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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments Type of Survey: Re-Licensure and Complaint Complaint#: NJ00169349 Census 12/20/23: 104 Census 12/21/23: 68 Sample Size: 8 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 223	8:43F-3.1(b)(1-7) Administration (b) The administrator shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including participant rights; 2. Planning and administering the managerial, operational, fiscal, and reporting components of the facility; 3. Participating in the quality improvement program for participant care and staff	M 223		

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

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M 223	Continued From page 1 performance; 4. Ensuring that all personnel are assigned duties based upon their education, training, competencies, and job descriptions; 5. Ensuring the provision of staff orientation, staff education, and ongoing staff training in accordance with N.J.A.C. 8:43F-6.3; 6. Establishing and maintaining liaison relationships and communication between facility staff and services providers and with participants and their caregivers; and 7. Verifying that each Medicaid-eligible participant is eligible to receive services available at the adult day health services facility prior to the participant's entry into the program. For the purposes of this section, the administrator shall be entitled to rely on any prior authorization performed by the Department for the participant in accordance with N.J.A.C. 8:86. This REQUIREMENT is not met as evidenced by: NJ00169349 Based on interview, observation, and pertinent document review, it was determined the facility failed to ensure all staff fire drill training was	M 223		

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accurately timed and correctly dated, and daily aspects of physical plant and kitchen operations are maintained. In addition, the facility failed to ensure the implementation and enforcement of all policies and procedures, including "Physical Plant Precautions," "Nursing Space and Equipment," "Blood Glucose Testing," "Van Maintenance," "Seat Belts," and "Fire and Other Emergencies: General" This deficient practice was evidenced by the following:

1. On 12/20/23 at 11:40 a.m., Surveyor #1 observed the Director of Transportation (DOT) in the lobby of the facility requesting staff to sign an in-service record.

At 11:45 a.m., Surveyor #1 interviewed the DOT in the presence of the Administrator and Surveyor #2, who stated he was in the process of conducting a fire drill in-service with the transportation staff. The surveyor requested the in-service signature record from the DOT, and upon surveyors review, the in-service signature record was back dated for 11/15/23 and the time listed was for 2:30 p.m.

At 11:50 a.m., the surveyors interviewed the Administrator regarding the back dated fire drill in-service signature record, who stated he was unaware of the fire drill in-service or why the DOT conducted fire drill training today 12/20/23. Additionally, the Administrator stated all the emergency drills were completed for the year 2023.

2. On 12/20/2023 at 11:20 a.m., the surveyor observed furniture and facility supplies were stored in the egress service corridor.

At 11:25 a.m., the surveyor observed the

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ceiling-mounted "EXIT" signs in the service corridor and in the main kitchen had electrical tape holding the fixtures together and securing them to the ceiling.

At 1:50 p.m., the surveyor observed facility floor plan postings, however there were no emergency evacuation diagrams posted which displayed the location of fire extinguishers, alarm boxes, nor fire exits identified.

On 12/21/23 at 10:40 a.m., 10:44 a.m., and 10:45 a.m., the surveyor interviewed the Administrator who stated he was aware items were in the egress corridor, but the area was not used for storage daily. The Administrator also stated he thought the facility was compliant if there were diagrams of the floor plan with directional arrows posted. Additionally, the Administrator stated he was not aware of the damage to the exit signs until alerted by the surveyor.

The surveyor reviewed the facility policy and procedure titled, "Fire and Other Emergencies: General" which revealed, "1. The fire and disaster plan shall be prominently posted in both English and other languages if needed, evacuation directions. The evacuation routes will be posted in every room in the center...6. Stairways and hallways should be well lit and kept free of obstructions...The center shall have at least two well-identified exits."

3. On 12/20/23 at 10:02 a.m. and 10:08 a.m. while on the facility tour with the Administrator the surveyor observed five staff members in the kitchen without hair nets. The Administrator stated that it was facility policy is to wear a hair net in the kitchen.

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M 223	Continued From page 4 Reference: The New Jersey State Sanitary Code N.J.A.C. 8:24-2.4(c)1 - "The following requirements shall apply to hair restraints: 1. Except as provided in (c)2 below, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens; and unwrapped single-service and single-use articles." 4. On 12/20/23 at 10:18 a.m., the surveyor, in the presence of the Alternate Director of Nursing (DON), observed two blood glucose meters, along with alcohol pads and lancets in the examination room, however, the surveyor did not observe any disinfection solution to clean the blood glucose meters. During the above observation, upon inquiry, the Alternate DON explained the examination room was where participants came to have their vital signs assessed each day. The surveyor interviewed the Alternate DON to inquire if the blood glucose meters were intended for multi-patient use. The Alternate DON stated their blood glucose meters were multi-patient use, and they were used for multiple participants at the center. The surveyor then inquired about what solution the blood glucose meters were cleaned and disinfected with. The Alternate DON stated the blood glucose meters were cleaned and disinfected with alcohol pads. The surveyor reviewed the, "True Metrix Pro Professional Monitoring Blood Glucose Meter Owner's Manual," and reviewed the	M 223		

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manufacturer's instructions for use (IFUs) which indicated, "To Clean and Disinfect the Meter: ...With ONLY Super Sani-Cloth* Wipes (or any disinfectant product with the EPA* reg. no. of 9480-4), rub the entire outside of the meter using 3 circular wiping motions with moderate pressure of the front, back, left side, right side, top and bottom of the meter."

The surveyor then inquired if Sani-Cloth Wipes were available for cleaning and disinfection of blood glucose meters at the facility, and the Alternate DON stated they did not have any Sani-Cloth Wipes.

On 12/21/23 at 10:32 a.m., the surveyor interviewed the DON to inquire about what solution the blood glucose meters were cleaned and disinfected with. The DON stated alcohol was used to clean the blood glucose meters. The surveyor showed the DON the blood glucose meter manual that indicated only Sani-Cloth Wipes were to be used to clean and disinfect the blood glucose meters. The DON stated she did not know the blood glucose meters were to only be cleaned and disinfected with Sani-Cloth Wipes, and there were no Sani-Cloth Wipes available.

The surveyor reviewed the facility policy titled, "Blood Glucose Testing," which indicated, "...The nurse shall test the blood glucose in accordance with the manufacturer's directions for the particular machine in use..."

5. On 12/20/23 at 10:27 a.m., the surveyor, in the presence of the Alternate Director of Nursing (DON) and two Registered Nurses (RN), inspected the emergency equipment in the Nurses' Station/Room. The surveyor observed a

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suction machine with a broken canister, which was held together with tape. The surveyor did not observe any yankauer suction tip (a tool used for oral suctioning).

At the time of the above observation, the surveyor interviewed the Alternate DON, who stated there was no other suction canister, and she did not know how long the suction canister had been broken, or when it was taped. The Alternate DON stated the facility did not have yankauer suction tips.

