STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOB HAINES HOME FOR AGED PEOPLE	250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003

(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 Standard Survey: 2/22/23 Census: 39 Sample Size: 14 A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		3/17/23

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

Electronically Signed | 03/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOB HAINES HOME FOR AGED PEOPLE	250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003

(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 755	Continued From page 1 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to a) reconcile, identify and remove three of the expired medication intravenous medication supply set (IV set) located in the bottom of a medication cart observed in 1 of 1 of the subacute unit; b) ensure the accurate execution of a Drug Enforcement Agency (DEA) Form 222 (a federal narcotic requisition form), to enable accurate reconciliation of controlled-dangerous substances (medications, with high potential for abuse and tracked with detail), which was identified in 1 of 1 form reviewed. This deficient practice was evidenced by the following: 1) On 02/16/23 at 11:53 AM, the surveyor began the inspection of the non-controlled portion of the medication cart in the subacute unit in the presence of the Registered Nurse (RN). The surveyor observed three expired IV set. The surveyor and the RN further examined the sealed IV sets which reflected a manufacturer expiration date of 8/28/22. At that time, the surveyor interviewed the RN who stated the expired IV set should not have been on the cart because the medication could have permeated and leaked through the IV bag. The	F 755	Immediate corrective action Immediate unit and med carts inspection were done on both units. New log and policy created to reconcile, identify and remove expired supplies. New policy and procedure establish to enable accurate execution and reconciliation of 222 Form. Other Residents with potential to be affected While all residents have the potential to be affected by this alleged deficient practice, no negative outcomes were identified. Systemic Changes to Ensure Compliance Immediately contacted the pharmacy and arrange a QA meeting to discuss labeling of supplies, removal of expired medical supplies and copies of 222 forms. All medications carts and supply rooms were checked to ensure that the facility is free of expired medical supplies. A log was also created for all nurses to monitor and sign daily for expired medical supply to ensure compliance.	

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	315392	A. BUILDING _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOB HAINES HOME FOR AGED PEOPLE	250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003

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F 755	Continued From page 2 RN also stated that she did not have any residents using the IV set at that time and it was stored in the cart as an emergency supply. On 2/17/23 at 1:28 PM, the surveyor was provided copies of the pharmacy provider invoices that included listings for IV sets by the Director of Nursing (DON). At that time, in the presence of the survey team, the DON was asked to clarify that the expired IV set found was the item listed on the invoices provided. The DON stated she would conduct further research. On 2/22/23 at 11:25 AM, in the presence of the survey team, the DON stated the pharmacy provider was unable to provide documentation to reconcile the items on the invoice was the expired IV set. At 11:54 AM, the DON provided an email from the provider Pharmacist and the Unit Inspection conducted by the Consultant Pharmacist. A review of the facility provided email from the provider Pharmacist reflected that the Provider pharmacy conducted a unit inspection on 2/15/23. A review of the facility provided Unit Inspection conducted by the Consultant Pharmacist (CP) dated 2/15/23, did not indicate an expired IV set was observed. At 1:26 PM, during a follow up interview with the surveyor, the DON stated that medical supplies were supposed to be checked for expiration and removed from active inventory. The pharmacy provider, CP and the nursing staff, missed it. The	F 755	DON immediately reviewed Instructions for DEA Form 222 with pharmacist and medical director with returned demonstration. Night Supervisor will check the medication carts and the cabinets daily; and the pharmacy consultant will check the medication/treatment carts and cabinets monthly during visits to make sure that there are no expired supplies in the facility. Pharmacy consultant will also check 222 form for compliance monthly. DON or designee will check the log weekly and will be responsible for compliance. System Maintenance An environmental rounding tool was developed and will include checking the medical supply room, medication cabinets, and medication carts in the facility, and Form 222.DON or designee will conduct this audit weekly x 4, then bi-weekly x 2 and then monthly x 1 for the next 6 months. All findings or concerns will be immediately addressed and reported to the QAPI committee monthly for further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOB HAINES HOME FOR AGED PEOPLE	250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003

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F 755	Continued From page 3	F 755		

DON confirmed that all residents were checked, and determined no resident was scheduled to use the IV set at that time.

A review of the facility provided policy Storage of Medication, revised on 11/22 included, under Procedures, section 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. The nurse is responsible to check al supplies before using them. Upon receiving the medical supplies, staff will check the packaging slip and keep them in a binder. Pharmacy consultant, pharmacist and staff will check supplies at least monthly and will remove all expired supplies.

2) On 02/16/23 at 1:04 PM, a review of the facility's DEA Form-222 reflected on the reverse side instructions required by Title 21 Code of Federal Regulations Part 1305. Further review revealed the facility did not execute the following:
Part 1. Purchaser Information
3. Enter the total number of line items ordered.
4 ...Purchaser must make a copy of the order form for its records before mailing the original to the supplier.

Order Form Number: 220405269 did not include the last line completed (bottom, left corner). The facility provided DEA Form-222 had a completed information for Part 4 Controlled Substance Shipment (to be filled out by the supplier).

On 2/17/23 at 1:28 PM, the surveyor in the presence of another surveyor, discussed with the DON, the concern regarding the DEA Form-222. The DON stated the forms were new and was discussed with the medical director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING _____ B. WING _____	02/22/2023

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JOB HAINES HOME FOR AGED PEOPLE	250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003

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F 755	Continued From page 4 On 2/22/23 at 11:25 AM, in the presence of the survey team, the DON explained her process for executing the DEA Form-222. The DON stated she filled out the form and sent it to the pharmacy. At that time, The DON confirmed she did not make a copy of the DEA Form-222 before it was sent to the pharmacy. The provider pharmacy returned the form to the facility after they had filled out their portion. The DON stated she reconciled the DEA Form-222 with the items and the invoice received. At that time, the DON was unable to explain how the order form could be reconciled properly when a copy of the DEA Form-222 was not made and retained for its records prior to sending the form to the pharmacy. The DON informed the surveyors that moving forward she would retain a copy of the executed DEA Form-222 prior to sending to the pharmacy. A review of the facility provided policy Utilizing DEA form 222 for ordering CII medications for backup replacement revised 2/22 included, under procedures: Please send the original form to the pharmacy, a copy must be kept in your records for two years ...Be sure to fill in "Last line Completed". NJAC 8:39-19.4(a), 29.4(g), 29.7(c)	F 755		

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)
315392	A. Building B. Wing	3/17/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JOB HAINES HOME FOR AGED PEOPLE	250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003

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 F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 03/17/2023	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	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 2/22/2023	☐ 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
	315392	A. BUILDING **03 - JOB HAINES** B. WING _____	**02/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOB HAINES HOME FOR AGED PEOPLE	**250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/15/23 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Job Haines Home for Aged People is a two story building with a basement. The first floor and basement were built in 1903 and the second floor was built in 1986. It is composed of Type II protected construction. The facility is divided into four smoke zones. The generator does approximately 50 % of the building as per the Administrator. The current occupied beds are 39 of 40.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure battery-powered emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 edition) Section 7.3. This deficient practice had the potential to affect all 39	K 291	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by this practice. The new emergency light was	3/17/23

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

Electronically Signed | 03/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING **03 - JOB HAINES** B. WING _____	**02/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOB HAINES HOME FOR AGED PEOPLE	**250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003**

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K 291	Continued From page 1 residents. Findings include: An observation on 02/15/23 at 1:42 PM revealed battery-powered emergency lighting was not present at the emergency generator transfer switch located in the basement. During an interview at the time of the observation, the Administrator and the Director of Environmental Services confirmed the emergency lighting was not present and stated they did not know it was a requirement. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	installed by the facility electrician on February 22, 2023. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the Home have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur The Maintenance Director or Designee will monitor the emergency light for proper operation weekly X 4 weeks, then bi-weekly for 2 months, and monthly thereafter for 6 months. The findings will be reported to the Administrator immediately. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur Maintenance Director/designee will present the results of the weekly checks at the facility Safety Meeting and QAPI meeting quarterly.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918		3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING **03 - JOB HAINES** B. WING _____	**02/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOB HAINES HOME FOR AGED PEOPLE	**250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003**

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K 918	Continued From page 2 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. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure the 50 KW (kilowatt) diesel emergency generator had a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where	K 918	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by this practice. The remote manual stop station	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING **03 - JOB HAINES** B. WING _____	**02/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 3 the prime mover is located outside the building in accordance with NFPA 110 Standard for Emergency and Stand by Power Systems (2010 Edition) Section 5.6.5.6. This deficient practice had the potential to affect all 39 residents. Findings include: A review of the generator "Preventative Maintenance Check List," located in the "Regulatory Inspection Manual" dated January 2022 through January 2023 and provided by the Administrator, revealed the generator was inspected on 03/31/22 and 12/01/22 and there was no documentation of installation of a remote manual stop station. An observation on 02/15/23 at 1:31 PM revealed the 50 KW diesel emergency generator, located outside the building, did not have a remote manual stop station. During an observation on 02/15/23 at 2:15 PM, the Director of Environmental Services showed the surveyor a circuit breaker for the generator located on the main electrical panel in the basement. During an interview at the time of the observations, The Director of Environmental Services stated the facility would use the circuit breaker to stop the generator. NJAC 8:39-31.2(e)	K 918	will be installed on March 16, 2023. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the Home have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur The remote manual stop station will be installed for the generator on March 16, 2023. The Director of Maintenance or Designee will inspect the manual stop station to ensure that there is unrestricted access. The audit will be conducted weekly X 4 weeks, then bi-weekly for 2 months, and monthly thereafter for 6 months. The findings will be reported to the Administrator immediately. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Director of Maintenance or Designee will present the results of these inspections at the facility Safety Meeting and QAPI meeting quarterly.	

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
315392 Y1	A. Building 03 - JOB HAINES B. Wing Y2	3/17/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JOB HAINES HOME FOR AGED PEOPLE	250 BLOOMFIELD AVE BLOOMFIELD, NJ 07003

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 Reg. # NFPA 101 LSC K0291	Correction Completed 03/17/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 03/17/2023	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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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 2/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			