| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315471 | A. BUILDING _____ B. WING _____ | 10/06/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST CATHERINE OF SIENA | 7 RYERSON AVENUE CALDWELL, NJ 07006 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found to not be in substantial compliance with 42 CFR 483 subpart B.<br><br>Survey Dates: 10/03/22 to 10/06/22<br><br>Survey Census: 23<br><br>Sample Size: 12 | F 000 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. | F 623 | | 11/30/22 |

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

Electronically Signed | 10/27/2022

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 623 | Continued From page 1 | F 623 | | |

(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for

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| F 623 | Continued From page 2<br>the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to notify their designated State Ombudsman for hospital transfers, or discharges, for two (Resident (R) 11 and R24) of two residents reviewed for hospitalizations or discharges, resulting in the potential for hospital transfers and unplanned discharges by the facility | F 623 | PLAN OF CORRECTION CFR 483.15¿(3)-(6)(8)<br>F623 Requirement before Transfer/Discharge<br>1.) POTENTIAL FOR RESIDENT:<br>a. There was no actual harm to the residents. Resident 11 returned to the | |

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| F 623 | Continued From page 3<br>to go unnoticed by the State Ombudsman.<br><br>Findings include:<br><br>1. Review of R11's "Admission Record", undated, in the Electronic Medical Record (EMR) under the Profiles tab, indicated the facility admitted the resident on [redacted] R11 was hospitalized on [redacted].<br><br>Review of the "Progress Notes" in the EMR for R11 revealed R11 was transferred to the hospital on [redacted] at 2:26 PM for " .. [redacted] ..." R11 was admitted to the hospital on [redacted] and discharged back to the facility on [redacted].<br><br>Review of R11's "Progress Notes" in the EMR revealed no documentation which indicated the State Ombudsman was notified of the hospital transfer.<br><br>2. Review of R24's "Admission Record", undated, EMR under the Profiles tab, indicated the facility admitted the resident on [redacted]. R24 was discharged to another facility on [redacted]<br><br>Review of the "Progress Notes" in the EMR for R24 revealed R24 had a planned discharge to a facility specifically for [redacted], at his request, on [redacted]<br><br>Review of R24's "Progress Notes" in the EMR revealed no documentation which indicated the State Ombudsman was notified of the discharge.<br><br>During an interview on 10/04/22 at 4:00 PM the Administrator and Director of Nursing (DON) | F 623 | facility Resident 24 [redacted] requested to be transferred to be with the other members of [redacted]<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>a. There was no actual harm to other residents. The individual responsible parties were notified of the physician order and impending emergent transfer to an acute care facility and were in agreement. The resident was returned to the facility.<br>b. Resident 24 requested the transfer/discharge, the responsible party and Head of the order were in agreement, initiated and facilitated the transfer and the physician obliged the resident request. NJ DOH Office of Community Choice Options (OCCO) office was notified<br>3.) SYSTEMIC CHANGES:<br>a. A notice of transfer/discharge was sent to Office of Ombudsman<br><br>A notice of transfer/Discharge will be sent to the Ombudsman office and documentation of transfer to an acute care facility will be sent to the responsible party by the facility Social Services Department. A note in the resident medical record and a monthly monitor of each transfer will maintained by Social Service Department.<br>4.) MONITORING:<br>a. The Social Worker will maintain a monthly log and will report quarterly to QAPI Committee<br>5.) IMPLEMENTATION:<br>October 6, 2022.<br>A Steering Committee of the QAPI is | |

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| F 623 | Continued From page 4<br>stated no information was sent to the State Ombudsman regarding discharges, or transfers of any kind. The Administrator also stated they [the facility] were not aware that needed to occur and the facility only had a social worker (SW) two days a week and the SW did not send anything either. The Administrator further stated the facility does not have a policy regarding notifications to the Ombudsman.<br><br>During an interview on 10/06/22 at 12:30 PM, the State Ombudsman stated the facility should be sending notice to the state office for all transfers and discharges related to residents. The State Ombudsman also stated that had been communicated to all facilities in the state when the regulation went into effect on 11/28/17.<br><br>NJAC 8:39-4.1(a)32 | F 623 | scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee for at least one year | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility | F 637 | PLAN OF CORRECTION CFR 483.20(b) | 11/28/22 |

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| F 637 | Continued From page 5<br>failed to complete a significant change "Minimum Data Set (MDS)" assessment for one of 12 residents (Resident (R) 25) reviewed for "MDS" accuracy in a total sample of 12 residents. This deficient practice increased the potential for missed opportunities of care or services.<br><br>Findings include:<br><br>1. Review of R25s "Admission Record," undated and located in the electronic medical record (EMR) under the "Profile" tab, indicated an admission date of [redacted] and diagnoses of; [redacted]<br><br>Review of R25's "Progress Notes," located in the EMR under the "Progress Notes" tab, revealed R25 was placed on [redacted] services on [redacted]<br><br>Review of R25's completed, and accepted, "MDS" located in the EMR under the "MDS" tab, revealed no significant change "MDS" was completed when R25 was placed on [redacted] services on [redacted]<br><br>During an interview on 10/04/22 at 4:00 PM the Director of Nursing (DON) stated she was the responsible person for completing " ...nursing related "MDS" sections ...", including any significant changes. The DON stated she was aware when a resident was placed on [redacted] services that triggered for a significant change "MDS" to be completed and stated R25's " ...was missed ..." The DON also stated the facility does not have a specific policy related to the "MDS" they follow the MDS manual. | F 637 | (2)(ii) F637<br><br>1.) POTENTIAL FOR RESIDENT:<br>a. There was a potential to affect the resident. The resident was admitted to with an interdisciplinary plan of care.<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>a. There was no harm to the residents. The facility and Hospice provider will continue to include in the medical record an interdisciplinary plan of care to decrease the potential for missed opportunities of care or services<br>3.) SYSTEMIC CHANGES:<br>a. We currently use an electronic medical record (EMR). We have changed the current process to include any ADT (admission, discharge, transfer) or payer change as a high priority. This will trigger on the dashboard thereby communicating the need for a potential significant change MDS/CP.<br>b. In the current system, the nursing or progress notes can be flagged to show communication or edit care plan immediately. This current process was modified to include incident notes and hospice notes. This will trigger onto the dashboard thereby communicating the need for a potential significant change MDS/CP<br>c. The MDS nurse will check the dashboard daily review all ADT and payer changes from previous 24 hours. The DON will check the dashboard and communicate with the MDS RN twice a | |

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| F 637 | Continued From page 6<br>NJAC 8:39-11.2(i) | F 637 | week or more frequently as indicated<br>d. Education of the professional nursing staff to the changes to EHR<br>4.) MONITORING:<br>a. The DON will check the dashboard and communicate with the MDS RN twice a week or more frequently as needed to ensure any significant changes are captured<br>b. Hospice provider Plan of Care notes will trigger to dashboard<br>5.) IMPLEMENTATION:<br>October 26, 2022<br>A Steering Committee of the QAPI met on October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and policy review, the facility failed to ensure staff monitored and documented ordered NJ Exec. Order 26:4.b.1 [redacted] for one of one resident (Resident (R) 11) reviewed for medications. This failure had the potential for R11 to receive unneeded or missed | F 684 | PLAN OF CORRECTIONCFR 483.25 F 684<br>Transcription error resulting in resident receiving medication without physician ordered parameters being followed.<br>1.) POTENTIAL FOR RESIDENT: A | 11/28/22 |

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| F 684 | Continued From page 7<br>blood pressure medications.<br><br>Findings include:<br><br>1. Review of R11's "Admission Record" undated, located in the resident's electronic medical record (EMR) under the "Profile" tab, indicated a current admission date to the facility of [redacted], with diagnoses of; [redacted]<br><br>According to the "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted], revealed R11 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] which indicated the resident was [redacted]<br><br>Review of the September 2022 monthly "Pharmacy Recommendations" provided by the Director of Nursing (DON) for R11 revealed on [redacted], the pharmacist identified [redacted]<br><br>Review of R11's [redacted] physician's "Orders" located in the EMR under the "Orders" tab, indicated the [redacted] was ordered on [redacted], with the parameters for holding the medication if the [redacted] | F 684 | [redacted] medication was prescribed by physician with parameters for administration. The medication was decreased, with a therapeutic interchange and parameters (supplemental documentation [redacted]). RN transcribed the order correctly including resident, medication name, time, dose and route. The RN did not include the hold parameters as ordered by physician<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>To minimize any potential effect on any other residents the clinical staff will be in-service in medication administration including ensuring parameters are included in the transcription of the medication<br>3.) SYSTEMIC CHANGES:<br>Education of all professional nursing staff including the 5 R□s<br>The night nurse downloads the daily orders from the previous day.<br>The nurse will review all medication orders to ensure accuracy in transcription and report any discrepancies to the DON<br>4.) MONITORING:<br>The Director of Nursing Services (DON) or designee will continue monthly audits and expand the current audits to include parameters are followed<br>Pharmacist will continue monthly audits to ensure compliance and report findings to the Director of Nursing and Licensed Nursing Home Administrator (LNHA)<br>The results of all medication audits are reported through the QAPI committee quarterly<br>5.) IMPLEMENTATION: | |

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| F 684 | Continued From page 8<br><br>Review of R11's [Exec Order 26, 4b1 NJAC 8:] "MAR" located in the EMR under the "Orders" tab, revealed the Exec Order 26, 4b1 NJAC 8:43E-2.1 however, Exec Order 26, 4b1 NJAC 8:43E-2.1 on the "MAR" or in the nursing "Progress Notes."<br><br>Review of R11's [Exec Order 26, 4b1 NJAC 8:43E-2.1] MAR" located in the EMR under the "Orders" tab, revealed the Exec Order 26, 4b1 NJAC 8:43E-2.1 however no [Exec O] was recorded on the "MAR" or in the nursing "Progress Notes." On [Exec Order 26, 4b1], the [Exec O] was [Exec Order 2], on [Exec Order 26, 4b1], the [Exec O] was [Exec Order 26] on [Exec Order 26, 4b1], the [Exec O] was [Exec Order 2], and on [Exec Order 26, 4b1], the BP was [Exec Order 26] The [Exec O] measures were completed, however they were below the ordered parameters and documented the medication was held due to the specified parameters and referred additional documentation to the nursing "Progress Notes," however no additional documentation was found for those dates.<br><br>During an interview on 10/06/22 at 11:00 AM, the DON verified the resident's [Exec Order 26, 4b1 NJAC 8:43E-2.] should be documented on the "MAR" when the medication was given, held, or outside the parameters. The DON also stated a [Exec Order 2] obtained in the morning should not be used to determine if the medication was appropriate to give at the 5:00 PM scheduled time. The DON further stated when the nurses documented on the "MAR" for holding the medication "See progress notes," the DON would expect to find a corresponding note in the "Progress Notes."<br><br>During an additional interview on 10/06/22 at | F 684 | October 19, 2022<br>A Steering Committee of the QAPI met October 26, 2022 to review the statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one year | |

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| F 684 | Continued From page 9<br>11:45 AM, the DON stated it's " ...standard of nursing practice ..." to document [redacted] when giving a medication that has a specific orders for them. The DON also stated her expectation would be for the nurses to document the [redacted] each day the medication was given.<br><br>Review of the facility policy and procedure "Administration of Medications" revised January 5, 2021, revealed " ... Medications must be charted immediately following the administrationby the person administering the drugs. Information including the date, time administered, dosage, etc., must be entered in the medical record and signed by the person entering the data. ..."<br><br>NJAC 8:39-29.2(d), 27.1(a) | F 684 | | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census. | F 732 | | 11/28/22 |

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| F 732 | Continued From page 10<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interviews, the facility failed to ensure that staffing information was prominently posted in an area that was readily assessable to residents and visitors daily. This had the potential to affect all residents and visitors of the facility.<br><br>Findings include:<br><br>1. Observation on 10/03/22 at 10:28 AM, revealed the daily staffing information was not posted on the unit.<br><br>On 10/05/22 at 10:28 AM, an interview with the Director of Nursing (DON) revealed that the nurse staffing is located at the back of the nursing | F 732 | PLAN OF CORRECTION CFR 483.35 (g) (1)-(4) F 732 Posting of Staff<br>1.) POTENTIAL FOR RESIDENT:<br>a. There was no harm to the residents<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>a. There was no affect on any resident.<br>b. Posting immediately resumed in addition to the electronic transmission of information posting as required<br>3.) SYSTEMIC CHANGES:<br>a. Posting on the daily staffing was resumed and in a conspicuous location at the nursing station<br>4.) MONITORING:<br>a. The Director of Nursing will ensure | |

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|---|---|---|---|
| | 315471 | A. BUILDING _____ B. WING _____ | 10/06/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST CATHERINE OF SIENA | 7 RYERSON AVENUE CALDWELL, NJ 07006 |

| (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 |
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| F 732 | Continued From page 11<br>station on the counter. However, it did not contain the daily census and was not visible to residents and families. The DON stated, "We used to have it posted on the bulletin board. The last time the state was here, they told us it no longer had to be posted and we removed it from the bulletin board."<br><br>NJAC 8:39-41.2 | F 732 | the posting is continued and will audit to insure compliance weekly<br>b. The DON will include in the quarterly Nursing QA report the compliance<br>c. Records will be maintained for 18 months as outlined<br>5.) IMPLEMENTATION:<br>October 4, 2022.<br>A Steering Committee of the QAPI is scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee for at least one year | |
| F 882 SS=F | Infection Preventionist Qualifications/Role<br>CFR(s): 483.80(b)(1)-(4)(c)<br><br>§483.80(b) Infection preventionist<br>The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must:<br><br>§483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;<br><br>§483.80(b)(2) Be qualified by education, training, experience or certification;<br><br>§483.80(b)(3) Work at least part-time at the facility; and<br><br>§483.80(b)(4) Have completed specialized training in infection prevention and control.<br><br>§483.80 (c) IP participation on quality assessment and assurance committee. | F 882 | | 12/8/22 |

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| F 882 | Continued From page 12<br>The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:<br>Based on interview and facility policy review, the facility failed to ensure that the designated individual responsible for the infection control program was certified in infection prevention. This failure has the potential to affect all 23 current residents at the facility, new admissions, and the potential to have missed opportunities for prevention of the spread of the COVID-19 virus, or other infections among residents and staff.<br><br>Findings include:<br><br>1. During an interview on 10/03/22 at 9:30 AM, the Administrator and Director of Nursing (DON) stated the facility did not have a specified staff member as the Infection Preventionist (IP). The Administrator stated they have an IP consultant (IPC) who was certified, and the IPC comes to the facility at least once a week or more often if needed.<br><br>During an interview on 10/05/22 at 2:00 PM, with the DON and IPC, the IPC stated she was at the facility " ...on average 8 hours a month ..." but will visit more when needed. The IPC stated she was certified in IP and confirmed the DON has not completed any infection control (IC) certification courses. During the same interview the DON re-confirmed she has not taken any IC certification courses and was under the impression the IPC credentials met the requirement. | F 882 | PLAN OF CORRECTION Infection Preventionist Qualifications/ Role<br>CFR 483.80(b)(1)-(4)(c) F882<br>The facility must designate one or more individuals as the Infection Control Preventionist<br>1.) POTENTIAL FOR RESIDENT:<br>a. There was no actual harm to the residents. We have hired an RN that successfully completed the CDC course. In addition, we will continue the support of The Infection Control Preventionist as a consultant who provides additional onsite and off site support.<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>a. There was no harm to the residents. We have hired an RN that successfully completed the CDC course. In addition, we will continue the support of The Infection Control Preventionist as a consultant that provides additional onsite and off site support<br>3.) SYSTEMIC CHANGES:<br>b. We hired RN for a part time position and she completed Centers for Disease Control and Prevention and has received the CDC certification<br>RN enrolled in course<br>c. This position is part time employee that will work with the current IP. This RN will actively participate in the IC | |

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| F 882 | Continued From page 13<br><br>According to the facility "Infection Prevention and Control Manual," updated April 2021 policy and procedure, under the "Scope of Infection Control Program" it stated, " ... The Director of Nursing is the Infection Preventionist ..." and under the "Role of the Infection Control Preventionist" it stated " ...The Administrator has designated the Director of Nursing to establish and conduct the Infection Control Program for Health Care Facility as the Infection Control Preventionist, Requires education or Experience in area of Infection Control and Attendance at an Infection Control Seminar, workshop or other appropriate educational programs at a minimum of once a year. ..."<br><br>NJAC 8:39-19.1(b) | F 882 | Committee, Steering Committee and QAPI Committee to ensure the IC program is followed.<br>4.) MONITORING:<br>a. This position reports directly to the LNHA with active participation in the IC Committee, QAPI Steering Committee, and QAPI Committee<br>5.) IMPLEMENTATION:<br><br>RN completed and received certification in CDC and Prevention 19.75 credit course on December 8, 2022<br>A Steering Committee of the QAPI scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee<br>Next quarterly meeting for QAPI is January 2023 | |

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 |
|---|---|---|
| 315471 Y1 | A. Building<br>B. Wing Y2 | 1/9/2023 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST CATHERINE OF SIENA | 7 RYERSON AVENUE<br>CALDWELL, NJ 07006 |

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 F0623 | Correction | ID Prefix F0637 | Correction | ID Prefix F0684 | Correction |
| Reg. # 483.15(c)(3)-(6)(8) | Completed | Reg. # 483.20(b)(2)(ii) | Completed | Reg. # 483.25 | Completed |
| LSC | 11/30/2022 | LSC | 11/28/2022 | LSC | 11/28/2022 |
| ID Prefix F0732 | Correction | ID Prefix F0882 | Correction | ID Prefix | Correction |
| Reg. # 483.35(g)(1)-(4) | Completed | Reg. # 483.80(b)(1)-(4)(c) | Completed | Reg. # | Completed |
| LSC | 11/28/2022 | LSC | 12/08/2022 | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | 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? |
|---|---|
| 10/6/2022 | ☐ YES ☐ NO |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315471 | A. BUILDING **01**<br>B. WING _____ | **10/06/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ST CATHERINE OF SIENA** | **7 RYERSON AVENUE**<br>**CALDWELL, NJ 07006** |

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| E 000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 10/05/22. The facility was found to be in compliance with 42 CFR 483.73. | E 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 10/05/22. The facility was found not to be in compliance with the requirements of 42 CFR 483.90.<br><br>The building was constructed in 1960 as a three story, concrete block exterior, flat concrete roofing and concrete flooring. The facility has a 30-bed certification unit on the second floor. The facility also contains assisted living and independent living. | K 000 | | |
| K 211 SS=E | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain the means of egress prohibiting storage rooms under stairways in accordance with NFPA 101 (2012) Section 7.2.2.5.3. This | K 211 | PLAN OF CORRECTION NFPA 101 (2012) Section 7.2.2.5.3<br>K211<br>Storage of water under stairs | 10/26/22 |

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

Electronically Signed | 10/26/2022

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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| | 315471 | A. BUILDING **01**<br>B. WING _____ | **10/06/2022** |

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| K 211 | Continued From page 1<br>deficient practice had the potential to affect 11 patients in one smoke zone.<br><br>Findings Include:<br><br>An observation on 10/05/22 at approximately 10:30 AM revealed a door under the stairway that opened to a storage compartment. The stairway was connected to the second-floor nursing center and used as an exit.<br><br>An interview with the Maintenance Director at the time of observation verified the existence of the room.<br><br>NJAC 8:39-31.1(c), 31.2(e) | K 211 | 1.) POTENTIAL FOR RESIDENT:<br>a. There was a potential harm to the residents<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>a. The door was removed and water containers relocated<br>3.) SYSTEMIC CHANGES:<br>a. Water storage area relocated<br>4.) MONITORING:<br>a. Director of safety will report quarterly to QAPI Committee the entire POC including the area is free of obstruction<br>5.) IMPLEMENTATION:<br>October 6, 2022.<br>A Steering Committee of the QAPI is scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee for at least one year | |
| K 311 SS=E | Vertical Openings - Enclosure<br>CFR(s): NFPA 101<br><br>Vertical Openings - Enclosure<br>2012 EXISTING<br>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6<br>If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.<br>This REQUIREMENT is not met as evidenced | K 311 | | 12/19/22 |

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| K 311 | Continued From page 2<br>by:<br>Based on observation and interview with facility staff, the facility failed to ensure that one of three stairway doors on the second floor had at least a one-hour fire resistance rating in accordance with NFPA 101 (2012 edition) Section 19.3.1.1. This deficient practice had the potential to affect 13 residents in the smoke zone.<br><br>Findings include:<br><br>An observation on 10/05/22 at 10:00 AM revealed the second-floor stairway door near bedroom 208 did not have a fire resistance label of one hour or greater. The door lacked any label. Lack of a fire resistance label indicates the door is rated as fire resistance of 20 minutes. The end side of the door and top were inspected for a fire resistance label, and none were found. This stairway (stairway A) communicated with three floor levels and a lower level.<br><br>An interview with the Maintenance Director at the time of the observation verified the door lacked a label.<br><br>NJAC 8:39-31.1(c), 31.2(e) | K 311 | PLAN OF CORRECTION NFPA 101 (2012) Section 19.3.1.1.<br>NJAC 8:39-31.1¿, 31.2(e) Fire Door Inspection and Certification<br><br>1.) POTENTIAL FOR RESIDENT:<br>Potential to affect smoke zone<br>There was no direct harm to any resident<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>Potential to affect smoke zone<br>a. There was a potential for residents to be affected<br>3.) SYSTEMIC CHANGES<br>a. Fire door was replaced on stairwell near bedroom 208<br>Contracted with vendor for all 2nd floor doors. The vendor will inspect and verify fire rating of doors is > or = 2 hours on all fire doors.<br>4.) MONITORING:<br>a. Thee Director of Maintenance Using Quality Indicators as the monitoring tool will ensure testing is done annually. This is to ensure all door properly maintained and labeled<br>b. Annual testing in 2022 will be reported to the QAPI Steering Committee on October 26, 2022 and thereafter<br>c. Subsequent reporting through the safety committee to the quarterly QAPI committee<br>5.) IMPLEMENTATION:<br>OCTOBER 26, 2022<br>A Steering Committee of the QAPI is scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported | |

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| K 311 | Continued From page 3 | K 311 | quarterly to the QAPI Committee for at least one year | |
| K 341 SS=E | Fire Alarm System - Installation<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview with the facility staff, the facility failed to ensure that smoke detectors were installed at least 36-inches from air diffusers in accordance with NFPA 72 (2010 edition) Section 29.8.3.4 (6). This deficient practice had the potential to affect all 10 residents in the smoke zone.<br><br>Findings include:<br><br>An observation of one smoke detector in the corridor near bedroom 219 on 10/05/22 at 9:55 AM revealed the smoke detector was 12 inches | K 341 | PLAN OF CORRECTION NFPA 101 NFPA 72 K 341<br>Smoke Detector next to room 219 as per survey must be moved at least 3 ft from the ceiling vent<br>The smoke detector was movedto 3ft from the air diffuser, and work completed on 10/11/2022<br>1.) POTENTIAL FOR RESIDENT:<br>There was a potential harm to any resident<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS: | 11/28/22 |

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| K 341 | Continued From page 4<br>from an air diffuser. The air diffuser is a supply vent from the rooftop heating and air conditioning unit.<br><br>An interview with the Maintenance Director at the time of the observation verified the measurement of the smoke detector to the air diffuser.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 70, 72 | K 341 | a. There was a potential affect on other residents<br>3.) SYSTEMIC CHANGES<br>a. Smoke detector was moved work completed on 10/11/2022<br>b. The distance of other smoke detectors was verified that the distance of 3 ft is maintained<br>4.) MONITORING:<br>a. The smoke detector was relocated to 3ft and verified. Annually or if replacement is required the Safety Director/Maintenance Director will again verify the distance meets the 3 ft requirement. All smoke detectors distance will be verified with the semi annual fire alarm system testing<br>b. Report to the QAPI Steering Committee on October 26,2022 and thereafter any change to location of a smoke detector will be verified and reported through the safety committee to the quarterly QAPI committee<br>5.) IMPLEMENTATION:<br>OCTOBER 11, 2022<br><br>A Steering Committee of the QAPI is scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee for at least one year | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying | K 345 | | 11/28/22 |

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| K 345 | Continued From page 5<br>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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of facility fire safety records and interview with facility staff, the facility failed to ensure they had conducted a smoke detection sensitivity test in the past 24 months in accordance with NFPA 72 (2010 edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 23 residents in the nursing facility.<br><br>Findings:<br><br>A review of the most recent facility fire safety document titled, "Annual Report," in the fire safety binder for the fire alarm system dated 05/17/22 revealed the report failed to describe a smoke detection sensitivity report had been completed.<br><br>During an interview on 10/05/22 at 1:50 PM, the Maintenance Director stated no record of a smoke detection sensitivity report was available. He/she stated the facility had a self-testing system but also indicated the contractor would provide a printout of the facilities sensitivity testing. The facility did not provide documentation of smoke detection sensitivity testing.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 70, 72 | K 345 | PLAN OF CORRECTION NFPA 72 2013 14.4.4.3.1 K345 Smoke detector sensitivity must be checked within one year after installation, then checked every alternate year thereafter. If the results indicate the device remains within its listed and marked sensitivity range, the length of time between tests is permitted to be extended to a maximum of 5 years.<br>1.) POTENTIAL FOR RESIDENT:<br>There was a potential to any resident<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>a. The smoke detector sensitivity testing was completed on 10/07/2022 by<br>b. There was a potential to any resident<br>3.) SYSTEMIC CHANGES<br>a. Smoke detector sensitivity testing will be done in accordance with NFPA<br>72 2013 14.4.4.3.1 in 2023<br>b. Our Fire Alarm System constantly monitors smoke detector to ensure<br>sensitivity levels are maintained in compliance with NFPA 72<br>c. Any device out of range automatically sends a trouble signal to vendor<br>and facility to ensure all detectors are in compliance.<br>d. Biennial testing with a written report by the vendor to facility will<br>begin subsequent to this report after | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315471 | A. BUILDING **01**<br>B. WING _____ | **10/06/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ST CATHERINE OF SIENA** | **7 RYERSON AVENUE**<br>**CALDWELL, NJ 07006** |

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|---|---|---|---|---|
| K 345 | Continued From page 6 | K 345 | October 2023<br>4.) MONITORING:<br>a. The report will be received by Dir of Maintenance, the results reported<br>Using Quality Indicators as the monitoring tool to ensure testing at<br>proper intervals<br>b. Annual testing in 2022 will be reported to the QAPI Steering Committee<br>on October 26,2022 and thereafter<br>c. Subsequent reporting through the safety committee to the quarterly QAPI<br>committee by the Dir of Maintenance<br>5.) IMPLEMENTATION:<br>OCTOBER 7, 2022<br>A Steering Committee of the QAPI is scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee for at least one year | |
| K 372<br>SS=F | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS. | K 372 | | 11/28/22 |

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|---|---|---|---|
| | 315471 | A. BUILDING **01**<br>B. WING _____ | **10/06/2022** |

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|---|---|---|---|---|
| K 372 | Continued From page 7<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review, observation, and interview, the facility failed to ensure that the smoke dampers had been maintained in accordance with NFPA 101 (2012 edition) section 8.5.5.4.2. to NFPA 105 (2010 edition) sections 6.5.7, 6.6.2 and 6.6.6. The problem can affect all 23 residents.<br><br>Findings include:<br><br>An observation of the facility smoke/fire walls on 10/05/22 located near bedroom #219 at 9:40 AM and at bedroom #214 at 10:15 AM revealed smoke dampers were present. A review of the facility inspection documents for the fire alarm system dated 05/17/22 indicated the facility had smoke dampers but did not indicate how many.<br><br>A review of the facility inspection report dated 05/17/22 revealed no smoke damper tests were completed. A review of the fire safety binder yielded no additional inspection reports indicating smoke dampers were maintained.<br><br>An interview with the Maintenance Director on 10/05/22 at 1:30 PM indicated he called the contractor, and no smoke damper tests were ever done. He/she indicated he/she has scheduled a time for the smoke damper inspection to take place after the survey. He/she acknowledged that no smoke damper test had been documented as completed since he/she has worked at the facility for the past 16 years.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 105 | K 372 | PLAN OF CORRECTION NFPA 101 (2012) Section 19.3.1.1.<br>NJAC 8:39-31.1¿, 31.2(e) Fire Door Inspection and Certification<br>A vendor was secured and contract signed to perform Dampers Inspection<br>1.) POTENTIAL FOR RESIDENT:<br>Potential to affect smoke zone<br>There was potential harm to any resident<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>Potential to affect smoke zone<br>a. There was a potential to affect other residents<br>3.) SYSTEMIC CHANGES<br>b. Fire Dampers are inspected, tested and in working order<br>4.) MONITORING:<br>a. Using Quality Indicators as the monitoring tool will ensure testing is done annually<br>b. Annual testing in 2022 will be reported to the QAPI Steering Committee on October 26, 2022 and thereafter<br>c. Subsequent reporting through the safety committee to the quarterly QAPI committee by the Dir of Maintenance<br>5.) IMPLEMENTATION:<br>OCTOBER 26, 2022<br>A Steering Committee of the QAPI is scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee for at least one year | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315471 | A. BUILDING **01**<br>B. WING _____ | **10/06/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ST CATHERINE OF SIENA** | **7 RYERSON AVENUE**<br>**CALDWELL, NJ 07006** |

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|---|---|---|---|---|
| K 918 | Continued From page 8 | K 918 | | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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 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.<br>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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by: | K 918 | | 11/28/22 |

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|---|---|---|---|
| | 315471 | A. BUILDING **01**<br>B. WING _____ | **10/06/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 918 | Continued From page 9<br>Based on observation, document review, and interview, the facility failed to ensure that the 300 KW (kilowatt) stand by diesel generator was load tested in accordance with NFPA 110 (2010 edition) section 8.3.4. and 8.4.5.9.1. This deficient practice had the potential to affect all 23 residents.<br><br>Findings include:<br><br>An observation of the 300 KW stand by diesel generator on 10/05/22 at 9:50 AM revealed the generator was positioned outdoors with the diesel fuel tank below the generator.<br><br>A review of the fire safety records from the generator book revealed a load bank test was not available. The facility also did not have information related to routine load testing at 30% or greater as indicated by review of the generator log over the past 12 months.<br><br>An interview with the Maintenance Director on 10/05/22 at 1:30 PM indicated the facility has never done a load bank test and the Maintenance Director has never heard of this requirement.<br><br>NJAC 8:39-21.2(e), 31.2(g)<br>NFPA 99, 110 | K 918 | PLAN OF CORRECTION CFR NFPA 101 110 K 918 Essential Electric System<br>Load Bank Test<br>The Generator Load Bank Test was completed on 10/19/2022<br>1.) POTENTIAL FOR RESIDENT:<br>There was potential to affect any resident<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>a. The Generator Load Bank Test was completed<br>b. There was potential to affect any other residents<br>3.) SYSTEMIC CHANGES<br>a. Load Bank Test will be done in accordance with NFPA 72 and was in compliance .<br>b. Every 36 month or more frequently if indicated testing with a written report by the vendor to facility will begin subsequent to this report.<br>It will be reviewed and a copy of the written report will be maintained by Dir of Maintenance<br>4.) MONITORING:<br>a. Testing will be done in conjunction with the already established PM to ensure testing at proper intervals and maintained on the generator log<br><br>b. Testing in October 2022 will be reported to the QAPI Steering Committee on October 26, 2022 and thereafter<br>c. Subsequent reporting through the safety committee to the 4th quarter | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315471 | A. BUILDING **01**<br>B. WING _____ | **10/06/2022** |

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| K 918 | Continued From page 10 | K 918 | QAPI committee<br>5.) IMPLEMENTATION:<br>OCTOBER 19, 2022<br>A Steering Committee of the QAPI is scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee for at least one year | |
| K 926 SS=F | Gas Equipment - Qualifications and Training<br>CFR(s): NFPA 101<br><br>Gas Equipment - Qualifications and Training of Personnel<br>Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.<br>11.5.2.1 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of training and interview with facility staff, the facility failed to ensure that it had provided safety training for staff who handle oxygen cylinders in the past 12 months in accordance with NFPA 99 (2012 edition) Section 11.5.2.1. This deficient practice had the potential to affect all 23 residents.<br><br>Findings include:<br><br>A review of the facility training documentation on 10/05/22 at 2:15 PM revealed no training had been provided in the past 12 months related to safety when handling oxygen cylinders for | K 926 | PLAN OF CORRECTION NFPA 101<br>K926 Gas Equipment □Qualifications and training of personnel<br>1.) POTENTIAL FOR RESIDENT:<br>a. There was potential affect to any resident<br>2.) POTENTIAL AFFECT ON OTHER RESIDENTS:<br>a. There was potential affect to any other resident.<br>The preferred method of oxygen delivery to any resident is the use of oxygen concentrators. This includes portable oxygen concentrators | 11/28/22 |

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| K 926 | Continued From page 11<br>relevant staff including nurse aides, nurses, and maintenance staff.<br><br>An interview with the facility Maintenance Director on 10/05/22 at 1:50 PM revealed the facility had not provided in-service training related to safety for staff handling oxygen cylinders.<br><br>NJAC 8:39-31.2(e)<br>NFPA 99 | K 926 | Education of staff to review the use and safety oxygen cylinders<br>3.) SYSTEMIC CHANGES:<br>a. Education on the use of oxygen and oxygen concentrators including the safe use, storage and transportation by a member of the safety committee<br>b. Annual In-services beginning 2022<br>4.) MONITORING:<br>a. Department Mangers will be responsible to ensure each staff member receives the required training<br>b. The Department Managers will provide as part of the QAPI report the in-services completed and compliance<br>5.) IMPLEMENTATION:<br>October 26, 2022.<br>A Steering Committee of the QAPI is scheduled for October 26, 2022 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee for at least one year | |

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 |
|---|---|---|
| 315471 Y1 | A. Building 01 - MAIN BUILDING 01<br>B. Wing Y2 | 1/9/2023 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST CATHERINE OF SIENA | 7 RYERSON AVENUE<br>CALDWELL, NJ 07006 |

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 | K0211 | 10/26/2022 | LSC | K0311 | 12/19/2022 | LSC | K0341 | 11/28/2022 |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | NFPA 101 | Completed | Reg. # | NFPA 101 | Completed | Reg. # | NFPA 101 | Completed |
| LSC | K0345 | 11/28/2022 | LSC | K0372 | 11/28/2022 | LSC | K0918 | 11/28/2022 |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | NFPA 101 | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | K0926 | 11/28/2022 | LSC | | | LSC | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | | LSC | | | LSC | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | | LSC | | | LSC | | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | | |
|---|---|---|
| 10/6/2022 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? | ☐ YES ☐ NO |