At 10:32 a.m., and 10:34 a.m., the surveyor interviewed RN #1 and RN #2, who both stated they did not know the suction canister was broken or for how long it was broken. RN #1 and RN #2 both stated they did not know who taped the suction canister, and there was no other suction canister.

On 12/21/23 at 10:32 a.m., the surveyor interviewed the DON, who stated she did not know who taped the suction canister or when it broke.

The surveyor reviewed the facility policy titled, "Physical Plant Precautions," which indicated, "...All equipment will be maintained (cleaned, laundered, disposed of, etc.) and replaced as necessary by the center."

The surveyor reviewed another facility policy titled, "Nursing Space and Equipment," which showed, "...Equipment and supplies in the center shall be of the quality and in the quantity necessary for care of participants as ordered or indicated..."

6. On 12/21/23 at 12:26 p.m., the surveyor

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observed as participants boarded Bus #5 to depart home. The surveyor observed the Director of Transportation (DOT) in the driver's seat of Bus #5 as he prepared to depart from the facility with 4 unsampled participants, two of which did not have a seat belt on. The surveyor interviewed the DOT to inquire if he was ready to depart from the facility. The DOT stated he would apply his own seat belt, and then he was ready to depart. The surveyor inquired about the two unsampled participants in the bus without their seat belts applied. The DOT stated he told everyone to apply their seat belt when they boarded the bus. The surveyor inquired about who was responsible for ensuring participants applied their seat belts prior to departure. The DOT stated the drivers were responsible for "telling the participants to apply their seat belt."

At 12:39 p.m., the surveyor observed as participants boarded Bus #18 to depart home. The surveyor observed a walker and multiple participant belongings in the front of the bus and partially in the walkway, all of which were not secured. The surveyor observed Driver #1 depart from the facility without securing the belongings.

The surveyor reviewed the facility policy titled, "Seat Belts," which indicated, "...The driver and all passengers shall wear seat belts at all times when the van is in motion...All passengers transported in a center vehicle must wear a seat belt at all times...Drivers shall be responsible for assisting and reminding participants to use their seat belts...Drivers shall make sure all participants and riders are wearing a seat belt before departing."

7. On 12/21/23 at 12:32 p.m., the surveyor observed Bus #19 pull up to the center to drop-off

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M 223	Continued From page 8 participants for the second session. The surveyor observed Bus #19 had clear tape wrapped all around the right side-view mirror and antenna. At 1:27 p.m., the surveyor interviewed the Director of Transportation and the Administrator, who both stated on November 14, 2023, a tree struck Bus #19 and broke the right side-view mirror. The DOT stated the right side-view mirror was attached to a pole, which secured the right side-view mirror to the vehicle, and tape was added so the right side-view mirror did not vibrate when the vehicle was in motion. The surveyor reviewed the facility policy titled, "Van Maintenance," which indicated, "Center vehicles shall be properly maintained, licensed and inspected to ensure the safety and comfort of the passengers...The Program Director shall be responsible for ensuring the Transportation Daily and Weekly Vehicle Check is completed as indicated, as well as ensuring that the vehicle receives all scheduled maintenance appointments and repairs..." Reference: 8:43F-14.17(b) M-679 8:43F-16.2(i)(1-8)(i-iv) M-0783 8:43F-17.1(c)(d)(e) M-0825 8:43F-17.2 M-0827 8:43F-14.17(a) M-0677 8:43F-14.17(d)-M-0685 8:43F-10.5(a)-M0539	M 223		
M 539	8:43F-10.5(a) Dietary Services The dietary service shall comply with the provisions of N.J.A.C. 8:24.	M 539		

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This REQUIREMENT is not met as evidenced by:
Complaint#: NJ00169349

Based on observation, interview, and pertinent facility document review, it was determined that the facility failed to ensure 5 of 5 staff entering the kitchen wore hair nets or coverings. This deficient practice was evidenced by the following:

On 12/20/23 at 10:02 a.m. and 10:08 a.m. while on the facility tour with the Administrator the surveyor observed five staff members in the kitchen without hair nets.

At 10:02 a.m. on 12/20/23 while on tour with the Administrator the surveyor observed a Program Coordinator (PC) who also functions as a Program Aide and two Kitchen Staff (KS) members who also function as Program Aides in the kitchen without hair nets. The Administrator stated that it was facility policy is to wear a hair net in the kitchen.

At 10:08 a.m. the surveyor noticed a Transportation Diver (TD) who also functions as Program Aide and the Administrator enter the kitchen without hair nets.

At 10:08 a.m. when the surveyor interviewed PC to inquire why they did not wear a hairnet, PC stated "I usually wear one, I just went to grab a

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M 539	Continued From page 10 Christmas stocking." At 1:28 p.m. when the surveyor interviewed KS #1 to inquire why they did not wear a hairnet, KS #1 stated "Maybe the hair net fell down." At 1:33 p.m. when the surveyor interviewed TD, to inquire why they did not wear a hairnet, TD stated they went in the kitchen looking for a hair net but could not find it. Reference: The New Jersey State Sanitary Code N.J.A.C. 8:24-2.4(c)1 - "The following requirements shall apply to hair restraints: 1. Except as provided in (c)2 below, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens; and unwrapped single-service and single-use articles."	M 539		
M 677	8:43F-14.17(a) Physical Plant Requirements The facility shall develop written emergency plans, policies, and procedures which shall include plans and procedures to be followed in case of medical emergency, equipment breakdown, fire or other disaster. This REQUIREMENT is not met as evidenced by:	M 677		

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M 677	Continued From page 11 Based on observation, interview, and facility policy review, the facility failed to maintain the building per emergency plans/policies. Findings included: A review of a facility policy titled, "Fire and Other Emergencies: General" dated 2021 revealed, "In order to keep participants and staff as safe and comfortable in the time of a disaster, [facility name] has identified specific disaster procedures to be taken in time of both man-made, or acts of God disaster, which when implemented will help to ensure the maximum safety and well-being of participants and staff." The policy revealed, "6. Stairways and hallways should be well lit and kept free of obstructions." An observation on 12/20/2023 at 11:20 AM revealed furniture and facility supplies were stored in the egress service corridor. During an interview on 12/21/2023 at 10:40 AM, the Administrator stated he was aware items were in the egress corridor, but the area was not used for storage daily. He stated that a cleaning company cleaned the facility every evening and removed any storage that had accumulated in the area.	M 677		
M 679	8:43F-14.17(b) Physical Plant Requirements The facility shall maintain emergency equipment, including at a minimum, oxygen, suction, airway and ambu-bag.	M 679		

