STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315239	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #s NJ 174969 STANDARD SURVEY: 9/23-9/26/24 CENSUS: 54 SAMPLE SIZE: 14+2 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure a.) a physician orders for administration was followed, route of administration was clarified (Resident 18), and b.) dosing was clarified for an NJ Ex Order 26.4(b)(1), prior to administration (Resident 44 and Resident #2) in accordance with professional standards of practice and facility policy. The deficient practice was identified for three (3) of seven (7) residents, administered by three (3) of five (5) nurses, observed during the medication administration observation, and was evidenced by the following:	F 658	1. Three (3) resident (residents #2, 18 and 44) were found to NJ Ex Order 26.4(b)(1) by the deficient practice outlined in the CMS 2567. After disclosure of deficient practice; the route of resident #18's NJ Ex Order 26.4(b)(1) order was updated to administration via NJ Ex Order 26.4(b)(1)) and resident #2's and resident #44's NJ Ex Order 26.4(b)(1) order was updated include an amount to apply 2. All residents have the potential to be	10/25/24

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

Electronically Signed | 10/11/2024

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F 658	Continued From page 1 Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.) On 9/25/24 at 7:41 AM, the surveyor observed Licensed Practical Nurse (LPN #1) prepare two (2) medications for Resident #18. The medications orders were: NJ Ex Order 26.4(b)(1) [redacted]) capsule, to be administered by mouth (PO) at 6:00 AM. The order was started on [redacted]	F 658	affected by the deficient practice outlined in the CMS 2567. 3. The Director of Nursing, Assistant Nurse Managers, Nurse Educator or their designee will provide all Registered Nurses (RN) and Licensed Practical Nurses (LPN) with education by the completion date, or before their next shift, on the Children's Specialized Hospital policy "MM - Medication Management (Policy & Procedure)". 4. Compliance for adhering to policy "MM - Medication Management (Policy & Procedure)" will be monitored by the Director of Nursing, Assistant Nurse Managers, Nurse Educator or their designee, in the form of direct observation and completion of an audit tool. The Director of Nursing, Assistant Nurse Managers, Nurse Educator or their designee will complete five (5) observations per week until 100% compliance has been maintained for four (4) consecutive weeks. Then five (5) observations per month until 100% compliance has been maintained for three (3) consecutive months. Audit reports will be submitted to the QAPI committee quarterly by the Director of Nursing or designee.	

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F 658		F 658		

Continued From page 2

NJ Ex Order 26.4(b)(1), to be administered PO twice daily (BID) at 6:00 AM and at 6:00 PM. The order was started on [redacted].

At that time, LPN #1 was observed removing both [redacted] from a unit dose package, opened the [redacted] and poured into a medication cup, drew approximately, NJ Ex Order 26.4(b)(1) then emptied the water into a medication cup, and opened the NJ Ex Order 26.4(b)(1) into [redacted] in the medication cup. LPN #1 [redacted] another [redacted] into a [redacted].

On 9/25/24 at 7:43 AM, the surveyor observed LPN #1 asked Resident #18 if they can administer the medication [redacted]. Resident #18 turned their head left and right twice.

LPN #1 attached an [redacted] to a [redacted] administered [redacted] through the [redacted] and was followed with a [redacted].

On 9/25/24 at 7:49 AM, during an interview with the surveyor, LPN #1 was asked why she administered [redacted] orders via [redacted] without a physician's order for another route and was the physician's order for PO appropriate for Resident #18. The LPN stated she would discuss with the medical team and the U.S. FOIA (b) (6).

The surveyor reviewed the medical record for Resident #18.

A review of the resident's electronic Medical Record reflected Resident #18 was a long-term care resident with diagnoses that included [redacted], NJ Ex Order 26.4(b)(1), [redacted].

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F 658	Continued From page 3 NJ Ex Order 26.4(b)(1)) and NJ Ex Orde A review of the quarterly Minimum Data Set, an assessment tool, dated NJ Ex Order 26 reflected that Resident #18, sometimes NJ Ex Order 26.4(b)(1) and sometimes was NJ Ex Order 26.4(b)(1). The Brief Interview for Mental Status (BIMS; an evaluation for aspects of NJ Exec Order 26.4b was NJ Ex nd the resident had NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Further review of the qMDS reflected the resident had a NJ Ex Order 26.4(b)(1) problem that involved NJ Ex Order 26.4(b)(1) from the NJ Ex Order 2 when NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) after NJ Ex Order 26 A review of Resident #18's comprehensive person-centered care plan reflected Resident #18 had NJ Ex Order 26.4(b)(1) and the interventions included that the resident was in NJ Ex Order 26.4(b)(1) again, had a NJ Ex Order 26.4(b)(1) that will not efficiently NJ Ex Order 26.4(b)(1), and safely manage NJ Ex Order 26.4(b)(1) and " NJ Ex Order 26.4(b)(". A review of the physician's progress note dated NJ Ex Order 26.4 , included that all medications were given through NJ Ex Order 26.4(b)(1) button except for NJ Ex Order 26.4(b)(1) which was taken orally NJ Ex Order 26.4(b)(1)). The resident received NJ Ex Order 26.4(b)(1) during daytime with NJ Ex Order 26.4(b)(1). 2. On 9/25/24 at 9:23 AM, the surveyor observed the US FOIA (b)(6) prepare medications for Resident #44 that included NJ Ex Order 26.4(b)(1)), One (1) application every three (3) hours (8 applications per day).	F 658		

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F 658		F 658		

Continued From page 4

On 9/25/24 at 9:42 AM, the surveyor observed the [US FOIA] administer the NJ Ex Order 26.4(b)(1) [redacted] in varying length in the [NJ Ex] [redacted]

A review of the Resident #44's physician's order for the NJ Ex Order 26.4(b)(1) [redacted] revealed that the order did not indicate a length of measurement to reflect the dose for each administration. The order was started on [NJ Ex Order 26] [redacted]

3. On 9/25/24 at 11:36 AM, the surveyor observed LPN #2 prepare medications for Resident #2 that included NJ Ex Order 26.4(b)(1) [redacted], One (1) application every two (2) hours (12 applications per day).

At that time, LPN #2 stated that Resident #2's family member administered the medication to the resident and had been doing so for years. The surveyor observed LPN #2 in the room, near the resident and resident representative during the medication administration.

A review of the Resident #2's physician's order for the NJ Ex Order 26.4(b)(1) [redacted] revealed that the order did not indicate a [NJ Ex Order 2] [redacted] of measurement to reflect the dose for each administration. The order was started on [NJ Ex Order 26] [redacted]

On 9/25/24 at 12:35 PM, in the presence of the survey team, the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6) [redacted], the surveyor discussed the concerns that occurred the medication pass for Resident #18

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F 658	Continued From page 5 wherein the physician order for [NJ Ex Order 26.] "to be administered [NJ Ex Order 26] was administered [NJ Ex Order 26.4(b)(1] to Resident #18 without clarification with the physician. The concern with Resident #44 and Resident #2 NJ Ex Order 26.4b1 order that did not include dosing and was also not clarified prior to administration. On 9/25/24 at 12:44 PM, the [U.S. FOIA] stated that Resident #18 was able to take the medication by [NJ Ex Order 2] and [NJ Ex Order 26.4(b)(1], and acknowledged the orders should have been clarified. A review of the provided facility policy, Medication Management, dated 1/9/24 included the following under procedures: B. Ordering and Transcribing 4. Orders for medication and fluids mist contain name and dosage, frequency, route of administration and an indication for use ... D. Administration 6. Just prior to administration, compares the medication to the order and adheres to the "5 rights of medication administration" rules: a. right patient b. right medication c. right dosage d. right time e. right route NJAC 8:39-27.1(a), 29.2(d)	F 658		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		9/27/24

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F 812	Continued From page 6 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods (PHF) in a manner to prevent food borne illness. This deficient practice was evidenced by the following: On 9/24/24 at 10:30 AM, in the presence of the U.S. FOIA (b) (6)), the surveyor observed the following: In the walk-in refrigerator, the surveyor observed the following: -a 1/4 size steam table pan which contained green beans in a liquid with a sticker on the top of the container that indicated a use by date of 9/20/24, -an opened, half used package of sliced salami with no use by date on it, - an opened, half used package of un-sliced beef bacon with no use by date on it,	F 812	1. At the time of survey there were three (3) residents who received food prepared or stored in the dietary department and six (6) who received formula prepared in dietary department. These residents have the potential to be affected by the deficient practice outlined in CMS-2567. 2. All current residents who may advance in their diets and any future residents who require nutrition and/or storage of food have the potential to be affected by this deficient practice. All residents who require nutrition and/or storage of food have the potential to be affected by this deficient practice. 3. On the day of finding, the following actions were taken: a. The 1/4 size steam table pan which contained green beans in a liquid with a	

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F 812	Continued From page 7 In the reach in cheese refrigerator, the surveyor observed the following: -an opened package of un-sliced provolone with an open date of 9/8/24, - an opened package of shredded mozzarella with an open date of 9/15/24, -an opened package of sliced yellow cheese with an open date of 9/16/24, In the dry storage room, the surveyor observed an opened package of mixed grain cereal with an open date of 2/4/24. The U.S. FOIA indicated that the PHF should been stored appropriately and thrown out according the facility policy, between five and seven days. The U.S. FOIA also stated that all items should have use by dates on them. On 9/24/24 at 11:16 AM, the surveyor discussed the above concerns with the U.S. FOIA (b) (6) A review of the undated policy titled, Disposition of Potentially Hazardous Foods which revealed that all potentially hazardous foods that are prepared in the hospital will have a shelf life of five days, all other potentially hazardous food that have been put into production will have a shelf life of seven days, and pre-prepared items should be discarded after seven days of package being opened form its original package. The policy also indicated that the products are to be dated after opening. NJAC 8:39-17.2(g)	F 812	sticker on the top of the container that indicated a use by date of 9/20/24 was discarded. b. An opened, half used package of sliced salami with no use by date on it was discarded. c. an opened, half used package of un-sliced beef bacon with no use by date on it was discarded d. An opened package of un-sliced provolone with an open date of 9/8/24 was discarded e. An opened package of shredded mozzarella with an open date of 9/15/24 was discarded f. An opened package of sliced yellow cheese with an open date of 9/16/24 was discarded g. An opened package of mixed grain cereal with an open date of 2/4/24 was discarded A Food and Nutrition Team Meeting was held to review all findings from the survey tour and the Assistant Dietary Director provided an in-service on the label, dating and storage of food. Compliance with Dietary Policies and Procedures will be validated through the comprehensive checklist which is completed daily by the Dietary Manager, Food Services Supervisor or their designee. The comprehensive check included open items, labeling, dating and expirations. 4. The Food Service Manager or their designee will report the checklist findings	

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F 812	Continued From page 8	F 812	to the LNHA weekly. The results of the checklist will be reported to the QAPI Committee on a quarterly basis until there are two consecutive quarters of 100% compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315239	A. Building B. Wing	11/26/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 10/25/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 09/27/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 09/25/2024 and 09/26/2024. Children's Specialized Hospital Mountainside was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/25/2024 and 09/26/20204. Childrens Specialized Hospital of Mountainside and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Childrens Specialized Hospital of Mountainside is a seven (2) story facility, Type II Protected building.	K 000		
K 132 SS=F	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for	K 132		10/11/24

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

Electronically Signed | 10/11/2024

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CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	**150 NEW PROVIDENCE ROAD** **MOUNTAINSIDE, NJ 07092**

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K 132	Continued From page 1 four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/26/2024 in the presence of the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)], it was determined that the facility failed to ensure that sections of health care facilities classified as other occupancies were separated from areas of healthcare occupancies by construction having two hour fire resistance rating in accordance with NFPA 101:2012 Edition, Section 19.1.3.3, 42 CFR 482.41, and 42 CFR 485.623. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:23 AM, revealed that the 2-hr separation from the 1100 corridor into the 1103 corridor contained a penetration approximately 5-inch x 6-inch wide. Several other unprotected penetrations were observed for the passage of electrical conduit and other wires. An observation at 10:48 AM, revealed that the 2-hr separation near multi-purpose room 1046 contained an unprotected penetration through a 2-inch pipe and other unprotected penetration for the passage of wires. In interviews at the time of the observations, the [U.S. FO] confirmed the observations. The facility's [U.S. FOIA (b) (6)] was notified of the deficient practice at the Life Safety Code exit	K 132	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. The Facilities Management Leadership team will receive education from the AVP & Administrator on CMS-2786R FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE by the completion date, or before their next shift. The penetration was filled with fire caulk. 4. Compliance with mainlining the integrity of smoke barrier partitions will be audited by the Director of Facilities Management or their designee the form of direct observation. There will be five (5) observations per week until 100% compliance, then five (5) observations per month until 100% compliance for 3 consecutive months. Audit reports will be submitted to the QAPI committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315239	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	**150 NEW PROVIDENCE ROAD** **MOUNTAINSIDE, NJ 07092**

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K 132	Continued From page 2 conference at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 132		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/26/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that the exit discharge near the outside playground area was provided with a level walking surface in accordance with NFPA 101:2012 Edition, Sections 7.7, 7.1.7 and 19.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:10 AM, revealed an approximately 2-ft x 2-ft section of previously patched concrete in the exit discharge that posed a tripping hazard. The patch was cracked down the middle with one corner missing concrete and the other had loose pieces filling the corner. In an interview at the time, the U.S. FOIA [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the	K 271	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. Interim life safety initiated. The Facilities Management Leadership team will receive education from the AVP & Administrator on CMS-2786R "FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE" by the completion date, or before their next shift. Children's Specialized Hospital has repaired the broken and patched concrete. 4. The Director of Facilities Management or their designee will report to the QAPI Committee quarterly the status of the repair until 100% compliance	12/4/24

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	315239	A. BUILDING **01** B. WING _____	**09/26/2024**

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K 271	Continued From page 3 deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 271		
K 342 SS=F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/26/2024 in the presence of the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that the operation of smoke detectors would automatically accomplish any control function to be performed by that device in accordance with NFPA 101:2012 Edition, Sections 9.6.2, 9.6.5, 19.3.4.4 and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:33 PM, revealed that LTC storage room B 521 contained two smoke	K 342	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. The Facilities Management Leadership team will receive education from the AVP & Administrator on CMS-2786R “FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE” by the completion date, or before their next shift. The tape was removed from the smoke detectors by Facilities Maintenance Staff.	10/2/24

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	315239	A. BUILDING **01** B. WING _____	**09/26/2024**

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CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	**150 NEW PROVIDENCE ROAD** **MOUNTAINSIDE, NJ 07092**

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K 342	Continued From page 4 detectors with blue painter's tape covering their sensing chambers. In an interview at the time, the [U.S. FOIA] and [U.S. FOIA] confirmed the observations. N.J.A.C 8:39-31.2(e) NFPA 72	K 342	4. Compliance with operation of smoke detectors will be audited by the Director of Facilities Management or their designee the form of direct observation. There will be five (5) observations per week until 100% compliance, then five (5) observations per month until 100% compliance for 3 consecutive months. Audit reports will be submitted to the QAPI committee quarterly.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other	K 363		10/9/24

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	315239	A. BUILDING **01** B. WING _____	**09/26/2024**

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K 363	Continued From page 5 materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/26/2024 in the presence of the U.S. FOIA (b) (6) [redacted] it was determined that the facility failed to ensure that there was no impediment to the closing of corridor doors in accordance with NFPA 19.3.6.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:45 AM, revealed that the resident laundry room door in corridor 1108 was unable to close because a washing machine had been placed in the required space the door needed to close. In an interview at the time, the U.S. FOIA [redacted] confirmed the observation after attempting and being unable to close the door. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 363	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice 3. The Facilities Management Leadership team will receive education from the AVP & Administrator on CMS-2786R "FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE" by the completion date, or before their next shift. The washing machine was re-positioned so that the door now closes properly. 4. Compliance with no impediment to the closing of corridor doors will be audited by the Director of Facilities Management or their designee the form of direct observation. There will be five (5) observations per week until 100% compliance, then five (5) observations per month until 100% compliance for 3 consecutive months. Audit reports will be submitted to the QAPI committee	

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	315239	A. BUILDING **01** B. WING _____	**09/26/2024**

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K 363	Continued From page 6	K 363	quarterly.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/26/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that resident bathrooms were provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2, 9.2.1 and NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:23 AM, revealed the ventilation in room 100 was not functioning when tested by the U.S. FOI[redacted] An observation at 11:30 AM, revealed the ventilation in room 101 was not functioning when tested by the U.S. FOI[redacted] In interviews at the time, the U.S. FO[redacted] confirmed the observations.	K 521	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. The Facilities Management Leadership team will receive education from the AVP & Administrator on CMS-2786R "FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE" by the completion date, or before their next shift. Children's Specialized Hospital has contracted with Perfect Temp who has completed the repair to the ventilation in rooms 100 and 101. 4. Compliance of facility's ventilation systems for bathroom exhaust systems will be monitored by the Director of Facilities Management, or designee, in the form of direct observation and	12/13/24

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K 521	Continued From page 7 The U.S. FO asked facility maintenance personnel if there was a switch somewhere that could turn the ventilation on. Facility maintenance personnel replied that their HVAC contractor was already contacted regarding the ventilation, and they are working on getting it repaired. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 90 A	K 521	completion of the audit tool. There will be five (5) observations per week until 100% compliance has been maintained for four (4) consecutive weeks. Then five (5) observations per month until 100% compliance has been maintained for three (3) consecutive months. Audit reports will be submitted to the QAPI committee quarterly by the Director of Facilities Management or designee.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 09/25/2024 and 09/26/2024 in the presence of the U.S. FOIA (b) (6) it was determined that the facility failed to ensure that fire/smoke door assemblies were maintained in accordance	K 761	1. No residents were found to have been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice.	12/24/24

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	315239	A. BUILDING **01** B. WING _____	**09/26/2024**

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CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	**150 NEW PROVIDENCE ROAD** **MOUNTAINSIDE, NJ 07092**

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K 761	Continued From page 8 with NFPA 101:2012 Edition, Sections 7.2.1.5.10.1, 7.2.1.5.11, 7.2.1.15, and NFPA 80 Standard for Fire Doors and Other Opening Protectives. This deficient practice had the potential to affect all residents and was evidence by the following: A documentation review on 09/26/2024 revealed that of the 19 tested fire/smoke door assemblies, 12 doors were documented as failing the annual test that was conducted in March of 2024. In an interview at 2:00 PM, the [redacted] confirmed that the fire/smoke door assemblies that failed the inspections nearly 6 months ago, had not been repaired. The [redacted] stated that they were in the process of getting the doors fixed and deficiencies cleared. No further documentation was provided regarding the fire/smoke door assemblies. The facility's [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 09/26/2024 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 761	3. The Facilities Management Leadership team will receive education from the AVP & Administrator on CMS-2786R FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE by the completion date, or before their next shift. Children's Specialized Hospital has contacted with JGlaski Enterprise Inc. to complete the required remediation. 4. Compliance with fire/smoke door assemblies will be audited by the Director of Facilities Management or their designee the form of direct observation. There will be five (5) observations per week until 100% compliance, then five (5) observations per month until 100% compliance for 3 consecutive months. Audit reports will be submitted to the QAPI committee quarterly.	
K 928 SS=F	Gas Equipment - Labeling Equipment and Cylind CFR(s): NFPA 101 Gas Equipment - Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL." Flowmeters, pressure reducing regulators, and	K 928		10/2/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 928	Continued From page 9 oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/26/2024 in the presence of the U.S. FOIA (b) (6)), U.S. FOIA (b) (6) U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that when empty and full oxygen cylinders were stored in the same enclosure, empty cylinders were marked to avoid confusion and delay in accordance with NFPA 99:2010 Edition, Sections 11.6.5.2 and 11.6.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:55 AM, revealed that oxygen storage room 1024 contained both full and empty oxygen cylinders. There was no signage or markings indicating which cylinders were filled or empty. In interviews at the time, the U.S. FOI U.S. FOIA (U.S. FOIA and U.S. FOIA (confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit	K 928	1. No residents were found to have been affected by the deficient practice outlined in the CMS-2567. 2. All residents that receive oxygen therapy have the potential to be affected by this deficient practice. 3. Signs were created and posted in the oxygen storage room to distinguish between full and empty oxygen cylinders. 4. Compliance of the proper labeling of stored oxygen cylinders will be monitored by the Respiratory Therapy Manager or their designee in the form of audits. There will be five (5) observations per month until 100% compliance 3 consecutive months. Audit reports will be submitted to the QAPI committee quarterly.	

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K 928	Continued From page 10 conference on at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K 928		

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
315239 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092

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 K0132	10/11/2024	LSC K0271	12/04/2024	LSC K0342	10/02/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	10/09/2024	LSC K0521	12/13/2024	LSC K0761	12/24/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0928	10/02/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
9/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO