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	25A000	A. BUILDING: _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAKER PLACE	685 S. BREWSTER ROAD VINELAND, NJ 08360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Census: 38 Sample Size: 8 TYPE OF SURVEY: Standard Survey of 39 residential units The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 511	8:36-5.5(a) General Requirements (a) The facility or program shall develop and implement written job descriptions to ensure that all personnel are assigned duties based upon their education, training, and competencies and in accordance with their job descriptions. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to ensure all employees were provided a job description. This deficient practice was observed	A 511		

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

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A 511	Continued From page 1 in 1 of 5 employee files, Home Health Aide #10. Findings included: The surveyor reviewed the employee file for Home Health Aide (HHA) #10 that revealed the employee had not been provided with a job description at the time of hire on [redacted NJ Ex Order 26.4(b)(1)]. On 08/04/2021 at 3:15 PM, the Administrative Coordinator told the surveyor in an interview that they were unable to find a job description for HHA #10. A review of the facility policy, titled, "Job Descriptions- Employees and Volunteers" dated 10/2018, revealed, in part, "At the time of hire, each individual will be provided a Job Description specific to the role they are accepting. Once reviewed, they will date and sign a copy to be placed in their Personnel Folder ..."	A 511		
A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment;	A 517		

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A 517	Continued From page 2 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review it was determined the facility failed to ensure all staff received orientation at the time of employment and at least annually for 2 of 5 employee files reviewed, Housekeeper #4 and Home Health Aide #10. This deficient practice had the potential to affect all residents.	A 517		

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A 517	Continued From page 3 Findings included: 1. On 08/03/2021 at 8:20 AM, Housekeeper #4 was observed and was not wearing a face mask while vacuuming the hallway. The housekeeper told the surveyor that he/she did not know to wear a mask. Housekeeper #4 said he/she had been working at the facility for approximately [NJ Ex Order 26.4(b)(1)] and that was not covered during orientation. Housekeeper #4's date of hire was [NJ Ex Order 26.4(b)(1)]. On 08/03/2021 at 2:40 PM, Administrative Coordinator (AC) #9 told the surveyor that Housekeeper #4 may not have had any orientation yet. On 08/03/2021, a review of employee files for Housekeeper #4 and Home Health Aide (HHA) #10 revealed neither had received orientation at the time of employment. HHA #10 had not received annual in-service education. HHA #10 had a date of hire of [NJ Ex Order 26.4(b)(1)]. On 08/04/2021 at 8:00 AM, Housekeeper #4 stated he/she had been oriented to the building by the Maintenance Director and was given a packet of information but was unsure what was included in the packet. On 08/04/2021 at 3:15 PM, AC #9 told the surveyor in an interview that he/she was unable to locate any orientation records for Housekeeper #4 or HHA #10. On 08/04/2021 at 5:00 PM, AC #9 told the surveyor in an interview that HHA #10 did not have access to annual in-services because they was completed online and HHA #10 needed to call the Information Technology department to	A 517		

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A 517	Continued From page 4 have his/her login information reset. The facility policy titled "Staff Orientation and Training" dated 9/1/2016, revealed, in part, "A standardized Orientation Checklist is completed for new employees and can be found in the personnel files of employees," and "Employee education and re-education are held on a regularly scheduled basis to ensure the provision of high levels of resident care and customer service."	A 517		
A 577	8:36-5.11(a)(2) General Requirements (a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public: 2. A copy of the last annual licensure inspection survey report and the list of deficiencies from any valid complaint investigation during the past 12 months; This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to post a notice alerting residents and staff of the availability of the last annual licensure inspection survey report and the list of deficiencies from any complaint investigation during the last 12 months. This deficient practice had the potential to affect all residents. Findings included:	A 577		

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A 577	Continued From page 5 On 08/03/2021 at 9:20 AM, the surveyor observed that there was no notice posted of the availability of a copy of the most recent annual licensure inspection survey report and the list of deficiencies from any complaint investigation during the last 12 months. On 08/03/2021 at 4:04 PM, Resident #5 told the surveyor in an interview that he/she did not know where the last annual licensure inspection survey was posted. On 08/04/2021 at 9:15 AM, Resident #4 told the surveyor in an interview that he/she did not know where the last annual licensure inspection survey was posted. On 08/04/2021 at 10:18 AM, the Director of Nursing told the surveyor in an interview that the annual licensure inspection was in a book at the front desk but there was no signage posted directing residents and/or visitors as to how to access this information.	A 577		
A 581	8:36-5.11(a)(4) General Requirements (a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public: 4. Business hours of the facility; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	A 581		

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A 581	Continued From page 6 determined that the facility failed to post a notice of the business hours of the facility. The deficient practice had the potential to affect all residents. Findings included: On 08/03/2021 at 9:20 AM, the surveyor observed that a notice of the facility business hours was not posted. On 08/04/2021 at 10:18 AM, during an interview, the Director of Nursing (DON) confirmed that the business hours of the facility were not posted. The DON was unaware of a policy requiring business hours to be posted.	A 581		
A 585	8:36-5.11(a)(6) General Requirements (a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public: 6. The toll-free hot line number of the Department; telephone numbers of county agencies and of the State of New Jersey Office of the Ombudsman; This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to post the toll-free hotline number of the Department and telephone numbers of county agencies and of the State of New Jersey Office of the Ombudsman. This deficient practice had the potential to affect all residents.	A 585		

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A 585	Continued From page 7 Findings included: On 08/03/2021 at 9:20 AM, the surveyor observed that the toll-free hotline number of the Department of Health and the telephone numbers of county agencies and of the State of New Jersey Office of the Ombudsman were not posted. On 08/03/2021 at 4:04 PM, Resident #5 told the surveyor told the surveyor in an interview that the resident did not know where the numbers to the hotline of the Department, county agencies, or the office of the Ombudsman were posted. On 08/04/2021 at 9:15 AM, Resident #4 told the surveyor in an interview that the resident did not know where the numbers to the hotline of the Department, county agencies, or the office of the Ombudsman were posted. On 08/04/2021 at 10:18 AM, the Director of Nursing told the surveyor in an interview that the toll-free hotline number of the Department and telephone numbers of county agencies and of the State of New Jersey Office of the Ombudsman were not posted.	A 585		
A 783	8:36-7.5(e) Resident Assessments and Care Plans (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that	A 783		

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A 783	Continued From page 8	A 783		

the facility or program is capable of providing.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined that the facility failed to ensure that the residents were medically on an annual basis to ensure that the residents do not have needs which exceed the care that the facility is capable of providing. This affected 3 of 6 residents, Residents #1, #2, and #3.
Findings included:

1. Resident #2 was admitted to the facility on NJ Ex Order 26.4(b)(1). Upon admission, the physician examined the resident and documented on a "Physician Plan of Care" form, in part, NJ Ex Order 26.4b1 [redacted] " There was no further indication in the record that Resident #2 had been reevaluated on an annual basis to ensure the resident continued to be appropriate for this level of care.

On 08/04/2021 at 11:00 AM, the Director of Nursing (DON) stated Resident #2 did not have annual certifications.

2. Resident #1 was admitted to the facility on NJ Ex Order 26.4(b)(1). Upon admission, the physician examined the resident and documented on a "Physician Plan of Care" form, in part, NJ Ex Order 26.4b1 [redacted] " There was no further indication in the

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A 783	Continued From page 9 record that Resident #1 had been reevaluated on an annual basis to ensure they continued to be appropriate for this level of care. On 08/04/2021 at 11:00 AM, the Director of Nursing (DON) stated Resident #1 did not have annual certifications. 3. Resident #3 was admitted to the facility on [redacted]. A review of the resident's record revealed there was no annual evaluation conducted to ensure the resident did not have needs which exceeded the care that the facility was capable of providing. On 08/04/2021 at 11:00 AM, the Director of Nursing (DON) stated Resident #3 did not have annual certification. On 08/04/2021 at 5:00 PM, the DON stated the facility did not have a policy regarding completing annual certifications that resident care needs did not exceed those which could be met in an assisted living facility.	A 783		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.	A 891		