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M 679	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to maintain emergency exit signage and failed to ensure an exit from the facility. Findings included: A review of a facility policy titled, "Fire and Other Emergencies: General" dated 2021, revealed, "In order to keep participants and staff as safe and comfortable in the time of a disaster, [facility name] has identified specific disaster procedures to be taken in time of both man-made, or acts of God disaster, which when implemented will help to ensure the maximum safety and well-being of participants and staff." The policy revealed, "6. The center shall have at least two well-identified exits." A review of a facility policy titled, "Maintenance and Housekeeping," dated 2021, revealed the facility "shall at all times provide a safe, clean and in good repair facility for the participants." A review of a facility policy titled, "Evacuation Plan" dated 2021 revealed, "The purpose of the evacuation policy is to safely remove all participants, staff and volunteers from the facility in the event of an emergency." The policy revealed "3. When the decision to evacuate has been made, all available employees/volunteers shall assist the participants in leaving the building in the following manner: a. Participants will be evacuated through the nearest exit and proceed to the parking lot if safe. If the parking lot is not a safe site, participants should proceed to the front sidewalk."	M 679		

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M 679	Continued From page 13 An observation on 12/20/2023 at 11:25 AM revealed the ceiling-mounted "EXIT" signs in the service corridor and in the main kitchen had electrical tape holding the fixtures together and securing them to the ceiling. A sticker installed on the exit signs indicated that the required annual inspection of these lights was conducted in March 2023. During an interview on 12/21/2023 at 10:45 AM, the Administrator stated he was not aware of the damage to the exit signs until alerted by the surveyor. During an observation on 12/20/2023 at 1:08 PM, an "EXIT" sign was observed mounted directly above the door from the dining room to an exterior patio. An observation revealed the patio was surrounded by a five-foot-high wrought iron fence, and a key-operated padlock was observed on the exterior gate of the patio. During an interview on 12/20/2023 at 1:08 PM, the Administrator stated he was aware there was a lock on the gate. The Administrator stated that the lock was installed to keep unauthorized people out of the facility and to prevent building occupants from possible elopement from within the facility. He stated he always had a key with him to unlock the lock. He stated that there was another key located at the front desk, and staff were instructed that the key was there. The Administrator stated he believed the instructions on the location of the spare key were in the facility fire plan and emergency procedures. A review of a facility policy titled, "Fire and Other Emergencies: General" dated 2021 and "Evacuation Plan" dated 2021 revealed no	M 679		

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	12021	A. BUILDING: _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIRCLE OF LIFE ADULT DAY SERVICES	3000 HADLEY ROAD SOUTH PLAINFIELD, NJ 07080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 679	Continued From page 14 reference to a key-operated lock. Complaint #: NJ00169349 Based on observation, interview, and pertinent document review, it was determined that the facility failed to maintain 1 of 4 required emergency equipment, suction. This deficient practice was evidenced by the following: On 12/20/23 at 10:27 a.m., the surveyor, in the presence of the Alternate Director of Nursing (DON) and two Registered Nurses (RN), inspected the emergency equipment in the Nurses' Station/Room. The surveyor observed a suction machine with a broken canister, which was held together with tape. Also, the surveyor did not observe any yankauer suction tip (a tool used for oral suctioning). At that time, the surveyor interviewed the Alternate DON, who stated there was no other suction canister, and she did not know how long the suction canister had been broken, or when it was taped. The Alternate DON stated the suction was last used approximately two weeks ago, and at that time, the suction canister was not broken or taped. The surveyor inquired if the facility had any yankauer suction tips for the suction machine. The Alternate DON stated the facility did not have yankauer suction tips. The Alternate DON stated she was not aware of any log used to track and/or monitor emergency equipment checks. At 10:32 a.m., and 10:34 a.m., the surveyor interviewed RN #1 and RN #2, who both stated they did not know the suction canister was broken or how long it was broken. RN #1 and RN #2 both	M 679		

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M 679	Continued From page 15 stated they did not know who taped the suction canister, and they did not know of any log used to track and/or monitor emergency equipment checks. RN #1 and RN #2 both stated there was no other suction canister. On 12/21/23 at 10:32 a.m., the surveyor interviewed the DON, who stated she did not know who taped the suction canister or when it broke. The surveyor reviewed the facility policy titled, "Physical Plant Precautions," which indicated, "...All equipment will be maintained (cleaned, laundered, disposed of, etc.) and replaced as necessary by the center." The surveyor reviewed another facility policy titled, "Nursing Space and Equipment," which showed, "...Equipment and supplies in the center shall be of the quality and in the quantity necessary for care of participants as ordered or indicated..." The facility failed to ensure all emergency equipment was maintained and in working order.	M 679		
M 685	8:43F-14.17(d) Physical Plant Requirements The emergency plans, including a written evacuation diagram specific to the unit that includes evacuation procedure, location of fire exits, alarm boxes, and fire extinguishers, and all emergency procedures shall be conspicuously posted throughout the facility. All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and evacuation as part of their initial orientation and at least annually	M 685		

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M 685	Continued From page 16 thereafter. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and pertinent document review, the facility failed to post a written evacuation diagram that included evacuation procedures and the location of fire exits, alarm boxes, and fire extinguishers. Findings included: A review of a facility policy titled, "Fire and Other Emergencies: General" dated 2021 revealed, "1. The fire and disaster plan shall be prominently posted in both English and other languages if needed, evacuation directions. The evacuation routes will be posted in every room in the center." An observation on 12/20/2023 at 1:50 PM revealed a written evacuation diagram specific to the unit that included evacuation procedures, and the location of fire exits, alarm boxes, and fire extinguishers were not posted anywhere in the facility. During an interview on 12/21/2023 at 10:44 AM, the Administrator stated he thought the facility was compliant if there were diagrams of the floor plan with directional arrows posted.	M 685		
M 783	8:43F-16.2(i)(1-8)(i-iv) Infection Control, Santation, Housekeeping (i)Written infection control policies and procedures shall include, but not be limited to, policies and procedures for the following:	M 783		

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M 783	Continued From page 17 1. In accordance with N.J.A.C. 8:57 a system for investigating, reporting, and evaluating the occurrence of all infections or diseases which are reportable or conditions which may be related to activities and procedures of the facility, and maintaining records for all participants or personnel having these infections, diseases, or conditions; 2. Infection control in accordance with 29 CFR--1910.1030 Bloodborne pathogens as amended and supplemented, incorporated herein by reference; 3. Exclusion from work, and authorization to return to work, for personnel with communicable diseases; 4. Surveillance techniques to minimize sources and transmission of infection; 5. Techniques to be used during each participant contact, including handwashing before and after caring for a participant; 6. Protocols for identification of participants with communicable diseases and education of participants regarding prevention and spread of communicable diseases; 7. The prevention of decubitus ulcers; and 8. Where applicable, cleaning, sterilization and disinfection practices and techniques used in the facility, including but not limited to, the following:	M 783		

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M 783	Continued From page 18 i. Care of utensils, instruments, solutions, dressings, articles, and surfaces; ii. Selection, storage, use, and disposition of disposable and nondisposable participant care items. Disposable items shall not be reused; iii. Methods to ensure that sterilized materials are packaged, labeled, processed, transported, and stored to maintain sterility and to permit identification of expiration dates; and iv. Care of urinary catheters, intravenous catheters, respiratory therapy equipment, and other devices and equipment that provide a portal of entry for pathogenic microorganisms. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00169349 Based on observation, interview, and pertinent document review, it was determined that the	M 783		

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M 783	Continued From page 19	M 783		

facility failed to implement their policy and procedure titled, "Blood Glucose Testing," to ensure that equipment used for the care of the participants, which provided a portal of entry for blood-borne pathogens, was adequately disinfected before use on each participant. This deficient practice was evidenced by the following:

On 12/20/23 at 10:18 a.m., the surveyor, in the presence of the Alternate Director of Nursing (DON), observed two blood glucose meters, along with alcohol pads and lancets in the examination room, however, the surveyor did not observe any solution to clean and disinfect the blood glucose meters.

Upon inquiry, the Alternate DON explained the examination room was where participants came to have their vital signs assessed each day. The surveyor interviewed the Alternate DON to inquire if their blood glucose meters were intended for multi-patient use. The Alternate DON stated the blood glucose meters were multi-patient use, and they were used for multiple participants at the center. The surveyor then inquired about what solution the blood glucose meters were cleaned and disinfected with. The Alternate DON stated the blood glucose meters were cleaned with alcohol pads.

The surveyor reviewed the, "True Metrix Pro Professional Monitoring Blood Glucose Meter Owner's Manual," and reviewed the manufacturer's instructions for use (IFUs) which indicated, "To Clean and Disinfect the Meter: ...With ONLY Super Sani-Cloth* Wipes (or any disinfectant product with the EPA* reg. no. of 9480-4), rub the entire outside of the meter using 3 circular wiping motions with moderate pressure of the front, back, left side, right side, top and

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M 783	Continued From page 20 bottom of the meter." The surveyor then inquired if Sani-Cloth Wipes were available for cleaning and disinfection of blood glucose meters at the facility, and the Alternate DON stated they did not have any Sani-Cloth Wipes. On 12/21/23 at 10:32 a.m., the surveyor interviewed the DON to inquire about what solution the blood glucose meters were cleaned and disinfected with. The DON stated alcohol was used to clean and disinfect the blood glucose meters. The surveyor showed the DON the blood glucose meter manual that indicated only Sani-Cloth Wipes were to be used to clean and disinfect the blood glucose meters. The DON stated she did not know the blood glucose meters were to only be cleaned and disinfected with Sani-Cloth Wipes, and there were no Sani-Cloth Wipes available. The surveyor reviewed the facility policy titled, "Blood Glucose Testing," which indicated, "...The nurse shall test the blood glucose in accordance with the manufacturer's directions for the particular machine in use..." According to the Centers for Disease Control and Prevention (CDC), "Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared."	M 783		

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M 825	Continued From page 21	M 825		
M 825	8:43F-17.1(c)(d)(e) Transportation Services (c) Vehicles shall be maintained in safe operating order. (d) The facility shall maintain insurance on the vehicles. (e) The facility shall comply with all applicable Department of Transportation rules promulgated under N.J.S.A. 39:1-1 et seq. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00169349 Based on observation, interview, and pertinent document review, it was determined that the facility failed to ensure its vehicles were maintained in safe operating order, as evidenced by: On 12/21/23 at 12:32 p.m., the surveyor observed Bus #19 pull up to the center to drop-off participants for the second session. The surveyor observed Bus #19 had clear tape wrapped all around the right side-view mirror and antenna. At 1:27 p.m., the surveyor interviewed the Director of Transportation and the Administrator, who both stated on November 14, 2023, a tree	M 825		

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M 825	Continued From page 22 struck Bus #19 and broke the right side-view mirror. The DOT stated the right side-view mirror was attached to a pole, which secured the right side-view mirror to the vehicle, and tape was added so the right side-view mirror did not vibrate when the vehicle was in motion. The surveyor reviewed the facility policy titled, "Van Maintenance," which indicated, "Center vehicles shall be properly maintained, licensed and inspected to ensure the safety and comfort of the passengers...The Program Director shall be responsible for ensuring the Transportation Daily and Weekly Vehicle Check is completed as indicated, as well as ensuring that the vehicle receives all scheduled maintenance appointments and repairs..."	M 825		
M 827	8:43F-17.2 Transportation Services The facility shall develop and implement plans for security and accountability for the participant and the participant's personal possessions while transportation services are being provided. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00169349 Based on observation, interview, and pertinent document review, it was determined that the facility failed to consistently ensure security and accountability for all participants and their	M 827		

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M 827	Continued From page 23 belongings while transportation services were being provided, as evidenced by: On 12/21/23 at 12:26 p.m., the surveyor observed as participants boarded Bus #5 to depart home. The surveyor observed the Director of Transportation (DOT) in the driver's seat of Bus #5 as he prepared to depart from the facility with 4 unsampled participants, two of which did not have a seat belt on. The surveyor interviewed the DOT to inquire if he was ready to depart from the facility. The DOT stated he had to apply his own seat belt, and then he was ready to depart. The surveyor inquired about the two unsampled participants in the bus without their seat belts applied. The DOT stated he told everyone to apply their seat belt when they boarded the bus. The surveyor inquired about who was responsible for ensuring participants applied their seat belts prior to departure. The DOT stated the drivers were responsible for "telling the participants to apply their seat belt." At 12:39 p.m., the surveyor observed as participants boarded Bus #18 to depart home. The surveyor observed a walker and multiple participant belongings in the front of the bus and partially in the walkway, all of which were not secured. The surveyor observed Driver #1 depart from the facility without securing the belongings. At 1:25 p.m., the facility was informed of the imminent danger to participants who used facility transportation due to seat belt noncompliance and unsecured belongings. At 3:19 p.m., the facility submitted a removal plan for the aforementioned imminent danger. The surveyor reviewed the facility policy titled,	M 827		

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M 827	Continued From page 24 "Seat Belts," which indicated, "...The driver and all passengers shall wear seat belts at all times when the van is in motion...All passengers transported in a center vehicle must wear a seat belt at all times...Drivers shall be responsible for assisting and reminding participants to use their seat belts...Drivers shall make sure all participants and riders are wearing a seat belt before departing."	M 827		

accepted 1/30/24 MM

Tag M 223 Point 1: Fire Drill Documentation:

1. ***How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

The facility shall ensure the implementation and enforcement of the policy and procedure including "Fire Drill and Other Emergencies." All requirements for fire drills were completed as required and evidenced below, excluding 11/15/23 documentation issues involving the Director of Transportation (DOT). On January 19, 2024, the Alternate Administrator will provide training and education to the Director of Transportation so that the fire safety in-service is conducted and precisely timed and dated. Additionally, an administrator must ensure that the Director of Transportation's in-service is carried out on time and follows up on it. The administrator shall maintain an ongoing In-service log to verify that the Director of Transportation conducts fire safety in-service for the bus drivers as planned on time, and with the appropriate date. In response to this incident all training will be conducted with the participation of the Administrator/Asst. Administrator along with the department head and must be documented and filed by close of business the same day. The Director of Transportation (DOT) has received written disciplinary action for failure to meet job requirements and falsification of records.

The requirement for fire drills was completed by the administration as evidenced by the following and shared at the time of inspection: An administrator and their assistant conducted a fire-drill in-service on 02/06/2023 at 10:45am for all staff members/employees. During the fire practice, the employees were instructed on the appropriate exits, designated assembly spots, and given detailed explanations of emergency evacuation strategies in sections of the workplace that may pose challenges. Furthermore, illustrating the necessary procedures to be followed in the event of a real fire including

1. *Rescue any individuals from the immediate vicinity,*

2. *Alarm activate the closest alarm and dial 911.*

3. *Confine close all entrances to the fire or hazardous area,*

4. *Extinguish If the fire prevents you from evacuating, extinguish it with the closest fire extinguisher and proceed to the designated meeting location.*

2.How the facility will identify other residents having the potential to be affected by the same deficient practice.

All participants have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The facility has implemented the following measures: The Alternate Administrator and Assistant Administrator will promptly carry out the fire exercise in-service to instruct and inform all employees on the emergency evacuation measures. Going forward all in-service training must be conducted in the presence of the Administrator/Asst. Administrator and documentation filed by close of business the same day.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

DOT has been written up for backdating the fire drill in-service on 12/22/2023 and has been made aware of the importance of completing the in-service on time and that all employees attend and participate in the fire drill in-service as scheduled according to facility policy.

The Administrator/Alternate Administrator will be present for and sign-off on all in-service training conducted by department heads.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

5[illegible]0 Hadley Rd
South Plainfield, NJ 0[illegible]80
Phone: 732-[illegible]3[illegible]3

accepted 1/30/24

Tag M 223 Point 2: Egress supply storage & Exit Sign

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The facility shall ensure the implementation and enforcement of the policy and procedure including "Fire and Other Emergencies: General." Between 12:00 pm and 1:00 pm on December 22nd, all items, including the trash cart and any facility equipment, that were present in the egress corridor during the inspection have been cleared and removed. The passage is now fully clear and accessible for use in case of an emergency.

The fire signs were promptly repaired. The Fire protection firm was contacted by phone on 12/28/2023 to commence the conversation. Subsequently, the annual inspection for the fire safety lights, alarm system, and fire extinguishers was planned for 12/29/2023. The repairs for all the malfunctioning lights stated in the inspection report have been completed as on 01/03/2024 at 3:00 pm. A mandatory training session on Emergency Corridor and Building Safety was conducted by the facility administrator and alternate administrator on 12/22/2023.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

All participants have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The facility has enacted the following measures:

A mandatory training session on Emergency Corridor and Building Safety was conducted by the facility administrator and alternate administrator on 12/22/2023. The purpose of the training was to instruct staff members to always keep the egress corridor clear and free of clutter in order to ensure the safety of participants and prevent any accidents or falls.

During the inspection on December 22nd from 12:00 pm to 1:00 pm, all items, including the trash cart and any facility equipment, were removed from the egress corridor. As a result, the corridor is now completely free and can be used in case of an emergency.

Fire and general emergency signs have been translated and posted in the participant area in Gujarati, Korean, Chinese, and Spanish languages. The program coordinators for both shifts have provided comprehensive instruction to all participants regarding the information conveyed in this signage.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

The administrative assistant is responsible for the daily maintenance and observation of the corridors to ensure that the DOT, program coordinators, and kitchen coordinator operate under the direct supervision of the administrator. The administrator is responsible for overseeing the administrative assistant's work by maintaining a monthly inspection and checklist. This checklist should verify that the egress service corridor remains unobstructed, that fire alarms, fire extinguishers, and "Exit" signs are in working order, and that emergency evacuation diagrams are posted in each room in multiple languages. Upon identification of any obstructions in the egress corridor, their prompt removal is required. All items will be stored in designated storage closets, garbage and broken items will be removed from the center to the dumpsters promptly.

A monthly inspection checklist has been created for emergency exit lights and extinguishers as part of the monthly documented quality assurance check. Further, on 12/22/2023 all staff members were trained via an in-service on reporting techniques of any broken exit lights, fire extinguishers, open garbage cans, broken furniture, car repairs and other immediate evident participants safety hazards inside and outside the facility.

Consistent daily inspections are performed of the corridors within the facility.,

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

accepted 1/30/24

Tag M 223 Point 3: Proper Application and Utilization of Personal Protective Equipment

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The facility shall ensure the implementation and enforcement of the policy and procedure including, "The New Jersey State Sanitary Code Wearing appropriate Hair nets to effectively keep Head hair and Body hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service and single-use articles." As of 12/22/2023, disposable protective equipment including aprons, gloves, and hairnets has been stored outside the kitchen. Appropriate signs directing

employees to the upper compartment located to the left of the kitchen entrance door contain the location where these items are stored. The entire staff

participated in in-service training including the location of hair nets, aprons,

gloves, the proper use of these items, requirements for use and ramifications for non-compliance.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

All participants have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The following protocols have been implemented by the facility: prior to entering the kitchen, all employees, including the kitchen staff, have been duly informed and instructed to don hairnets, hand mitts, and aprons. Furthermore, in the event that an employee is observed entering the kitchen without a hairnet or is discovered in the kitchen without a hairnet, the necessary measures shall be implemented. In addition to donning hairnets, any exposed hair on the body, such as the beard and mustache, should be appropriately covered with hair nets.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

The ServSafe kitchen manager and Administrator/Alternate administrator will monitor compliance with the training and policy from the in-service on 12/26/23. Failure to adhere to the policy will result in disciplinary action from first warnings through termination for continued violations. The ServSafe kitchen manager is responsible for keeping a daily record to verify that all staff members adhere to the correct hair net policy before entering the kitchen area. An administrator shall maintain a weekly log to verify that the ServSafe kitchen manager is carrying out his or her duties with regard to the correct use of personal protective equipment (PPE), including hair nets, before entering the kitchen premises.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

Circle of life

accepted 1/30/24

Tag M 223 Point 4: Blood glucose monitor disinfection:

1. ***How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

The facility shall ensure the implementation and enforcement of the policy and procedure including "Blood Glucose Testing." As of Friday, December 22, 2023, in adherence to manufacturer recommendation and in adherence to our infection control policy, Super Sani-cloth disinfectant wipes were substituted for alcohol pads on the blood glucose meter. Director of Nursing (DON) has instructed all nursing personnel of the proper cleaning and disinfection procedure and material for the multi patient glucometer. Including the timing and duration after each patient's use.

2. ***How the facility will identify other residents having the potential to be affected by the same deficient practice.***

All participants have the potential to be affected by this deficient practice.

3. ***What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.***

The facility has enacted the following measures:

At the nursing station and examination room, super sani-cloth disinfecting wipes have been provided with adequate supply in storage.

In order to verify that the Blood Glucose Meter is appropriately cleaned and disinfected using Super sani-cloth wipes, DON will conduct ongoing observations and monitoring of nursing staff.

4. ***How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.***

DON shall provide annual in-service and education to new and current nurses regarding the proper utilization of Super Sani-Cloth cloths to clean and disinfect blood glucose meters, following the guidelines provided by the manufacturer in compliance with facility policy.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

accepted 1/30/24 pl

Tag M 223 Point 5: Broken/Missing emergency equipment:

1. ***How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

The facility shall ensure the implementation and enforcement of the policy and procedure including "Physical Plant Precautions" and "Nursing Space and Equipment." A new suction machine and suction canister were installed on 12/21/2023 to replace the malfunctioning suction canister. Furthermore, a second suction canister has been ordered as a preventative step in case the current canister malfunctions or is damaged. In addition to the suction canister, an order has been placed for a yankauer suction tip, which is a tool used for oral suctioning.

2. ***How the facility will identify other residents having the potential to be affected by the same deficient practice.***

All participants have the potential to be affected by this deficient practice.

3. ***What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.***

The facility has enacted the following measures:

At all times, the suction canister will be easily accessible in the nursing station. The nursing personnel is responsible for the maintenance of the suction canister. The DON will conduct a monthly check of all emergency equipment to ensure it is available and maintained in good working order. The DON will document on a log form at the nursing station maintained near the equipment.

In the event of any damage or breakage to the canister or other emergency equipment, prompt notification to the DON shall be given so that new equipment can be ordered and replaced.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

DON is responsible for conducting monthly inspections of the suction canister and other emergency equipment to verify its functioning properly. Additionally, DON will be responsible for maintaining and managing an Emergency Equipment record, which will be used to mark off each month following a thorough inspection of all emergency equipment that is available and in good working order.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

accepted 1/30 12/4

Tag M 223 Point 6: Transportation safety (seat belts/securing objects)

1. ***How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

The facility shall ensure the implementation and enforcement of the policy and procedure titled, "Seat Belts." The Director of Transportation (DOT) and alternate administrator organized a seat belt safety educational in-service on Thursday, December 21, 2023. All bus drivers involved in the in-service agreement have undergone comprehensive training and education regarding the importance of seat belts and safety regulations.

Mandatory vehicle safety policies have been implemented for all drivers. A training session was held on 01/15/2024, covering guidelines for storing products, walkers, and canes in vehicles during trips transporting participants to and from the daycare center.

Training included:

Upon boarding the bus, the DOT/Driver will remind all participants and riders to secure seat belts.

The DOT/Driver is responsible for assisting all participants and passengers in the proper utilization of seat belts, as required.

DOT/Driver must ensure that all participants and riders, including the bus driver, are wearing seat belts appropriately.

All drivers have received instruction on the significance of properly transporting participants. A training session was held, focusing on seat belt safety and the departure protocol for the whole transportation department.

All participants from both shifts have received instruction on the significance of seat belt safety. Additionally, they have been explicitly advised that the vehicle will not commence its route until every participant has fastened their seat belt. If necessary, drivers and program organizers will provide assistance in securing seat belts for the participants.

2. ***How the facility will identify other residents having the potential to be affected by the same deficient practice.***

All participants have the potential to be affected by this deficient practice.

3. ***What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.***

The facility has enacted the following measures:

All participants from both shifts will receive ongoing reminders on the significance of wearing seat belts while the bus/car is in motion during the seat belt safety training.

Program aides, coordinators, and drivers have been ordered to provide assistance to participants who need help with fastening their seat belts. DOT/Drivers are directed to physically inspect each participant and passenger to verify the correct usage of seat belts.

Both participants and drivers have been instructed on the storage policy to ensure their awareness of the situation. Drivers have been provided instructions on how to store walkers, canes, and wheelchairs in the designated storage space of vehicles equipped with such a feature.

Drivers and participants are advised to utilize the last row seating of vehicles as a storage place when there is no designated storage space available. This restriction is applicable just to participants who exclusively utilize canes and folding walkers. Drivers have been directed to inspect the storage of participants' belongings and the facility both before and during their trips to ensure they are secure.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

The Director of Transportation (DOT) is responsible for ensuring that all participants and riders adhere to the seat belt precautions/policy prior to boarding the bus.

The Director of Transportation (DOT) will require and provide seat belt safety training and educational in-service to both new and existing bus drivers annually. This measure aims to guarantee the safety of all those involved in bus transportation.

The Director of Transportation and Administrator will conduct spot checks of vehicles before departure to ensure continued adherence to our vehicle safety policy.

Completion of Plan of Corrections: 1/19/2024

[redacted] Administrator

accepted 1/22/24 AM

Tag M 223 Point 7: Vehicle Maintenance

1. ***How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

The facility shall ensure the implementation and enforcement of the policy and procedure titled, "Van Maintenance." Vehicle 19 was promptly repaired after contacting Deepa Auto Repair through a phone call and subsequent email exchange on 12/27/2023 at 9:48 am. The damaged mirror was repaired and adjusted on the evening of 12/28/2023, and the car was inspected and found to be free of any faults or shortcomings on 12/29/2023.

2. ***How the facility will identify other residents having the potential to be affected by the same deficient practice.***

All participants have the potential to be affected by this deficient practice.

3. ***What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.***

The facility has enacted the following measures:

In order to prevent any further policy violations, the transportation department has received training on reporting methods for vehicle repairs and identifying any immediate evident safety risks to clients both within and outside the facility, including the vehicles themselves. Since 01/03/2024, a regular on-site car inspection schedule has been put into effect. This schedule involves documenting any necessary vehicle repairs, which will then be submitted to the Director of Transportation (DOT).

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

The reports and requests will be promptly forwarded to the Director of Transportation (DOT), and immediate actions will be implemented to address the issue or arrange for repairs to be scheduled at the earliest opportunity. If there are any delays in obtaining the necessary parts for repairs, the vehicle will be taken out of service until the repairs are completed. An administrator shall be accountable for conducting quarterly reviews and audits of all reported vehicle damage and ensuring that repairs are completed promptly.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

accepted 1/30/24

Tag M 539 Dietary Services:

1. ***How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

The facility shall ensure the implementation and enforcement of the policy and procedure including, "The New Jersey State Sanitary Code, the following requirements shall apply to hair restraints: Wearing appropriate Hair nets to effectively keep Head hair and Body hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service and single-use articles." As of 12/22/2023, disposable protective equipment including aprons, gloves, and hairnets has been stored outside the kitchen. The items mentioned above are accessible for storage in the uppermost compartment located to the left of the kitchen entrance door with signage indicating its location. All staff have been in-serviced on the need for and location of hair nets, gloves and aprons while providing dietary services inside the kitchen and while serving.

2. ***How the facility will identify other residents having the potential to be affected by the same deficient practice.***

All participants have the potential to be affected by this deficient practice.

3. ***What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.***

The facility has enacted the following measures:

Clear signage has been displayed to indicate the location of the food safety equipment. Additionally, all kitchen staff and aids received instructions at an in-service session held on 12/22/2023 regarding the proper application and utilization of protective gear prior to entering the kitchen. Staff will be monitored by the certified ServSafe food manager and the administrator for compliance.

4. ***How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.***

The Kitchen manager and Administrator will monitor compliance. One verbal warning and three written warnings will be issued for the initial entry into the kitchen without appropriate food safety equipment, with subsequent violations incurring additional penalties. All employees of the Circle of Life are obligated to abide by this policy.

The ServSafe kitchen manager is responsible for keeping a daily record to verify that all staff members adhere to the correct hair net policy before entering the kitchen area.

An administrator shall maintain a weekly log to verify that the ServSafe kitchen manager is carrying out his or her duties with regard to the correct use of personal protective equipment (PPE), including hair nets, before entering the kitchen premises.

Completion of Plan of Corrections: 1/19/2024

[redacted] Administrator

Circle of life

accepted 1/30/24 DH.

Tag M 677 Physical Plant:

1. ***How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

The facility shall ensure the implementation and enforcement of the policy and procedure including "Fire and Other Emergencies: General." The egress service area has been cleared and the furniture and facility supplies that were previously observed in the hallway and corridor have been relocated to the storage area. The cleaning company, according to the administrator's statement, removed the accumulated storage from the area on 12/22/2023 between 12:00 pm and 1:00 pm.

2. ***How the facility will identify other residents having the potential to be affected by the same deficient practice.***

All participants have the potential to be affected by this deficient practice.

3. ***What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.***

The facility has enacted the following measures:

On December 22, 2023, an emergency plan in-service was executed, and every employee was instructed and educated regarding the significance of corridor clearance and safety protocols and reporting requirements.

4. ***How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.***

Under the direct supervision of the Administrator, daily corridor inspections are carried out by the Admin Assistant, Kitchen Coordinator, Program Coordinators, and Director of Transportation to ensure that the egress corridor remains secure and compliant. No items will be allowed to be placed in egress corridors. All items must be stored in designated storage areas.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

3000 Hadley Road
South Plainfield, NJ 07080
Phone: 732-839-3333

Circle of Life

accepted. 1/30/24 DR

Tag M 679 Facility Exit & Emergency equipment:

1. ***How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

The facility shall ensure the implementation and enforcement of the policy and procedure including "Fire and Other Emergencies: General", "Maintenance and Housekeeping," and "Evacuation Plan." Immediate action was taken to repair the identified exit signs and ensure the facility was in compliance. Following the phone conversation on 12/28/2023 with the fire protection company, the annual inspection of the fire safety lighting, alarm system, and fire extinguishers was planned for 12/29/2023. As of 01/03/2024 at 3:00 pm, every malfunctioning light has been repaired. Further, on 12/22/2023 all staff members were trained via an in-service on reporting techniques of any broken exit lights, fire extinguishers, open garbage cans, broken furniture, car repairs and other immediate evident participants safety hazards inside and outside the facility.

The padlock has been permanently removed from the patio gate to allow emergency egress.

A new suction machine and suction canister were installed on 12/21/2023 to replace the malfunctioning suction canister. Furthermore, a second suction canister has been ordered as a preventative step in case the current canister malfunctions or is damaged. In addition to the suction canister, an order has been placed for a yankauer suction tip, which is a tool used for oral suctioning.

2. ***How the facility will identify other residents having the potential to be affected by the same deficient practice.***

All participants have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The facility has enacted the following measures:

A monthly inspection checklist has been created for emergency exit lights and extinguishers as part of the monthly documented quality assurance check.

The administrative assistant, under the direct supervision of the administrator, will have the responsibility of ensuring that the patio gate remains unlocked at all times, serving as an emergency exit.

In order to verify that the Blood Glucose Meter is appropriately cleaned and disinfected using Super sani-cloth wipes, DON will conduct ongoing observations and monitoring of nursing staff.

DON shall provide annual in-service and education to new and current nurses regarding the proper utilization of Super Sani-Cloth cloths to clean and disinfect blood glucose meters, following the guidelines provided by the manufacturer in compliance with facility policy.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

Ongoing inspections shall be the responsibility of an administrator to ensure that the corridors and emergency exits are devoid of obstructions and that any emergency signs or equipment that is damaged or broken is promptly replaced or ordered back into service. Administrative Assistant will conduct daily inspections of corridors, emergency exits, exit signs, emergency exit plans, and emergency exit doors beginning on 01/03/2024. Any signs or doors that are damaged or misplaced will be repaired without delay. On a daily basis, Administrative Assistant conduct facility inspections both before and after shifts to identify any misplaced or damaged items. Reporting approaches to the appropriate personnel have been specified in detail.

The Director of Nursing (DON) will organize an annual nursing in-service to provide instruction and training to all nursing staff on the proper cleaning of blood glucose meters, operation of oxygen tanks, and utilization of a suction canister machine in case of an emergency.

DON will conduct monthly observations and supervision of all nurses to ensure adherence to proper nursing protocols.

DON will also maintain a monthly Emergency Equipment maintenance log to record and verify the proper functioning of the emergency equipment.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

accepted 1/22/24 DM

Tag M 685 Emergency plans:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The facility shall ensure the implementation and enforcement of the policy and procedure including "Fire and Other Emergencies: General." The revised emergency evacuation plan has been rectified and prominently displayed in every room within the facility. The evacuation diagram clearly indicates the labeling of all fire extinguishers, fire alarm boxes, and fire exit doors. The evacuation plan includes clearly marked routes from each room leading to the closest fire exit door. The Fire plans have been translated into Korean, Simplified Chinese, Spanish, and Gujarati, and have been displayed in every room of the facility on 01/09/2024.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

All participants have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The facility has enacted the following measures:

The administrator, as part of their monthly quality assurance check, will ensure that the emergency plans remain in place. Quarterly training on emergency plans and procedures will reinforce the emergency plans posted.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

Monthly quality assurance checks which include emergency plans, postings and drills will be maintained and conducted by the Administrator. The checks will ensure compliance and continued best practices.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

Circle of life
ADULT DAY SERVICES

accepted 1/30/24 DN

Tag M 783 Glucometer sanitizing:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The facility shall ensure the implementation and enforcement of the policy and procedure including "Blood Glucose Testing." As of Friday, December 22, 2023, in adherence to manufacturer recommendation and in adherence to our infection control policy, Super Sani-cloth disinfectant wipes were substituted for alcohol pads on the blood glucose meter. Director of Nursing (DON) has instructed all nursing personnel of the proper cleaning and disinfection procedure and material for the multi patient glucometer. Including the timing and duration after each patient's use.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

All participants have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The facility has enacted the following measures:

At the nursing station and examination room, super sani-cloth disinfecting wipes have been provided with adequate supply in storage.

In order to verify that the Blood Glucose Meter is appropriately cleaned and disinfected using Super sani-cloth wipes, DON will conduct ongoing observations and monitoring of nursing staff.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

DON shall provide annual in-service and education to new and current nurses regarding the proper utilization of Super Sani-Cloth cloths to clean and disinfect blood glucose meters, following the guidelines provided by the manufacturer in compliance with facility policy.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

3000 Hadley Road
South Plainfield, NJ 07080
Phone: 732-839-3333

Circle of life

accepted
1/30/24
DR

Tag M 825 Vehicle Maintenance:

1. ***How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

The facility shall ensure the implementation and enforcement of the policy and procedure including "Van Maintenance." Vehicle 19 was promptly repaired after contacting Deepa Auto Repair through a phone call and subsequent email exchange on 12/27/2023 at 9:48 am. The damaged mirror was repaired and adjusted on the evening of 12/28/2023, and the car was inspected and found to be free of any faults or shortcomings on 12/29/2023.

2. ***How the facility will identify other residents having the potential to be affected by the same deficient practice.***

All participants have the potential to be affected by this deficient practice.

3. ***What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.***

The facility has enacted the following measures: In order to mitigate communication errors, all personnel have received in-service orientation regarding the proper procedures for reporting any visible dangers to participant safety, including malfunctioning exit lights, fire extinguishers, open garbage cans, broken furniture, vehicle repairs, and any other such incidents that may occur both within and outside the facility.
Starting from 01/03/2024, a daily on-site examination of vehicles has been put into effect before morning runs. This examination includes the documentation of any necessary vehicle repairs, which will be transmitted to the Director of Transportation (DOT) electronically via the Connect Team Application. Any issue rendering the vehicle unsafe to operate will suspend operation of the vehicle until the repair is complete.

4. ***How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.***

An Administrator/Director of Transportation (DOT) will oversee adherence to vehicle inspection requirements during monthly meetings focused on vehicle damages and repairs.

Completion of Plan of Corrections: 1/19/2024

[redacted] Administrator

3000 Hadley Road
South Plainfield, NJ 07080
Phone: 732-839-3333

Circle of life

accepted 1/22/24 DR

Tag M 827 Transportation safety:

1.. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The facility shall ensure the implementation and enforcement of the policy and procedure including "Seat Belts." The Director of Transportation was spotted failing to adhere to the seat belt safety protocols while providing transportation services to the facility's participants. Furthermore, the participant's belongings were inadequately secured aboard the bus. The Director of Transportation received training from an alternate administrator to execute strategies ensuring the safety and responsibility of the participants and their personal belongings throughout the provision of transportation services. The Director of Transportation (DOT) and alternate administrator organized a seat belt safety educational in-service on Thursday, December 21, 2023. All bus drivers involved in the in-service agreement have undergone comprehensive training and education regarding the importance of seat belts and safety regulations.

Mandatory vehicle safety policies have been implemented for all drivers. A training session was held on 01/15/2024, covering guidelines for storing products, walkers, and canes in vehicles during trips transporting participants to and from the daycare center.

Training included:

Upon boarding the bus, the DOT/Driver will remind all participants and riders to secure seat belts.

The DOT/Driver is responsible for assisting all participants and passengers in the proper utilization of seat belts, as required.

DOT/Driver must ensure that all participants and riders, including the bus driver, are wearing seat belts appropriately.

All drivers have received instruction on the significance of properly transporting participants. A training session was held, focusing on seat belt safety and the departure protocol for the whole transportation department.

All participants from both shifts have received instruction on the significance of seat belt safety. Additionally, they have been explicitly advised that the vehicle will not commence its route until every participant has fastened their seat belt. If necessary, drivers and program organizers will provide assistance in securing seat belts for the participants.

1/20 p.d. accepted DL

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

All participants have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The facility has enacted the following measures:

All participants from both shifts will receive ongoing reminders on the significance of wearing seat belts while the bus/car is in motion during the seat belt safety training.

Program aides, coordinators, and drivers have been ordered to provide assistance to participants who need help with fastening their seat belts. DOT/Drivers are directed to physically inspect each participant and passenger to verify the correct usage of seat belts.

Both participants and drivers have been instructed on the storage policy to ensure their awareness of the situation. Drivers have been provided instructions on how to store walkers, canes, and wheelchairs in the designated storage space of vehicles equipped with such a feature.

Drivers and participants are advised to utilize the last row seating of vehicles as a storage place when there is no designated storage space available. This restriction is applicable just to participants who exclusively utilize canes and folding walkers. Drivers have been directed to inspect the storage of participants' belongings and the facility both before and during their trips to ensure they are secure.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

The Director of Transportation (DOT) is responsible for ensuring that all participants and riders adhere to the seat belt precautions/policy prior to boarding the bus.

The Director of Transportation (DOT) will require and provide seat belt safety training and educational in-service to both new and existing bus drivers annually. This measure aims to guarantee the safety of all those involved in bus transportation.

The Director of Transportation and Administrator will conduct spot checks of vehicles before departure to ensure continued adherence to our vehicle safety policy.

An annual training and education process will be conducted by an administrator to ensure that the Director of Transportation implements the seat belt policy and procedures effectively. This is done to ensure the safety and responsibility of the participants and their personal belongings.

Completion of Plan of Corrections: 1/19/2024

NJ Exec Order 26.4b1 Administrator

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12021	A. BUILDING: _____ B. WING _____	R-C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIRCLE OF LIFE ADULT DAY SERVICES	3000 HADLEY ROAD SOUTH PLAINFIELD, NJ 07080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	Initial Comments Type of Survey: Re-Licensure and Complaint Complaint#: NJ00169349 Census 12/20/23: 104 Census 12/21/23: 68 Sample Size: 8 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	{M 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/19/24

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
12021 Y1	A. Building B. Wing Y2	1/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CIRCLE OF LIFE ADULT DAY SERVICES	3000 HADLEY ROAD SOUTH PLAINFIELD, NJ 07080

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0223	Correction	ID Prefix M0539	Correction	ID Prefix M0677	Correction
Reg. # 8:43F-3.1(b)(1-7)	Completed	Reg. # 8:43F-10.5(a)	Completed	Reg. # 8:43F-14.17(a)	Completed
LSC	01/30/2024	LSC	01/30/2024	LSC	01/30/2024
ID Prefix M0679	Correction	ID Prefix M0685	Correction	ID Prefix M0783	Correction
Reg. # 8:43F-14.17(b)	Completed	Reg. # 8:43F-14.17(d)	Completed	Reg. # 8:43F-16.2(i)(1-8)(i-iv)	Completed
LSC	01/30/2024	LSC	01/30/2024	LSC	01/30/2024
ID Prefix M0825	Correction	ID Prefix M0827	Correction	ID Prefix	Correction
Reg. # 8:43F-17.1(c)(d)(e)	Completed	Reg. # 8:43F-17.2	Completed	Reg. #	Completed
LSC	01/30/2024	LSC	01/30/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO