of tube feeding. A monthly audit of the accuracy of tube feeding orders and signing tube feeding orders post administration will be done by the dietician. A bi weekly audit of labeling of tube feeding bottles will be done by the director of nursing or designee. QA: The results of the audits will be monitored by the director of nursing. The results of said audits will be reviewed by the administrator or designee at the bi monthly quality assurance performance improvement meetings for recommendations and comments for the next 6 months.	

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F 658	Continued From page 11 A review of the December 2022 Electronic Medication Administration Record reflected that the resident had received a [redacted] at 8:00am as well as a [redacted] day at 9:00 AM from December 1st through December 5th. On 12/5/22 at 10:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1). When the surveyor asked what patient and physician order information should be present on a tube feeding label, LPN#1 stated, the resident's name, room number, the tube feeding rate or bolus amount as well as the date and time the feeding started. should all be on the tube feeding label. LPN#1 could not provide an explanation on why she/he did not write the above mentioned information on the Resident #41's [redacted] during the surveyor's observation on 11/30/22. LPN#1 further stated Resident #41 was not receiving the [redacted] and that the order should have been discontinued. LPN #1 stated the resident was only receiving a [redacted] The surveyor reviewed the December Electronic Medication Administration Record (eMAR) with LPN #1, which revealed that LPN #1 signed off as administered for [redacted] on December 1st, 2nd, and 5th. LPN #1 could not explain why she had signed off on the order when she stated that she did not administer the [redacted] LPN#1 could not explain why the order had not been discontinued.	F 658		

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	315494	A. BUILDING _____ B. WING _____	12/21/2022

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F 658	Continued From page 12 On 12/7/22 at 1:27 PM, the surveyor discussed the above concerns with the Executive Licensed Nursing Home Administrator and the Director of Nursing. No further information was provided. A review of the facility policy "Enteral Feeding", under procedure documents, "Check documentation of the orders in Medication Administration Record (MAR)." A review of the facility policy "Transcribing Physician Orders", the policy states under procedure section 4, "All orders shall be reviewed by a licensed nurse every 24 hours to ensure accuracy and that all orders have been carried out." NJAC 8:39-27.1 (a)	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 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 maintain necessary respiratory care and services for a resident who was receiving a [redacted] treatment according to the standards of practice. The deficient practice was identified for 1 of 2	F 695	Corrective action of residents in sample list: Both [redacted] masks for resident #126 were disposed of immediately. A new [redacted] mask was provided and placed in a plastic bag properly labeled in the	1/10/23

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F 695	Continued From page 13 residents (Resident #126) reviewed for respiratory care. This deficient practice was evidenced by the following: On 11/30/22 at 10:58 AM, the surveyor observed Resident #126 in bed in their room. The surveyor observed [redacted] masks placed inside the resident's night stand drawer. The surveyor reviewed Resident #126's medical records that revealed the following: The Admission Record revealed that Resident #126 was admitted to the facility with diagnoses that included but were not limited to [redacted]. The Admission MDS (Minimum Data Set) dated 10/10/22, revealed a Brief Interview of Mental Status score of [redacted] out of [redacted] which indicated that the resident had [redacted]. The November 2022 Order Summary Report revealed the following physician's order, [redacted] with a start date of 10/2/22. On 11/30/22 at 11:24 AM, the Unit Manager/Registered Nurse (UM/RN) accompanied the surveyor into Resident #126's room. During the interview, the UM/RN stated that when the [redacted] masks are not in use, they must be placed in plastic bags for proper storage.	F 695	bedside drawer. Corrective action for all remaining residents: All other residents that receive [redacted] treatments have the potential to be affected by the deficient practice. Immediate rounds were conducted by the unit manager to ensure there were no other [redacted] not in plastic, not placed by the bedside table drawer. Systemic change: All RNs and LPNs were re-inserviced on the use of masks/respiratory tubing, including proper labeling and storage y the regional director of respiratory. Weekly audits for compliance with [redacted] /respiratory tubing will be completed for all residents using [redacted] masks by the director of nursing or designee. QA Results of these audits will be monitored by the director of nursing. The results of said audit will be reviewed by the administrator or designee at the bi monthly quality assurance performance improvement meetings for the next 6 months,	

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F 695	Continued From page 14 A review of the facility's Policy and Procedure title Administering [redacted] with an effective date of January 2022, "19. When equipment is completely dry, store in a plastic bag with the resident's name and date on it." On 12/12/22 at 2:16 PM, the surveyor brought the above concern to the Executive Licensed Nursing Home Administrator, VP of Operations, Associate Administrator, Chief Nursing Officer (CNO), and Regional Quality Assurance Nurse. The CNO stated that the [redacted] masks are to be stored in plastic bags and placed inside the resident's drawer when they are not in use.	F 695		
F 755 SS=D	NJAC 8:39-19.4 (a)(k) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		1/10/23

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F 755	Continued From page 15 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of medical records, it was determined that the facility failed to a.) accurately follow facility policy related to the removing of back up control substances documentation for 4 of 12 reviewed control substances stored in the CUBEX system (automated medication dispensing system); b.) failed to remove expired medications in the medication storage room. This deficient practice was evidenced by the following: a.) On 12/1/22 at 11:00 AM, the surveyor reviewed the Back-Up Controlled Substance Administration Record form which documented the removal of controlled substances from the facility CUBEX system. The forms were noted with missing "Witness" signatures on numerous of the controlled substances reviewed. The surveyor reviewed each sheet which was	F 755	Corrective action of residents in sample list: The controlled substance declining sheets were immediately audited for accurate narcotic counts by the director of nursing. The counts of each medication were determined to be accurate by the director of nursing. Corrective action for all remaining residents: All other residents who receive controlled substances from the cubex machine have the potential to be affected. All Cubex controlled substance sign off sheets were removed. Systemic Change: The policy for witnessing and removal of controlled medication removal from the Cubex was revised to reflect that 2 nurses electronic signatures is required for	

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F 755	Continued From page 16 delegated to a single controlled substance. The sheets reviewed were: 1. [redacted] with missing "Witness" signatures for 11/19/22 and 11/22/22. 2. [redacted] with missing "Witness" signature for 10/10/22 3. [redacted] with missing "Witness" signatures for 10/7/22 and 10/9/22 4. [redacted] with missing "Witness" signature for 5/7/22 On 12/1/22 at 11:10 AM, the surveyor observed as the Registered Nurse in charge of the North Building and the Assistant Director of Nursing (ADON) performed an inventory count of controlled substances stored in the CUBEX system. All controlled substances stored in the CUBEX system were accurately inventoried. The surveyor interviewed the ADON who explained that all controlled substances removed from the CUBEX system require 2 nurses to enter their fingerprints into the system as well as sign the Back-Up Controlled Substance Administration Record form The surveyor reviewed the Policy and Procedure for the CUBEX Station which documented under section C. "Removal of controlled medications from the CUBEX will require two nurses, one being a witness. A witness is required to sign-in to the station to document the removal of a controlled medication." Review of the CUBEX print out, provided by the Licensed Nursing Home Administrator (LNHA) for each medication that was missing a "Witness" signature of the Back-Up Controlled Substance	F 755	removal of controlled substances. The daily activity report will be emailed by the pharmacy to the director of nursing, the assistant director of nursing, the administrator, and regional QA nurse for review. The cycle count will be performed daily by the director of nursing and the assistant director of nursing (or designees)-required 2 people. Inservices for all RNs and LPNs to educate them on the revised policy by the Director of nursing. A monthly audit of signatures will be given to the director of nursing by the pharmacy. QA: The results of the audits will be monitored by the director of nursing. The results of said audits will be reviewed by the administrator at the bi monthly quality assurance performance improvement meetings for recommendations and comments for the next 6 months.	

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F 755	Continued From page 17 Administration Record form depicted a "Witness" nurses name that was present at the time of the removal of the controlled substances from the CUBEX system. On 12/1/22 at 2:00 PM, the surveyors discussed the missing "Witness" signatures on the Back-Up Controlled Substance Administration Record form with the Director of Nursing, LNHA, ADON and LNHA Regional VP of Operations. No further information was provided to explain why the "Witness" signatures were missing on the Back-Up Controlled Substance Administration Record form.	F 755		
F 761 SS=D	N.J.A.C. 8:39 - 11.2(b), 29.4(b)3, 29.4(h) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs	F 761		1/10/23

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F 761	Continued From page 18 listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that 1. expired, discontinued medications were removed from the medication cart / room, 2. medications were maintained with appropriate labeling, and 3. medications were correctly administered during the medication pass. This deficient practice was identified for 2 of 4 floors inspected. The deficient practice was evidenced by the following: 1. On 12/1/22 at 9:50 AM, the surveyor inspected the North Building 2nd floor District 2 cart and found a box of [redacted] mg #32 belonging to Resident #123 with an order date of 5/4/22. Review of the May 2022 Electronic Medication Administration Record (eMAR) for Resident #123 showed [redacted] tablet by mouth every 12 hours for [redacted] was originally ordered on 5/3/22. The [redacted] was then reordered on 5/13/22 for 7 days and discontinued on 5/19/22. Review of the Discharged Medications Policy and Procedure revised on 5/10/21, explains under "2.	F 761	Corrective action of residents in sample list: [redacted] for resident #123 was discarded. [redacted] and expired medications were discarded. Medications found at the bedside for resident #202 were discarded. Resident #202 received her medication and was supervised while taking them. Corrective action for all remaining residents: All residents that take medication have the ability to be affected by the deficient practice. All medication rooms, medication carts, and patient bedside tables were checked for discontinued, expired and unlabeled medications. Systemic change: All RNs and LPNs were re-inserviced by the Director of nursing on timely disposal of expired medications, timely removal of discontinued medications and proper labeling and storage of medications. All RNs and LPNs were re-inserviced by the director of nursing on the medication administration policy, with particular focus on not leaving medications at the bedside and watching the resident swallow the medication.	

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F 761	Continued From page 19 Upon discontinuation of a medication, the medication will be removed from the medication treatment cart and they will be secured in the medication room." 2. On 12/1/22 at 9:50 AM, the surveyor inspected the North Building 2nd floor District 2 cart and found a plastic zip lock bag with #5 tablets of [redacted]) with no resident information designating whom it belonged to. On 12/1/22 at 10:00 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) that was assigned to the medication cart. The LPN could not explain or give any clarifying information as to why this medication was in the medication cart, without a resident name, or label. 3. On 11/30/22 at 12:12 PM, the surveyor inspected the 3rd floor South building medication storage room and found the following expired medications: a. [redacted] Exp. April 2022 b. [redacted] c. [redacted] 14-day courses (x2 14 day pack) The surveyor informed the RN/UM on 3rd floor South nursing unit who agreed that the above medications were expired and could not provide any further information.	F 761	All med rooms and med carts will be checked weekly by the unit managers or designee for expired medications, discontinued medications and unlabeled medications. The director of nursing or designee will audit a sample of 35 rooms bi weekly to check for medications at the bedside. Monthly audits will be done by the pharmacy consultant and reported in the monthly pharmacy unit evaluations QA: Results of said audits will be monitored by the director of nursing. The results of said audits will be reviewed by the administrator or designee at the bi monthly quality assurance performance improvement meetings for recommendations and comments for 6 months	

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F 761	Continued From page 20 3. On 11/30/22 at 10:45 AM, the surveyor observed Resident #202 who was alert and oriented sitting in bed wearing a gown. Resident #202 was in a private room, with no other roommates. The surveyor observed four (4) tablets on a tissue paper on the resident's over bed table. Resident #202 was in the process of taking the medications. The surveyor interviewed Resident #202, who stated that the blue ( ) and green pills are for , the orange is for , and the white oblong) is for . Resident #202 stated that the nurse sometimes leaves the medication on the table, but comes back to check. On 12/1/22 at 10:28 AM, the surveyor interviewed the Registered Nurse (RN#1) who was assigned as Resident #202's medication nurse on 11/30/22. RN#1 explained that she administered some of the scheduled medication to Resident #202, but left the rest of it because it takes a while for the resident to take the medication. RN#1 added that she checks on Resident #202 to see if all the medication was taken. RN#1 explained that she is not supposed to leave the medication in the resident's room, but that the unit is short staffed. On 12/1/22 at 10:49 AM, the surveyor interviewed the RN/UM regarding the medication left on top of resident's overbed table. The RN/UM stated that medication should never be left unattended with a resident. The RN/UM added that residents should only be administered their medications in the presence of a nurse. RN/UM added that if the resident is not ready to	F 761		

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F 761	Continued From page 21 take the medication the nurse should come back when the resident is ready. The surveyor reviewed the medical record for Resident #202. The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/6/22, which reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] indicating that the resident had [redacted] A review of the interdisciplinary care plan did not include a focus area that indicated that the resident could self-administer their medications. A review of the November 2022 eMAR did not included any order that the resident was able to self-administer medications. The eMAR revealed a Physician's Orders (PO) dated 10/27/22 for [redacted] to [redacted], an [redacted] another PO dated 10/30/22 for [redacted]) 750 mg to [redacted], and PO dated 10/28/22 for [redacted]	F 761		

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F 761	Continued From page 22 [redacted] A review of the November 2022 eMAR revealed a PO dated 10/27/22 for [redacted] with an administration time of 9:00 AM. The documented administration time for the [redacted] was signed by RN#1 as being administered on 10:28 AM on 11/30/22. The November 2022 eMAR revealed a PO dated 10/27/22 for [redacted] with an administration time of 9:00 AM. The administration time for the [redacted] was signed by the RN#1 as being administered at 10:28 AM on 11/30/22. The November 2022 eMAR revealed a PO dated 10/30/22 for [redacted]. The administration time for the [redacted] was signed by the RN #1 as being administered at 10:28 AM on 11/30/22. In addition, the eMAR also revealed a PO dated 10/28/22 for [redacted] the RN #1 as being administered at 10:28 AM on 11/30/22.	F 761		

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F 761	Continued From page 23 A review of the facility's policy for Medication Administration that was dated reviewed 10/2018 and was provided by the DON indicated the following, "Policy: Medications shall be administered in a safe and timely manner, and as prescribed." Continued review of the Medication Administration policy, Under Policies Interpretation and Implementation included, "3. Medications must be administered in accordance with the orders, including any required time frame." and "20. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary Care planning team, has determined that they have the decision-making capacity to so safely." On 12/7/22 at 1:32 PM, the survey team met with the Vice President (VP) Operations, License Nursing Home Administrator (LNHA), Chief Nursing Officer, Associate Administrator and Director of Nursing to discuss all the issues that were found. No further information was provided by the facility.	F 761		
F 812 SS=D	NJAC 8:39-29.4(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		1/10/23

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F 812	Continued From page 24 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly label, date, and store potentially hazardous foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was evidenced by the following: 1. On 11/30/22 at 9:47 AM, during the initial tour of the South building kitchen with the Food Service Director (FSD) and Regional Registered Dietitian (RRD) the surveyors observed a buildup of a greyish colored debris under the griddle on the heating coils. A review of the facility policy "Cleaning and Sanitation of Dining and Food Service Areas" explained, "The food service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a	F 812	Corrective Action of residents in sample list: The area under the griddle on the heating coils was cleaned immediately. Additional Sanitizing agent was added and retested to reach the required ppm. Dishes that were washed with incorrect ppm were re-washed. Food items found unlabeled and not dated were discarded immediately. Staff was given an inservice by the food service director on proper sanitizing process, dating and labeling food items when opened and updated kitchen/equipment cleaning schedules. Corrective Action for all remaining residents: All residents that have items that come from the kitchen have the potential to be	

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F 812	Continued From page 25 written, comprehensive cleaning schedule." On 11/30/22 at 9:50 AM, during an interview with the FSD, he explained that the heating coils are supposed to be cleaned weekly but could not explain why there was a buildup of debris. 2. On 11/30/22 at 9:55 AM, the surveyor observed the Dietary Aide (DA) using the 3 Compartment sink. The DA was observed testing the sanitizing solution using a Hydrion brand Quaternary Test Strip, which is used to test the sanitizing solution concentration in the water. The surevyor along with DA evaluated the used test strip, which revealed that the sanitizer solution concentration was between 50-100 Part Per million (PPM). On 11/30/22 at 10:00 AM, when interviewed by the surveyor, FSD stated that per regulation, the sanitizer solution concentration is required to be between 200-300 PPM for it to be effective. Review of the "Policy Interpretation and Implementation" under part 5., "Add sanitizer to the sanitizer sink in a concentration according to manufacturers specification via calibrated dispenser." In addition, the policy explains under Part 6., "Test the sanitizer sink water with the test strip. Hold the test strip in the water for at least 10 seconds. Compare the color on the test strip to the guide on the test kit. The test strip should read 200-400 ppm. This is recorded on the pot washing log sheet for each meal service." On 11/30/22 at 10:04 AM, the surveyor discussed the reduced concentration of santizing solution	F 812	affected. Systemic Changes: All staff were re-educated by the food service director on proper sanitation process, dating and labeling of food items when opened, and the cleaning schedule of kitchen and equipment. The food service director or designee will check and observe the 3 compartment sink cleaning/washing procedure to ensure sanitizing level is within regulation at each meal. The food service director or designee will audit daily opened food items for dating and labeling. Weekly sanitation audit will be done by the dietician or designee. The food service director will audit compliance on the cleaning schedule monthly. QA: Results of said audits will be reported to the administrator monthly. The administrator will bring the results of said audits to the bimonthly quality assurance performance improvement meeting for recommendations and comments for the next 6 months.	

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F 812	Continued From page 26	F 812		

with the DA, the FSD and the RRD. There was no further information provided to why the sanitizer solution was below the required concentration.

3. On 11/30/22 at 10:05 AM, while in the walk-in refrigerator, the surveyor observed an open package of liverwurst, and a package of deli turkey breast that were wrapped in plastic wrap without any labeling to when they were opened. The FSD informed the surveyor that the chef had just used both products for today's lunch. The FSD could not explain why the chef did not place a label documenting the opening date prior to returning the items to the refrigerator.

4. On 11/30/22 at 10:15 AM, while in the Dry storage area, the surveyor observed an open bag of vanilla wafers and five crackers bulk wrapped without an opening or best used by date label. The FSD could not explain why the date labels had not been placed on both items.

A review of the facility policy "Labeling Guidelines" under the "Policy Interpretation and Implementation" it explains, "Received and open labels will be placed on items that will be used more than once until complete. The employee receiving the deliveries will place the label and write in the received date. The employee that opens the product will write the open date. Received, opened and best if used by labels will be placed on products such as bulk cold items and opened repackaged items. The employee that opens the item will write in the open date and a best if used date which will be 7 days past the open date for cold items and the best if used by date that happens on the box."

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F 812	Continued From page 27 On 12/7/22 at 1:27 PM, the surveyor discussed all the above concerns with the Executive Administrator and the Director of Nursing. They did not provide any further information to explain why the opened items were not dated.	F 812		
F 880 SS=D	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		1/31/23

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F 880	Continued From page 28 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) adhere to infection control and isolation procedures for residents that were on contact isolation, Resident #195, #102, #168, b.) perform proper hand hygiene to prevent the spread of infection, Resident #195, #102, c.) adhere to accepted standards of infection control practices for the proper storage of a [redacted], Resident #195, and d.) ensure that clean linen was stored in a manner to prevent contamination and assist in the prevention of the spread of infection(s). This deficient practice was identified for 3 of 35 residents who were reviewed for infection control practices. The deficient practices were evidenced by the following: 1. On 12/12/22 at 8:18 AM, the surveyor was about to observe a nurse on the Subacute Unit in the North building. The surveyor noted a Physician exit Resident #102's room and enter Resident #195's room. Both rooms were noted with "Enhanced Barrier Precautions" signage. Another sign noted on the doors of Resident #102 and Resident #195 detailing "Providers and Staff Wear gloves and a gown for the following High-Contact Resident Care Activities" and listed "Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device Care, Wound Care." The surveyor observed the Physician in Resident #102's room with no gown or gloves as he	F 880	Corrective action of residents in sample list: The MD and RN were re-inserviced by the infection preventionist nurse on proper PPE use, Handwashing guidelines, and enhanced barrier precautions immediately. Resident #195 Ex.Order 26.4(b)(1) was checked immediately for proper placement. The linen aforementioned in F880 was removed and placed in the soiled linen. Corrective action for all remaining residents: All residents that are examined by MDs, receive medications, have Ex.Order 26.4(b)(1) and utilize linen have the potential to be affected by the deficient practice. All residents with Ex.Order 26.4(b)(1) were checked for placement by the infection preventionist. All linen storage areas were checked by the housekeeping director. All uncovered linen were removed and placed in the soiled utility bins by the housekeeping director. Systemic changes: All RN and LPNS were re-inserviced by the infection preventionist on enhanced barrier precautions, proper PPE, handwashing, and proper placement of Ex.Order 26.4(b)(1). All housekeeping staff were re-inserviced on	

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F 880	Continued From page 30 examined the resident. The surveyor then observed as the Physician left Resident #102's room and enter Resident #195's room without washing or sanitizing his hands. Once again, the physician was observed entering Resident #195's room without washing or sanitizing his hands, wearing gloves or putting on a gown. The Physician examined Resident #195 and upon exiting the room, the surveyor approached and interviewed him. The Physician explained that he should have worn a gown, gloves and washed his hands when entering and exiting both Resident #102 and Resident #195 rooms. Review of the Admission Record revealed that Resident #102 was admitted to the facility with diagnoses that included but not limited to [redacted] and [redacted] The Reentry MDS (Minimum Data Set) dated 12/6/22 revealed a Brief Interview of Mental Status score of [redacted] which indicated that the resident was [redacted] Review of the Admission Record revealed that Resident #195 was admitted to the facility with diagnoses that included but not limited to [redacted]	F 880	proper storage of clean linens by the infection preventionist. In-services will be done upon hire, quarterly, and as needed on the above topics by the infection preventionist. The infection preventionist will observe 5RNs, LPNs and/or physicians per week performing handwashing, proper use of PPE, and proper infection control techniques during patient care. The director of housekeeping will do biweekly audits of all clean linen storage areas to ensure all clean linens are store properly. QA: The results of the audits will be monitored by the director of nursing. The results of said audits will be reviewed by the administrator at the bimonthly quality assurance performance improvement meetings for the next 6 months. A directed plan of correction and root cause analysis has been conducted which will follow under seperate cover. The following directed in-service training has been completed. Module 1-infection prevention and control program watched by all topline staff including Infection Preventionist, CDC covid-19 prevention message for frontline long term care staff, Keep Covid-19 out! watched by all staff, CDC Covid-19 prevention message for front line long term care staff, clean hands watched by all staff, CDC covid-19 prevention message for front line long	

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F 880	Continued From page 31 The Admission MDS dated 10/24/22 revealed a Brief Interview of Mental Status score of [redacted], which indicated that the resident was [redacted]. Review of the facility Handwashing/Hand Hygiene policy and procedure reviewed by the facility on 12/2022 explains, "Before and after contact with patients and between patient contacts. On entering and leaving an isolation room." 2. On 12/12/22 at 8:23 AM, the surveyor observed Registered Nurse #1 (RN#1) prepare medication for administration to Resident #102. RN#1 was wearing a surgical mask and gloves when he entered the resident's room, no gown. RN#1 placed all the medications to be administered to Resident #102 in a plastic bin, placing the bin on the resident's over bed table. The surveyor noted that Resident #102's room had signs outside the room and on the door designating, "Enhanced Barrier Precautions" and detailing "Providers and Staff Wear gloves and a gown for the following High-Contact Resident Care Activities." Review of the most recent Physician's Order (PO) for Resident #102 documented an order for [redacted] RN#1 advised Resident #102 to [redacted] the [redacted] at RN#1 was holding at close proximity to the resident without wearing a gown to protect from contamination.	F 880	term care staff, Use PPE correctly for covid-19 watched by all staff, Module 11B-environment cleaning and disinfections, Module 4-infection surveilance, Module 7-hand hygiene watched by all staff, and module 6A-principles of standard precautions, Module 6B-Principles of transmission based precautions.	

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F 880	Continued From page 32 RN#1 then removed his gloves washed his hands and then carried the empty contaminated plastic bin and placed it onto the medication cart, without sanitizing the bin. RN#1 did not wash his hands after contaminating them by carrying the bin with his bare hands out of the room. RN#1 did not clean the bin prior to placing it on top of the medication cart. Review of the Equipment Cleaning policy and procedure revised by the facility on 1/24/22 explains, "It is the policy of the facility that staff clean equipment after use and as needed between residents." 3. On 12/12/22 at 8:45 AM, the surveyor observed RN#1 prepare medication for administration to Resident #168 utilizing a disposable plate to bring the medications into the room. Review of the Electronic Medical Administration Record (EMAR) that RN#1 was utilizing to prepare the medication for administration to Resident #168 documented that all medications were to be administered through a peg tube (A [redacted] . The surveyor noted that Resident #168's room had signs outside the room and on the door designating, "Enhanced Barrier Precautions" and detailing "Providers and Staff Wear gloves and a gown for the following High-Contact Resident Care Activities."	F 880		

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F 880	Continued From page 33 RN#1 was observed administering the medication via Resident #168's peg tube without wearing a gown. Review of the Admission Record revealed that Resident #168 was admitted to the facility with diagnoses that included but not limited to [redacted] The Reentry MDS (Minimum Data Set) dated 9/2/22 revealed a Brief Interview of Mental Status score of [redacted], which indicated that the resident had a [redacted] cognition. On 12/12/22 at 9:02 AM the surveyor interviewed RN#1 who stated that the plastic bin should have been sanitized before placing it onto the top of the medication cart. RN#1 added that he should have worn a gown and eye protection when taking care of Resident #102, spit out [redacted] with Resident #168, administering medication through a peg tube. Review of the Infection Control-Standard Precautions and Transmission Based Precautions policy and procedure explains, "12. Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of [redacted]." On 12/12/22 at 11:17 AM, the surveyor expressed their concerns to the Executive Licensed Nursing Home Administrator (LNHA),	F 880		

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F 880	Continued From page 34 Director of Nursing (DON), Chief Nursing Officer (CNO), LNHA/ VP of Operations, and the Associate LNHA. The LNHA explained that the Physician and RN#1 should have worn gowns when caring for residents on "Enhanced Barrier Precautions." The LNHA added that hand washing is a must when caring for any residents and especially going from resident to resident. 4. On 11/30/22 at 12:55 PM, the surveyor observed Resident #195 in bed and interviewed the resident at this time. The surveyor observed that the resident had a [redacted] that hung off the side of their bed, was in a [redacted], and did not touch the floor. The surveyor reviewed Resident #195's electronic medical record: The Admission Record revealed that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] Review of the 10/24/22 Admission MDS revealed that Resident #195 had a BIMS score of [redacted] out of [redacted] which indicated that the resident was [redacted] intact. The MDS also revealed that the resident had an [redacted]. The December Order Summary Report revealed that Resident #195 had a 10/19/22 active physician order for a [redacted] The care plan failed to reveal an active focus or	F 880		

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F 880	Continued From page 35 interventions related to Resident #195's [redacted] On 12/2/22 at 11:59 AM, the surveyor observed Resident #195 lying in bed with their [redacted]. The surveyor also observed the [redacted] Ex.Order 26.4(b)(1) hanging empty off the side of the resident's bed. On 12/2/22 at 12:27 PM, the surveyor interviewed the Certified Nursing Assistant (CNA). The CNA stated that the [redacted] for the [redacted] should be hung off the side of the bed in the [redacted] that should not touch the floor. On 12/2/22 at 12:31 PM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN stated that the [redacted] should not touch the floor and stated that it might have fallen out of the [redacted] and onto the floor when the CNA was performing morning care for the resident. On 12/7/22 at 1:27 PM, the surveyor expressed their concerns to the Executive LNHA, CNO, LNHA/ VP of Operations, and the Associate LNHA. The CNO stated that she expected that catheters should hang off the side of the resident's bed and should be inside the privacy bag and that they should not touch the floor. The facility policy, "Catheter Care, Urinary" with a revised date of 1/22 indicated under the Procedure section, "7. Be sure the catheter tubing and drainage bag are kept off the floor." 5. On 12/12/22 at 10:10 AM, two surveyors toured the South Laundry Room with the	F 880		

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Housekeeping Director (HD). . The surveyors observed two shelving units with uncovered clean linens stored on the shelves. The surveyors observed that some of the linens including bedding and towels were unfolded and were hanging off the sides of the shelves. The HD stated that the facility's linens were cleaned by an outside vendor and that they were delivered to the facility uncovered and were placed on the shelves.

On 12/12/22 at 10:16 AM, two surveyors toured the South Storage Room. The surveyors observed two mobile storage units with uncovered clean linens including towels and hospital gowns. The surveyors observed that some hospital gowns and towels were unfolded and that some were hanging off the side of the shelves.

The surveyors also observed a refrigerator, several chairs, and a television mounted to the wall. The surveyor observed that the television mounted to the wall was above the mobile storage unit of loose, uncovered clean towels and that some of the clean towels touched the bottom of the television.

The surveyor asked the HD if the linens should be covered. The HD stated that the linens should be covered when they are on the resident care units but that they do not need to be covered in the storage rooms.

On 12/12/22 at 10:43 AM, the survey team interviewed the HD. The HD explained that the South Storage room refrigerator was used to store food for employees, as well as storing clean

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ALARIS HEALTH AT THE CHATEAU	96 PARKWAY ROCHELLE PARK, NJ 07662

(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 880	Continued From page 37	F 880		

linens. The HD stated that the room was previously used as an employee lounge but that it should no longer be used that way.

During the interview, the HD continued to explain that linens should be covered when on resident occupied floors because the linens were clean and there could be infections throughout the facility. The surveyor discussed the possibility of the clean linens contaminated while stored in a room that employees had access to for food storage. The HD agreed that contamination was a possibility.

On 12/12/22 at 2:15 PM, the surveyors expressed their concern with the storage of clean linen to the Executive LNHA, CNO, Associate Administrator, LNHA/ VP of Operations, and Regional Quality Assurance RN. No further information was provided.

The facility policy, "Laundry Operations Manual" with a revised date of 1/2022 indicated under the Safety Precautions section to, "Keep storage areas clean, neat and sanitary at all times."

The facility policy also indicated under the Procedure for Storing Clean Linen "4. Do not stack linen too high- it will be a problem when removing." "6. Stored linen should be covered at all times in the event it is stored for periods of time, to avoid dust build up."

NJAC 8:39 - 19.4 (m) (a)2 5
8:39-21.1(d)

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
315494 Y1	A. Building B. Wing Y2	3/2/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	96 PARKWAY ROCHELLE PARK, NJ 07662

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 F0640	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	01/10/2023	LSC	01/10/2023	LSC	01/10/2023
ID Prefix F0695	Correction	ID Prefix F0755	Correction	ID Prefix F0761	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	01/10/2023	LSC	01/10/2023	LSC	01/10/2023
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	01/10/2023	LSC	01/31/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/21/2022	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**12/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/29/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This facility (south building) is a 3-story building with a basement, that was built in 2006, It is composed of Type I fire resistant construction. The facility is divided into 11 smoke zones. The fire sprinkler system is on domestic water with no fire pump. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. Emergency backup power to the building is supplied by 2- diesel generators. 1-125 KW and 1-350 KW both located outside the building. The facility generators are stated to be tied to 50% of the building, including the fire alarm control panel, cross corridor door (tied into the fire alarm system) hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 73 certified beds. At the time of the survey the census was 51.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**12/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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 000	Continued From page 1	K 000		

A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/29/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy

This facility (south building) is a 3-story building with a basement, that was built in 2006, It is composed of Type I fire resistant construction. The facility is divided into 11 smoke zones.

The fire sprinkler system is on domestic water with no fire pump. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms.

Emergency backup power to the building is supplied by 2- diesel generators. 1-125 KW and 1-350 KW both located outside the building. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**12/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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K 000	Continued From page 2 facility generators are stated to be tied to 50% of the building, including the fire alarm control panel, cross corridor door (tied into the fire alarm system) hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 73 certified beds. At the time of the survey the census was 51.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/28/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This facility (north building) is a 4-story building with a basement, that was built in 80's, It is composed of Type II protected construction. The facility is divided into 16- smoke zones. The fire sprinkler system is on domestic water with an electric fire pump. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. Emergency backup power to the building is supplied by 2- diesel generators. 1-125 KW and 1-350 KW both located outside the building. The facility generators are stated to be tied to 50% of the building, including the fire alarm control	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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K 000	Continued From page 3 panel, cross corridor door (tied into the fire alarm system) hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 175 certified beds. At the time of the survey the census was 146.	K 000		
K 131 SS=E	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 12/28/2022,	K 131	CORRECTIVE ACTION:	1/15/23

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K 131	Continued From page 4 the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.3.4. between the Nursing Facility and the Dialysis Center of the complex. The deficient practice could affect all residents. This deficient practice was evidenced by the following: On 12/29/2022 during the survey entrance at approximately 8:48 AM a request was made to the Executive Administrator (EA), Assistant Regional Maintenance (ARM) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. At this time the EA told the surveyor that the second floor and the Dialysis Center are not part of the Licensed Long Term Care Facility, they are under a different License. A review of the facility provided lay-out identified that the facility is a three-story building with a basement. Starting on 12/29/2022 at approximately 9:31 AM, a tour of the building with the ARM and MD was performed. Along the tour of the facility the surveyor observed the following, 1) At approximately 10:53 AM, an inspection above the ceiling tiles of the corridor door that separates the Nursing Facility and the Dialysis Center was performed. The surveyor observed one (1) approximately 1/2 inch penetration, one (1) approximately 1 inch penetration and one (1) approximately 1-1/2 inch penetration with nine white low voltage wires	K 131	All penetrations found were repaired covered with sheet rock and fire stop foam and caulk. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff on penetrations above ceiling tiles upon hire and annually. Maintenance director or designee will conducted monthly audits of looking for any penetrations above ceiling tiles. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	

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 131	Continued From page 5 running the the hole of the 2 hour fire rated wall. These penetrations would allow fire, smoke and poisonous gasses to pass from one occupancy to another in the event of a fire. The ARM and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 12/29/2022 at approximately 1:15 PM. No further information was provided. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.1.3.4.	K 131		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 12/28/2022, it was determined that the facility failed to provide 1 of 10 exit discharges with a stable, hard packed all-weather travel surface and maintain a level walking surface, free of all obstructions and impediments to reach a public way (street or parking lot) in the case of fire or other emergency in accordance with National Fire Protection	K 271	CORRECTIVE ACTION: Regional maintenance director contacted vendors for quotes on construction of either concrete walkway or pavers. An asphalt walkway was installed and completed 1/18/23. 2 exit signs will be visibly placed with emergency lighting to illuminate the	1/31/23

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K 271	Continued From page 6 Association (NFPA) 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. and the New Jersey Uniform Construction Code 5:23. This deficient practice was evidence by the following: On 12/28/2022 during the survey entrance at approximately 9:14 AM, a request was made to the Assistant Regional Maintenance (ARM) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified that there are four-stories and a basement in the Facility. Starting on 12/28/2022 at approximately 9:38 AM, a tour of the building with the ARM and MD was performed. At approximately 10:04 AM on 12/28/22, the surveyor observed outside of a Basement level designated exit discharge door (illuminated exit sign pointing to door) near the Main Elertrical room that there was no level walking path. The surveyor observed approximately 20 feet of un-level stones and there was no clear and level walking surface to reach a public way. The ARM and MD confirmed the findings during the observation times. The Administrator was informed of the deficiency at the survey exit on 12/29/2022 at approximately 1:15 PM. No further information was observed.	K 271	walkway to egress exit. The exit signs were installed on 1/23/23. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff on checking of exit signs, emergency lightings and walkway egress exits upon hire and annually. Maintenance director or designee will conducted quarterly audits of all exit signs, emergency lightings and walkway egress exits. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	

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K 271	Continued From page 7 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." Fire Safety Hazard. NJAC 8:39-31.1(e) NFPA 101:2012 - 7.7 NFPA 101:2012- 19.2 Means of Egress Requirements	K 271		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or	K 321		1/10/23

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 321	Continued From page 8 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 12/28/2022 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following:	K 321	CORRECTIVE ACTION: Laundry Room: The autocloser was adjusted so the laundry room door can close and latch properly. The bottom of the door was trimmed to prevent from scraping on floor. Medical Records Room: An autocloser was installed on the door for proper closure.	

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K 321	Continued From page 9 On 12/28/2022 during the survey entrance at approximately 9:14 AM, a request was made to the Assistant Regional Maintenance (ARM) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified that there are four-stories and a basement in the Facility. Starting on 12/28/2022 at approximately 9:38 AM, a tour of the building with the ARM and MD was performed. Along the tour of the facility the surveyor observed the following, 1) At approximately 9:51 AM on 12/28/22, an inspection in the basement of the Commercial Laundry room was performed. During a closure test of the corridor door leading into the laundry when the door was release from the magnetic hold open device the door did not self-close into its frame. The door rubbed on the floor tile approximately one inch and stopped. This test was repeated two additional times with the same results. This left a 43 inch opening to the corridor. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 1:01 PM on 12/28/22, an inspection of the first floor Medical Records room was performed. During a closure test of the corridor door leading into the Medical Records room was performed the door did not self-close into its frame. The surveyor observed that the door had no means to self-close the door into its	K 321	IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff to check all doors for proper closure upon hire and annually. Maintenance director or designee will conduct quarterly audit on all doors for proper closure and annual inspection of all smoke and fire doors. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	

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K 321	Continued From page 10 frame. The surveyor observed inside the room twenty (20) banker size boxes filled with combustible resident medical records, four (4) filing cabinets filled with combustible paper records. The surveyor also observed multiple combustible medical records on top of the cabinets. The surveyor recorded the room to be 12 feet 9 inches by 17 feet (216.75 square feet) which is larger than 50 square feet. The door failed to self-close into its frame as required by code. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The ARM and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 12/29/2022 at approximately 1:15 PM. No further information was provided. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		1/31/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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 345	Continued From page 11 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 12/29/22, in the presence of the Maintenance Director (MD), the facility failed to ensure a) smoke detection sensitivity testing was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2., b), that their building's fire alarm system documentation was maintained in accordance with the requirements of NFPA 70 and 72. The deficient practice was identified for 2 of 2 inspection reports and was evidenced by the following: A) On 12/29/22 at 11:10 AM, the surveyor reviewed all related fire alarm documentation provided by the MD from the fire alarm vendor to see if the sensitivity test was performed. An interview was conducted with the MD during document review. He indicated he was not sure if the required 5-year sensitivity test for the facility smoke detectors were performed. He notified the facility fire alarm vendor to see if sensitivity report was performed, but at the Life Safety Code exit on 12/29/22 no further documentation was provided. B-1) On 12/29/22 at 11:15 AM, the surveyor reviewed all fire alarm documentation from the fire alarm vendor. The reports dated: 07/07/22 and 12/09/21 were not full fire alarm inspection reports and were only a 1-page summery. The	K 345	CORRECTIVE ACTION: Vendor was contacted to do sensitivity test. Sensitivity test was completed 1/3/23. Regional director of maintenance inserviced mtc diretcor to have documentation are readily available. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff on timely inspections and proper documentation is readily available. Annual audit by maintenance director on 5 year inspection to ensure it is done timely and documentation is readily available. MONITOR: All findings will be reported and reviewed annually and reported yearly for the next year by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	

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 345	Continued From page 12 MD called the fire alarm vendor for the full reports, but as of the Life Safety Code exit on 12/29/22 no further documentation was provided. The Administrator was informed of the findings at the Life Safety Code Exit conference on 12/29/22. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 12/28/22, in the presence of the Maintenance Director (MD), the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. The deficient practice was identified for 3 of 3 inspection reports and was evidenced by the following: On 12/28/22 at 11:10 AM, the surveyor reviewed all related fire alarm documentation from the fire alarm vendor. The report's dated 10/03/22, 08/30/22 and 02/05/22, indicated that	K 345	CORRECTIVE ACTION: Vendor was contacted regarding difference in number of heads heat and duct detectors. The differences are as follows: The report for 8/10/22 states 217 photo 4 heat 5 duct detectors The report for 10/03/22 states 127 photo	2/15/23

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K 345	Continued From page 13 the total number of smoke detectors, photo detectors, heat detectors and duct detectors did not tally together on the reports 1. 10/3/22 report: 127- photo detectors 4- heat 5- ducts 2. 8/30/22 report: 217- photo detectors 4-heat 5-duct 3. 2/5/22 report: (different Fire Alarm vendor) 253- smoke detectors 12-heat 2-duct In an interview with the MD, he stated he was not sure why the reports indicated different tallys for the amount of smoke, photo, heat and duct detectors. No further documentation was provided. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/29/22 at approximately 1:15 PM. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	4 heat 5 duct detectors The vendors apologized for the typo and reissued the paperwork for 10/03/22. The correct number is 217 photo detectors 4 heat 5 duct detectors The 2/5/22 report is for the South pavilion and not the north pavilion. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff on timely inspections and proper documentation is readily available. Annual audit by maintenance director on 5 year inspection to ensure it is done timely and documentation is readily available. Number of detectors (each type) will be checked against the previous quarter to make sure there is no discrepancies. Maintenance director will audit yearly to ensure the most recent sensitivity inspection is on file and complete. MONITOR:	

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K 345	Continued From page 14	K 345	All findings will be reported and reviewed annually and reported yearly for the next year by the the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/28/2022, it was determined that the Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection	K 351	CORRECTIVE ACTION: All tiles found to have penetrations have been replaced. A new fire sprinkler was installed in the network closet on the 1st floor.	1/10/23

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K 351	Continued From page 15 Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 12/28/2022 during the survey entrance at approximately 9:14 AM, a request was made to the Assistant Regional Maintenance (ARM) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified that there are four-stories and a basement in the Facility. Starting on 12/28/2022 at approximately 9:38 AM, a tour of the building was conducted in the presence of the ARM and MD. Along the tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: 1) At approximately 9:42 AM on 12/28/22, the surveyor observed that inside the basement Porters closet there was a missing ceiling tile. 2) At approximately 11:02 AM on 12/28/22, the surveyor observed inside the 3rd. floor storage closet near the Nurse Managers office one ceiling tile had an approximately 6 inch hole in the tile. 3) At approximately 11:30 AM on 12/28/22, the	K 351	IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff to check all celining tiles upon hire and annually. Maintenance director or designee will conduct quarterly audit on all ceiling tiles for penetrations. Inservices on checking sprinklers will be done by regional maintnenace director to all maintnenace staff upon hire and annually. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	

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K 351	Continued From page 16 surveyor observed inside the 3rd. floor Nurse Storage room one ceiling tile with an approximately 1 inch hole in the tile. 4) At approximately 11:42 AM on 12/28/22, the surveyor observed inside the 3rd floor Men's Shower room the head of one of the sprinklers was missing an escheon cap leaving a 1/2 inch gap in the ceiling tile. With the opening in the ceilings and ceiling tiles, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 5) At approximately 1:12 PM on 12/28/22, the surveyor observed inside the 1st floor Network Equipment room no evidence of a fire sprinkler inside the room. At this time the surveyor asked the ARM, confirmed that there was no evidence of a fire sprinkler inside the room. The surveyor measured and recorded the room to be three (3) feet deep by four (4) feet wide. The ARM and MD confirmed the findings during the observation times. The Administrator was informed of the deficiency at the survey exit on 12/29/2022 at approximately 1:15 PM. No further information was provided. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		1/15/23

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K 353	Continued From page 17 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: Based on surveyor observation on 12/29/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. This deficient practice was evidenced for 3 of 3 wet systems from the provided documentation by the Maintenance Director. The 5-year internal obstruction investigation dated 3/9/20, of the pipe document was provided. Review of the document indicated " the check valve on the fire department connection line was not checked due to inaccessibility". The MD was interviewed during the document review and he	K 353	CORRECTIVE ACTION: Two private hydrants were inspected by the vendor. The check line on the fire department connection line was checked, 5 year test was performed and 2 leaking hose valves and 2 guages replaced. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all	

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K 353	Continued From page 18 stated that he was unsure why this statement was on the vendor inspection report for the 5-year report dated 3/9/22. The reviewed documentation indicated that the functional test of the facility's 2-private fire hydrant's were not performed as per NFPA 25.on the following dates 11/09/22, 9/30/22, 5/02/22 and 2/03/22. In an interview with the MD during the document review. The MD indicated he was not sure if the annual functional test of the facility's 2-private fire hydrant's were performed as per NFPA 25. The Administrator was informed of the findings at the life safety code exit conference on 12/29/22. No further information was provided. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	maintenance staff on 5 year inspection and documentation for Hydrant and line checks upon hire and annually. Maintenance director or designee will conducted quarterly audits of vendors to ensure hydrants are inspected per regulations. Maintenance Director or designee will conduct audit on hose valves and guages quarterly. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	
K 353 SS=F	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	K 353		1/15/23

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K 353	Continued From page 19 _____ 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: Based on surveyor observation on 12/28/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. This deficient practice was evidenced for 3 of 3 wet systems from the provided documentation by the MD. The 5-year internal obstruction investigation of the pipe document was not provided. An interview was conducted with the MD while reviewing the documentation. The MD stated he was not sure when the 5-year test was last performed and no further documentation was provided. Review of the Annual fire pump performance test dated 8/29/22, indicated under notes that the report recommended replacing 2-leaking hose valves on the test header and replacing 2-expired gauges as per NFPA 25. An interview was conducted with the MD while reviewing the documentation. The MD stated he was not sure if the 2-test valves and 2-expired gauges were replaced, and no further documentation was provided.	K 353	CORRECTIVE ACTION: Two private hydrants were inspected by the vendor. The check line on the fire department connection line was checked, 5 year test was performed and 2 leaking hose valves and 2 guages replaced. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff on 5 year inspection and documentation for Hydrant and line checks upon hire and annually. Maintenance director or designee will conducted quarterly audits of vendors to ensure hydrants are inspected per regulations. Maintenance Director or designee will conduct audit on hose valves and guages quarterly. MONITOR: All findings will be reported and reviewed	

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K 353	Continued From page 20 The Administrator was informed of the findings at the life safety code exit conference on 12/29/22. No further information was provided. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	
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 observation and review of facility documentation on 12/28/2022 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 1 of 26 portable fire extinguishers, 2) Maintain 3 of 26 portable fire extinguisher in proper working condition, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent	K 355	CORRECTIVE ACTION: Vendors replaced all discarged fire extinguishers and conduxted annual insoection on all fire extinguishers. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff pn checking fire extinguishers. Maintenance director or designee will conduct monthly inspection om all fire extinguishers to ensure all are ready for use.	1/10/23

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K 355	Continued From page 21 intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. According to NFPA 10- 4-3.4 the date the inspection was performed and the initials of the person performing the inspection shall be performed and recorded at least monthly. The records of the above inspections shall be kept on a tag or label attached to the fire extinguishers. On 12/28/2022 during the survey entrance at approximately 9:14 AM, a request was made to the Assistant Regional Maintenance (ARM) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified that there are four-stories and a basement in the Facility. Starting on 12/28/2022 at approximately 9:38 AM, a tour of the building with the ARM and MD was performed. Along the tour of the facility the surveyor observed and inspected twenty six (26) portable fire extinguishers that were last annually inspected January 2022 in various locations with the following issues identified: 1) At approximately 9:40 AM on 12/28/22, inside the basement elevator mechanical room the surveyor observed one (1) ABC type fire extinguisher pressure indicating needle was in the RED discharge zone on the pressure gauge.	K 355	Vendor will conduct yearly inspection on all fire extinguishers. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	

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ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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 355	Continued From page 22 At this time the surveyor requested that the MD replace the fire extinguisher with an available facility spare fire extinguisher. 2) At approximately 9:52 AM on 12/28/22, inside the basement Commercial Laundry room one (1) ABC type fire extinguisher was last annually inspected January 2022 with no evidence of a monthly examination being performed and documented on the tag attached to the extinguisher for November 2022. 3) At approximately 11:09 AM on 12/28/22, on the 3rd. floor Nursing station are the surveyor observed one (1) ABC type fire extinguisher pressure indicating needle was in the RED discharge zone on the pressure gauge. At this time the surveyor requested that the MD replace the fire extinguisher with an available facility spare fire extinguisher. 4) At approximately 11:13 AM on 12/28/22, on the 3rd. floor in the East Wing corridor the surveyor observed one (1) ABC type fire extinguisher (facility identification #19) pressure indicating needle was in the RED discharge zone on the pressure gauge. At this time the surveyor requested that the MD replace the fire extinguisher with an available facility spare fire extinguisher. The ARM and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 12/29/2022 at approximately	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**12/21/2022**

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ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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K 355	Continued From page 23 1:15 PM. No further information was provided. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 522 SS=E	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 12/28/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that 3 of 9 boilers were provided with certificates of inspection. The deficient practice was evidenced by the following: At 10:15 AM on 12/28/22, the surveyor observed the facility boiler documentation from their insurance company dated 2/28/22. The certificate inspection report indicated 3 of 9 boilers were not issued certificates due to the following issues: 1), Hydrotherm Cast Iron NJ 055761-07H (leaking boiler) 2), LAARS Watertube NJ 219300-17H (leaking safety valve)	K 522	CORRECTIVE ACTION: Two of the 3 boilers were repaired. The third boiler parts have been ordered and upon arrival, will be installed upon arrival of parts. Boiler #3 was completed on 1/17/23. These repairs included the leaking boiler, leaking safety valve, and leaking safety valve on boiler #3. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES:	1/31/23

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K 522	Continued From page 24 3), LAARS Watertube NJ 289374-19H 1), (leaking safety valve) 2), (No safety valve discharge line installed on the safety valve) An interview was conducted with the MD while reviewing documentation. The MD stated he was not sure if these issues were repaired and provided no further documentation. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/29/22. NJAC 8:39-31.2(e)	K 522	Inservice will be done by Regional Maintenance director or designee to maintenance staff om visual inspection of boilers when in season use upon hire and annually. Regional certified HVAC staff will check boilers semi annually and annually by the state. MONITOR: All findings will be reported and reviewed annually and reported quarterly for the next 3 quarters by the the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits..	
K 911 SS=E	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 12/29/20222, in the presence of facility management, it was determined that the facility failed to ensure that 4 of 8 electrical outlets located next to a water source (with-in 6 feet) was equipped with safe and secured Ground-Fault Circuit Interrupter (GFCI) protection.	K 911	CORRECTIVE ACTION: GFCI outlet in room 362 was replaced with a new GFCI outlet Non compliant GFCI in beauty salon (was removed and replaced with a new GFCI.	1/15/23

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K 911	Continued From page 25 This deficient practice was evidenced by the following: On 12/29/2022 during the survey entrance at approximately 8:48 AM a request was made to the Assistant Regional Maintenance (ARM) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility is a three-story building with a basement. Starting at approximately 9:31 AM on 12/29/22, in the presence of the facility's MD a tour of the building was performed. During the tour , the surveyor observed and tested eight (8) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following, 1) At approximately 10:15 AM on 12/29/22, the surveyor observed inside Resident room #325 bathroom one (1) GFCI electrical outlet. When the surveyor tested the GFCI electrical outlet with a GFCI tester the GFCI outlet was loose and moved when touched. 2) At approximately 10:22 AM on 12/29/22, the surveyor observed inside Resident room #334 bathroom one (1) GFCI electrical outlet. When the surveyor tested the GFCI electrical outlet with a GFCI tester the GFCI outlet was loose and moved when touched. 3) At approximately 10:32 AM on 12/29/22, the	K 911	Loose GFCI in rooms 325, 334, 314 were repaired. GFCI outlet was replaced in Jewish Kitchen. Loose GFCI in beauty salon (south) was repaired. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff on checking of GFCI. Maintenance director or designee will conduct monthly audits of all GFCI outlets. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	

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K 911	Continued From page 26 surveyor observed inside Resident room #314 bathroom one (1) GFCI electrical outlet. When the surveyor tested the GFCI electrical outlet with a GFCI tester the GFCI outlet was loose and moved when touched. 4) At approximately 10:51 AM on 12/29/22, the surveyor observed inside the first floor Jewish Kitchen one (1) Duplex electrical outlet 34 inches to the left of the kitchen sink. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 5) At approximately 10:53 AM on 12/29/22, the surveyor observed inside the Residents Salon one (1) GFCI electrical outlet next to the hair washing sink. When the surveyor tested the GFCI electrical outlet with a GFCI tester the GFCI outlet was loose and moved when touched. Electrical outlets need to be secured with-in the outlet boxes. The MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 12/29/2022 at approximately 1:15 PM. No further information was provided. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other	K 911		1/15/23

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K 911	Continued From page 27 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 12/28/20222, and review of documentation in the presence of facility management, it was determined that the facility failed to ensure that 2 of 10 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 12/28/2022 during the survey entrance at approximately 9:14 AM a request was made to the Assistant Regional Maintenance (ARM) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are four-stories and a basement in the Facility. Starting on 12/28/2022 at approximately 9:38 AM, in the presence of the facility's ARM and MD a tour of the building was performed. During the tour , the surveyor observed and tested ten (10) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following:	K 911	CORRECTIVE ACTION: GFCI outlet in room 362 was replaced with a new GFCI outlet Non compliant GFCI in beauty salon (was removed and replaced with a new GFCI. Loose GFCI in rooms 325, 334, 314 were repaired. GFCI outlet was replaced in Jewish Kitchen. Loose GFCI in beauty salon (south) was repaired. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff on checking of GFCI. Maintenance director or designee will conduct monthly audits of all GFCI outlets. MONITOR:	

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K 911	Continued From page 28 1) At approximately 11:19 AM on 12/28/22, the surveyor observed inside Resident room #362 bathroom one (1) GFCI electrical outlet. When the surveyor tested the GFCI electrical outlet with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. 2) At approximately 1:08 PM on 12/28/22, the surveyor observed inside the Residents Salon one (1) Duplex electrical outlet 4 feet 6 inches to the left of the hair washing sink. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The ARM and MD confirmed the findings during the observation times. The Administrator was informed of the deficiency at the survey exit on 12/29/2022 at approximately 1:15 PM. No further information was provided. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at	K 914		1/15/23

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K 914	Continued From page 29 intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 12/29/22, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in resident rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. Maintenance and testing 6.3.3.2 Receptacle Testing in Patient Care Rooms. This deficient practice was evidenced by documentation review and interview with the MD, for all resident rooms by the following: Record Review of the facility's annual electric inspection report from the facility vendor dated : 02/28/22 indicated a visual electrical survey only. The MD indicated resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The last annual electrical inspection by the facility vendor dated 2/28/22, indicated that there was	K 914	CORRECTIVE ACTION: Electrical outlet inspection was immediately conducted by both Maintenance Director in North and South buildings. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potemtially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to manitenance staff to check electrical outlets upon hire and annually. Maintenance director or designee will conduct yearly inspection of all outlet and monthly inspection of GFCI outlets. MONITOR:	

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K 914	Continued From page 30 no documentation for the annual inspection and itemized list of receptacle testing in patient care rooms. An interview was conducted with the MD, during document review. The MD stated that he was unsure if the facility electrical vendor was doing this inspection and currently could not provide any documentation this inspection was being performed. The Administrator was informed of the finding's at the Life Safety Code exit conference on 12/29/22 at approximately 1:15 PM. No further information was provided. NJAC 8:39-31.2(e) 6.3.4 (NFPA 99)	K 914	All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation bt the QAPI commitee to determine continuing frequency of audits.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the	K 914		1/15/23

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K 914	Continued From page 31 electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 12/28/22, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in resident rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. Maintenance and testing 6.3.3.2 Receptacle Testing in Patient Care Rooms. This deficient practice was evidenced by documentation review and interview with the MD, for all resident rooms by the following: Record Review of the facility's annual electric inspection report from the facility vendor dated 2/25/22, indicated a visual electrical survey only. The MD indicated resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The last annual electrical inspection by the facility vendor was dated 2/25/22, indicated that there was no documentation for the annual inspection and itemized list of receptacle testing in patient care rooms. An interview was conducted with the MD, during documentation review. The MD stated that he was unsure if the facility electrical vendor was	K 914	CORRECTIVE ACTION: Electrical outlet inspection was immediately conducted by both Maintenance Director in North and South buildings. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potemtially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to manitenance staff to check electrical outlets upon hire and annually. Maintenance director or designee will conduct yearly inspection of all outlet and monthly inspection of GFCI outlets. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation bt the QAPI commitee to determine continuing frequency of audits.	

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K 914	Continued From page 32 doing this inspection and currently could not provide any documentation that this inspection was being performed. The Administrator was informed of the finding's at the Life Safety Code exit conference on 12/29/22. No further information was provided. NJAC 8:39-31.2(e) 6.3.4 (NFPA 99)	K 914		
K 915 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 12/29/22, in the presence of the Maintenance Director (MD), it was determined	K 915	CORRECTIVE ACTION: An electrical engineer has been secured for consulting on adding additional branch	2/28/23

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K 915	Continued From page 33 that, the facility failed to provide a Type 1 Essential Electrical System in accordance with NFPA 99. This deficient practice was evidenced by the following: At approximately 11:00 AM on 12/29/22, the surveyor observed all documents provided by the facility for record review. The provided electrical annual inspection dated 2/228/22, did not provide any information on "Essential Electrical System Design Standards". The facility currently has a Ventilator (vent) unit that requires a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. At approximately 12:15 PM on 12/29/22, the surveyor interviewed the MD who indicated that he was not sure if the current electrical system for the vent unit was a TYPE 1 ESS (NFPA Essential Electrical System Classification Type) system. At approximately 1:15 PM on 12/29/22 while touring the facility, the surveyor and MD could not locate the required three branch panels (each branch is required to have at least 1-transfer switch) that are divided as follows: 1) Life Safety 2) Critical 3) Equipment The Administrator was informed of the finding at the Life Safety Code exit conference on 12/29/22. No further information was provided.	K 915	for the vent unit. The electrical engineering is completing electrical plans for the 3rd branch panel. Post completion of the blueprints, the contractor who has been secured will complete the work. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff on ensuring vendor is performing monthly preventative maintenance and yearly electrical inspection per regulation on a quarterly basis. The maintenance director will audit quarterly to ensure the 3rd branch of the electrical system is complete and functioning. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 2 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits. ****** We will be applying for a limited waiver for extension of time for completion date	

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ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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 915	Continued From page 34 *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. NJAC 8:39-31.2(e) NFPA 99- 6.7.5.1.1 6.7.5.1.3* Critical Branch 6.7.5.1.4 Equipment Branch 6.7.5.1.2 Life Safety Branch	K 915		
K 916 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 12/28/2022 in the presence of facility management, it was determined that the facility failed to provide a remote annunciator panel for one (1) of two (2) emergency generator's electrical systems to alert staff of the system's condition in accordance with National Fire Protection Association (NFPA) 99. This deficient practice was evidenced by the	K 916	CORRECTIVE ACTION: Vendors were contacted for quotes on adding secondary annunciator panel. Annunciator panel was ordered and will be delivered and installed on 2/24/23. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED:	2/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**12/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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K 916	Continued From page 35 following: On 12/28/2022 during the survey entrance at approximately 9:14 AM, a request was made to the Assistant Regional Maintenance (ARM) and Maintenance Director (MD), "Does the facility have an emergency generator and where is the location of the remote annunciator panel for the generator." The MD told the surveyor yes they have two (2) emergency generators and that the generator annunciator panel is located on the 2nd floor Nursing Station. During a tour of the building with the facility ARM and MD at 12:05 PM on 12/28/22, an inspection of the 2nd. floor Nursing station was performed. The surveyor observed one Emergency Generator annunicator panel. At this time the surveyor asked the MD, where is the second generator annunicator panel. The MD told the surveyor there is only one annunicator. The surveyor clarified with the ARM and the MD that if you have two generators for the facility you should have two annunicator panels to let you know what is going on with the two different generators. The ARM and MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency at the survey exit on 12/29/2022 at approximately 1:15 PM. No further information was provided. Reference: NFPA 99 - 6.4.1.1.17 Alarm Annunciator. A	K 916	All residents are potentially affected. SYSTEMIC CHANGES: Will have a secondary annunciator panel for the 2nd generator. Regional Maintenance Director or designee will give inservice to all maintenance staff on checking annunciator panel upon hire and annually. Maintenance director or designee will conduct monthly audits of annunciator panels. Quarterly inspection will be conducted by vendor on annunciator panels. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	

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	315494	A. BUILDING **01, 02** B. WING _____	**12/21/2022**

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ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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K 916	Continued From page 36 remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load. (b) When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall include the following: (a) Low lubricating oil pressure (b) Low water temperature (below that requirement in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less that a 4-hour operating supply (e) Over crank (failed to start) (f) Over speed NJAC 8:39-31.2(e) NFPA 99, 110	K 916		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually	K 918		1/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**12/21/2022**

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ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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K 918	Continued From page 37 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 observation, interview, and review of facility documents on 12/28/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems in accordance with the requirements of NFPA 110,	K 918	CORRECTIVE ACTION: Inservice was immediately done by Regional Maintenance Director to Campus Maintenance director on proper documentation on generator load test for transfer time. A new log was created to include transfer time field. A load test was performed and the time of 3 seconds was	

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K 918	Continued From page 38 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 1 of 2 generator log's provided by the MD by the following: At 9:30 AM on 12/28/22, a review of the generator records for the last twelve months lacked any documented certification that the generator would start and transfer power to the building within ten seconds for the 125 KW generator for 1 of 11 load-test logged on the following dates: DATE: TRANSFER TIME: 11/08/22 3 seconds 10/11/22 no time recorded 09/29/22 no time recorded 08/02/22 no time recorded 07/05/22 no time recorded 06/07/22 no time recorded 05/03/22 no time recorded 04/05/22 no time recorded 03/01/22 no time recorded 02/01/22 no time recorded 01/04/22 no time recorded An interview was conducted with the MD at the time of record review, who confirmed that only 1 of 11 transfer times were currently documented on the facility monthly-test log provided for the 125 KW generator. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 12/29/22. No further documentation was provided.	K 918	documented on the new form on 1/3/23. IDENTIFICATION OF OTHERS HAVING THE POTENTIAL TO BE AFFECTED: All residents are potentially affected. SYSTEMIC CHANGES: Regional Maintenance Director or designee will give inservice to all maintenance staff on proper documentation on generator load test to include transfer time. Regional Maintenance director will conduct audit on compliance of proper documentation of the generator load test including transfer time monthly. MONITOR: All findings will be reported and reviewed monthly and reported quarterly for the next 3 quarters by the maintenance director or designee to the QAPI committee. Evaluation by the QAPI committee to determine continuing frequency of audits.	

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 918	Continued From page 39 NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		

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
315494 Y1	A. Building 02 - FORMERLY ROCHELLE PARK BUILDING B. Wing Y2	3/30/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	96 PARKWAY ROCHELLE PARK, NJ 07662

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 K0271	01/31/2023	LSC K0321	01/10/2023	LSC K0345	02/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	01/10/2023	LSC K0353	01/15/2023	LSC K0355	01/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0522	01/31/2023	LSC K0911	01/15/2023	LSC K0914	01/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0916	02/24/2023	LSC K0918	01/15/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/21/2022	☐ YES ☐ NO