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A 891	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility document and policy reviews and New Jersey Administrative Code (NJAC) 8:24, it was determined the facility: 1. Failed to ensure non-food contact surfaces of equipment were kept free from dust, food residue, and other debris; 2. Failed to ensure refrigerator temperatures were recorded; 3. Failed to ensure tray line food temperatures were recorded; and 4. Failed to ensure the sanitizer concentration level in the 3-compartment sink was checked and contained the proper concentration of sanitizing solution. 5. Facility failed to ensure opened food products were dated prior to storing This deficient practice has the potential to impact all residents. Findings included: Reference: NJAC 8:24-4.6(c) requires, "Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 1. On 08/03/2021 at 8:45 AM, the surveyor observed dust and food splatter on the ceiling above the sink in the food preparation area. On 08/03/2021 at 12:00 PM, the surveyor observed food splatter on the wall behind the	A 891		

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A 891	Continued From page 11	A 891		

toasters.

On 08/03/2021 at 2:30 PM, the surveyor observed a build-up of debris on the wall behind the dish machine, and dust build-up on the wall of the dish room.

On 08/04/2021 at 8:30 AM, the surveyor observed crumbs and melted ice cream on the floor of both freezers. Crumbs and food build-up were also observed on the floor of refrigerator #4.

On 08/04/2021 at 8:45 AM, the Food Service Director (FSD) told the surveyor that deep cleaning was completed in the kitchen one time per week. The FSD confirmed the dust and food splatter on the ceiling above the sink in the food preparation area. The FSD told the surveyor that they had not cleaned the ceiling with a duster. The FSD observed the food splatter on the wall behind the toaster. The FSD stated the chemicals they have do not work properly to clean that area.

On 08/04/2021 at 9:00 AM, the FSD observed the build-up of debris on the wall behind the dish machine and dust build-up on the wall of the dish room. The FSD told the surveyor that they did not notice the walls needed to be cleaned in the dish room. The FSD observed the crumbs and melted ice cream in the freezers and crumbs and food build-up in refrigerator #4.

On 08/04/2021 at 1:45 PM, the FSD told the surveyor that the cleaning schedule and checklist was thrown away each week after completion. The FSD was not sure where the past three days cleaning schedule was located.

A review of the facility record titled, "Daily, Weekly, Bi-Monthly Kitchen Cleaning Checklist"

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dated 08/04/2021, revealed, in part, the following tasks were to be completed, "Weekly (or more as needed)": inside freezer - complete wipe-down including shelves; inside refrigerator - complete wipe-down including shelves; the following task was to be completed bi-monthly: wash wall behind the dish machine. The form indicated, "Date when completed and keep on file" and included space to record Sunday through Saturday. The tasks had not been checked off as completed.

A review of the facility policy, titled, "Kitchen Sanitation, Equipment Maintenance and Safety" dated 04/17/2017, revealed, in part, "Freezers, refrigerators ...should be cleaned on a regular schedule," and, "Schedules for routine and deep cleaning should be maintained and followed."

2. On 08/03/2021 at 9:00 AM, the Chef stated he/she was not sure where the temperature logs for the refrigerators were located.

On 08/03/2021 at 11:45 AM, the surveyor observed that the kitchen appliance temperature log had not been filled out since 07/16/2021.

On 08/03/2021 at 2:05 PM, the Chef told the surveyor that the Food Service Director (FSD) usually handled the refrigerator temperature logs. In his absence, the Chef said it would be his/her responsibility. The Chef stated refrigerator temperatures should be checked daily and written down. On 08/04/2021 at 8:30 AM, the FSD confirmed the facility stopped recording temperatures around 07/17/2021.

The facility policy titled, "Kitchen Appliance Temperature Logs" dated "7-14" revealed, in part, "Appliance temperatures must be monitored daily

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A 891	Continued From page 13	A 891		

and recorded on the Kitchen Appliance Temperature Log."

3. On 08/03/2021 at 11:45 AM, the surveyor observed that the food temperature record had not been filled out since 07/16/2021.

On 08/04/2021 at 8:30 AM, the Food Service Director confirmed that the facility stopped recording food temperatures around 07/17/2021.

The facility policy titled, "Minimum Cooking Temperatures" dated "7-18" revealed, in part, "A Food Temperature Log is used to record the food temperatures ... Record the temperature on the food temperature log immediately after taking the temperature."

Reference: Ecolab publication, located at www.ecolab.com, indicated, "Oasis 146 is an effective sanitizer against Escherichia coli, Staphylococcus aureas, Campylobactor jejuni, Escherichia coli 0157:H7, Klebsiella pneumoniae, Listeria monocytogenes, Salmonella choleraesuis, Shigella sonnei, Yersinia enterocolitica and Enterobacter sakazakii on food contact surfaces when used at 0.35 oz- 0.68 oz per gallon of 500 ppm hard water (200 ppm to 400 ppm active quat).

4. On 08/03/2021 at 11:45 AM, the Chef told the surveyor that he/she was not aware of the process for monitoring sanitizer in the 3-compartment sink. The Chef stated the Food Service Director (FSD) was handling that. The Chef tested the sanitizer solution in the 3-compartment sink. It was found to have no sanitizer. The Chef stated they would like the sanitizer to be at least 200 parts per million. The Chef refilled the sink and tested the solution. It

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A 891	Continued From page 14 was found to have 200 parts per million of Oasis Multi-Quat sanitizer. On the Kitchen Appliance Temperature log, there was a sanitation section that included "Quaternary Oasis 146 Range 200-400 ppm." The sanitation levels had not been recorded since 07/16/2021. The facility policy titled, "Cleaning and Sanitizing," dated "7-11," revealed, in part, "A Sanitizer is only effective when you have proper water temperature and correct concentration of sanitizer ...Replace the water and sanitizing solution if the concentration level falls below 200 ppm ..." Reference: N.J.A.C. 8:24-3.1 Characteristics Food shall be safe and unadulterated. 5. On 08/03/2021 at 8:45 AM, waffles, peaches, cake, chicken salad, and pudding were observed in the kitchen refrigerator without labels indicating dates opened/stored. There was no date these items were repackaged, "best by" date or expiration date. Items were opened, not dated and not in manufacturer packaging. On 08/04/2021 at 8:30 AM, a bowl of washed lettuce and six containers of salad dressing were observed in the refrigerator without labels indicating dates opened/stored. There was no expiration date on the salad dressing. The Food Service Director (FSD) stated if food was opened in the refrigerator, it was supposed to be labeled. The facility policy titled, "Leftovers and Prepared Food," dated 4/17/2017, revealed, in part, "prepared foods must be stored in appropriate container with an airtight lid or cellophane, and labeled with the type of food, date and use by date."	A 891		

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	25A000	A. BUILDING: _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 891	Continued From page 15 The facility policy titled, "Storage of Products" dated 4/17/2017, revealed, in part, "Once opened, items should be dated and sealed/covered appropriately for storage."	A 891		
A 901	8:36-10.5(c)(4) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 4. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus shall be posted in a conspicuous place in residents' area, and/or a copy of the menu shall be provided to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with changes or substitutes, shall be kept on file in the facility for at least 30 days; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to: 1. Ensure changes in the menu were recorded and kept on file in the facility for at least 30 days and 2. Ensure menus with portion sizes were posted in the food preparation area. This deficient practice had the potential to impact	A 901		

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A 901	Continued From page 16 all residents. Findings included: 1. On 08/03/2021 at 12:15 PM, the Chef was observed serving potato chips as a side with lunch. The menu identified "lima bean salad" as the side dish for this meal on this day. The Chef told the surveyor that the lima beans had not been received so they made a substitution. On 08/03/2021 at 2:15 PM, the Chef told the surveyor they were not sure if the facility had a substitution log. On 08/04/2021 at 8:15 AM, the Food Service Director (FSD) told the surveyor the Chef did not make the seafood chowder which was to be served with lunch that day and they were not sure why. The FSD told the surveyor that if the menu is adjusted, it should be written in the book. The FSD also reported that they were not aware of the lima bean salad substitution and the substitution form had not been filled out. On 08/04/2021 at 1:50 PM, the FSD stated there was no substitution log kept by the facility. A review of the facility policy titled, "Menu Substitution Record," undated, identified, in part, "Any deviation of the menu must be recorded on the Daily Food Production/ Substitution/ Temperature Log form." A review of the facility policy titled, "Standardized Menus and Meal Planning," dated 4/17/2017, required, in part, "Records of substitutions and meals-as-served will be maintained as required by State Regulations."	A 901		

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A 901	Continued From page 17 The surveyor reviewed the facility documents titled, "Record of Food Substitution" and "Daily Food Production/Substitution Log/Temperature Log," which revealed the substitution of lima bean salad and seafood chowder had not been recorded. 2. On 08/03/2021 at 2:15 PM, a review of the monthly menu in the food preparation area revealed there were no serving sizes listed. The Chef told the surveyor that the facility served 4 ounces of protein with meals. On 08/04/2021 at 1:00 PM, the Food Service Director (FSD) told the surveyor that the facility used "standard serving sizes." The menus however did not contain portion sizes and there were no calibrated serving utensils to provide a specific serving size. On 08/04/2021 at 1:50 PM, the FSD confirmed that there were no portion sizes listed on the facility menu. A review of the facility policy titled, "Portion Control," undated revealed, in part, "Each community has a copy of the current menu and recipes that displays portion sizes."	A 901		
A1041	8:36-14.3(a) Emergency Services and Procedures (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff,	A1041		

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A1041	Continued From page 18 and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills. This REQUIREMENT is not met as evidenced by: Based on interview and policy and document review it was determined that the facility had not performed emergency drills during 11 of 12 months reviewed for emergency drills. This deficient practice had the potential to affect all residents. Findings included: On 07/28/2021, while reviewing facility documentation, the surveyor identified that a fire drill had only been conducted one time on first shift. This was the only recorded fire drill for 12 months. On 08/04/2021 at 1:50 PM, the Maintenance Director told the surveyor during interview that he had only been at the facility for about [redacted] and there was no documentation of any fire drills except on 07/28/2021 on first shift. The facility policy, titled, "Fire Drills," dated 2019, revealed in part; "Fire drills will be conducted by Executive Director (ED), Nurse or designated alternative at least quarterly for each shift."	A1041		

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A1119	8:36-16.12(a) Physical Plant (a) Each assisted living facility shall provide at least one non-commercial washer and dryer to be used exclusively for residents' personal items. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide residents with a non-commercial washer and dryer to be used exclusively for resident's personal items. This deficient practice had the potential to affect all residents. Findings included: During an observation on 08/03/2021 at 11:02 AM with the Maintenance Director, the laundry room was observed with 4 commercial washers and 4 commercial dryers. During an interview on 08/03/2021 at 11:03 AM, the Maintenance Director indicated the facility only had commercial washers and dryers for resident use. The Maintenance Director further revealed all resident's laundry was done by staff. There was no policy related to residents being provided a non-commercial washer and dryer for the residents' exclusive use on their personal items.	A1119		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to	A1249		

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A1249	Continued From page 20 ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, document review, and facility policy review, it was determined the facility failed to ensure the building was kept free from fire hazards by failing to ensure the kitchen stove was not too close to the counter-top next to the stove to burn it. It was also determined that the facility failed to secure oxygen cylinders for 2 of 2 rooms (Room [redacted] and Room [redacted] observed with oxygen cylinders unsecured outside the doors. This deficient practice had the potential to impact all residents. It was determined the facility's non-compliance had the potential to cause serious injury, harm, impairment, or death to residents. On 08/04/2021 at 1:10 PM, a Removal Plan was requested for the kitchen fire hazard. Findings included: 1. On 08/04/2021 at 8:45 AM, the surveyor observed the Formica counter directly next to the gas stove in the kitchen to have a burned edge. The Food Service Director (FSD) said they were not sure if it had caught fire. They said they pushed the stove away after it happened, and a	A1249		

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A1249	Continued From page 21 stainless-steel countertop was requested. On 08/04/2021 at 9:50 AM and 10:45 AM, during an interview the FSD told the surveyor he/she was unsure when the burned edge of the counter occurred. The FSD confirmed the size of the burn to be 17 inches long and 2 inches at the widest point. On 08/04/2021 at 11:15 AM, the Regional Executive Director told the surveyor this burn was caused by a hot pan placed on the counter. On 08/04/2021 at 1:20 PM, the Deputy Fire Marshall, who had arrived to inspect the area, stated the stove had been moved while he was observing and there was currently no risk for fire. He/she stated this was a hazard and the facility should have a metal deflector installed because the stove was too close to the counter. On 08/04/2021, the facility received a Notice of Violations and Order to Correct from the Vineland Fire Department. It stated the nature of the violation cited on the premises was "Clearance from ignition sources." The description stated, "Clearance between ignition sources, flame-producing devices, and combustible materials shall be maintained in an approved manner." The facility policy titled, "Fire, Wildfire, Explosion, Natural Gas Leak, Hazardous Spill," dated 2019, revealed, in part, "The kitchen staff will take special precautions with heat-producing appliances." On 08/04/2021 at 2:00 PM, the facility submitted a Removal Plan which included: 1. Stove moved to prevent fire on 08/04/2021 at	A1249		

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A1249	Continued From page 22 1:10 PM. 2. The counter was to be cut 4 inches to make more room for the stove 3. A metal shield was to be installed on 08/05/2021. The completion date for the removal plan was 08/05/2021. A revisit was conducted on 8/16/21 which verified that the removal plan was implemented. 2. On 08/03/2021 at 10:08 AM in the presence of the Maintenance Director, the surveyor observed that there was an unsecured oxygen cylinder outside Room [NJ Ex Ord] On 08/04/2021 at 10:40 AM in the presence of the Maintenance Manager, the surveyor observed that there was an unsecured oxygen cylinder outside Room [NJ Ex Ord] During a second observation on 08/04/2021 at 9:45 AM, the surveyor observed that the oxygen cylinder remained unsecured outside of Room [NJ Ex Ord] On 08/04/2021 at 9:45 AM, Resident #7, who resided in Room [NJ Ex Ord] told the surveyor that the resident had placed the oxygen cylinder outside the door in [NJ Ex Order 26.4(b)(1)] and no one had removed it. During a second observation on 08/04/2021 at 9:50 AM, the surveyor observed the oxygen cylinder remained unsecured outside of Room [NJ Ex Ord]	A1249		

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A1249	Continued From page 23 During an interview on 08/04/2021 at 9:51 AM, Resident #8 told the surveyor during interview that when Resident #8 moved into the facility about [NJ Ex Order 26.4(b)(1)] the oxygen cylinders were outside the resident's door. Resident #8 [NJ Ex Order 26] [redacted]. During an interview on 08/04/2021 at 10:15 AM, the Regional Administrator told the surveyor that there was no policy on the storage of oxygen cylinders. During an interview on 08/04/2021 at 10:18 AM, the Director of Nursing (DON) told the surveyor that during [NJ Ex Order 26.4(b)(1)], the oxygen cylinders had been sent to the facility unsecured. During an interview on 08/04/2021 at 1:50 PM, the Maintenance Director revealed he had only been at the facility for about [NJ Exec Order 26.4] and that the oxygen cylinders should have been secured. The Maintenance Director continued to tell the surveyor that the oxygen cylinders did not belong to anyone at the facility and he/she was in the process of removing all the oxygen cylinders. The facility had no policy for the safe and secure storage of oxygen within the building.	A1249		
A1287	8:36-18.2(c) Infection Prevention and Control Services (c) The facility shall document evidence of annual vaccination against influenza for each resident, in accordance with the General Recommendations on Immunization of the Advisory Committee on Immunization Practices of the Centers for Disease Control, February 8, 2002, incorporated	A1287		

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A1287	Continued From page 24	A1287		

herein by reference, as amended and supplemented, unless such vaccination is medically contraindicated or the resident has refused the vaccine, in accordance with N.J.A.C. 8:36-4.1(a). The General Recommendations on Immunization of the Advisory Committee on Immunization Practices of the Centers for Disease Control, February 8, 2002, which are available on the Internet at http://www.cdc.gov/nip/publications/acip-list.htm. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year. Residents admitted after this date, during the flu season and up to February 1, shall, as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident.

This REQUIREMENT is not met as evidenced by:
Based on facility policy review, record review, and interview, it was determined that the facility failed to document evidence of an NJ Ex Order 26.4(b)(1) against NJ Ex Order 26.4(b) for 3 of 5 residents, Residents #1, #3 and #4 reviewed for NJ Ex Order 26.4(b)(1). This deficient practice had the potential to affect all residents.

Findings included:

1. The surveyor reviewed Resident #4's medical record and identified that the resident's move in date was on NJ Ex Order 26.4(b)(1). The surveyor identified that there was no documentation that the resident received or denied an NJ Ex Order 26.4(b)(1).

On 08/04/2021 at 10:18 AM, the Director of Nursing (DON) told the surveyor during interview that the NJ Ex Order 26.4(b)(1) were not

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A1287	Continued From page 25	A1287		

conducted at the facility. Rather, an outside agency came to the facility and gave the [NJ Ex Order 26.4(b)] to the residents. The DON confirmed Resident #4 did not have any documentation concerning the NJ Ex Order 26.4(b)(1) or the resident's [NJ Exec Order] of the [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order] The surveyor asked the DON for documentation of the residents that received the NJ Ex Order 26.4(b)(1). The facility did not have any such documentation.

The facility policy titled, "Infection Control," dated 09/01/2016, revealed in part, "Resident immunizations will be recorded in the resident's service binder."

2. Resident #1 was admitted to the facility on [NJ Ex Order 26.4(b)(1)]. Surveyor review of the resident's medical record revealed no evidence of [NJ Ex Order 26] against [NJ Ex Order 26.4(b)] or [NJ Exec Order] by the resident.

On 08/04/2021 at 11:00 AM, the Director of Nursing (DON) told the surveyor that they were unable to find a record NJ Ex Order 26.4(b)(1) for Residents #1. The DON told the surveyor the resident received the [NJ Ex Order 26.4(b)(1)] at their doctor's office.

3. Resident #3 was admitted to the facility on [NJ Ex Order 26.4b1]. Surveyor review of the resident's medical record revealed no evidence of [NJ Ex Order 26] against [NJ Ex Order 26.4(b)] or [NJ Exec Order] by the resident.

On 08/04/2021 at 11:00 AM, the Director of Nursing (DON) stated they were unable to find a record of NJ Ex Order 26.4(b)(1) for Residents #3. The DON told the surveyor that the resident received the [NJ Ex Order 26.4(b)(1)] at their doctor's office.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
25A000 Y1	A. Building B. Wing Y2	8/4/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BAKER PLACE	685 S. BREWSTER ROAD VINELAND, NJ 08360

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0511	Correction	ID Prefix A0517	Correction	ID Prefix A0577	Correction
Reg. # 8:36-5.5(a)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-5.11(a)(2)	Completed
LSC	09/10/2010	LSC	09/10/2021	LSC	09/10/2010
ID Prefix A0581	Correction	ID Prefix A0585	Correction	ID Prefix A0783	Correction
Reg. # 8:36-5.11(a)(4)	Completed	Reg. # 8:36-5.11(a)(6)	Completed	Reg. # 8:36-7.5(e)	Completed
LSC	09/10/2021	LSC	09/10/2021	LSC	09/15/2021
ID Prefix A0891	Correction	ID Prefix A0901	Correction	ID Prefix A1041	Correction
Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-10.5(c)(4)	Completed	Reg. # 8:36-14.3(a)	Completed
LSC	09/10/2021	LSC	09/10/2021	LSC	09/10/2021
ID Prefix A1119	Correction	ID Prefix A1249	Correction	ID Prefix A1287	Correction
Reg. # 8:36-16.12(a)	Completed	Reg. # 8:36-17.7	Completed	Reg. # 8:36-18.2(c)	Completed
LSC	09/15/2021	LSC	09/10/2021	LSC	09/15/2021
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	
8/4/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO