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 ______	04/04/2025

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: 3/26-4/1/25 Census: 37 Sample Size: 12+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. A deficiency was cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 1 of 5 residents, Resident #9, reviewed for NJ Exec Order 26.4b1 status. This deficient practice was by the following: Reference: A review of the CDC's Advisory Committee on Immunization Practices (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 10/26/24, included the following. The CDC recommended administration of pneumococcal conjugate vaccine (PCV20 or PCV21) at least 1 year for all adults 50 years or older who have received PCV 13 only at any age.	F 641	1--Corrective Action. The Director of Nursing conducted an audit of current residents receiving an Omnibus Budget Reconciliation Act Assessment during the last 14 days to verify accurate coding of Section O of the Minimum Data Set (MDS) per the Resident Assessment Instrument (RAI) Manual guidelines. If needed, modifications will be completed by the MDS Designee per the RAI Manual guidelines. Resident #9 had a modification of section O to reflect accurate coding of not being up to date with NJ Exec Order 26.4b1 for Assessment Reference Date.	4/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/24/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	Continued From page 1 On 03/26/25 at 11:50 AM, the surveyor observed Resident #9, seated in the dining area with other residents while the staff prepared to serve lunch. The resident greeted the surveyor hello, then was observed looking around the room. The surveyor reviewed Resident #9's medical record. The Admission Record (AR, admission summary) reflected that Resident #9 was admitted to the facility with medical diagnoses which included but were not limited to: NJ Exec Order 26.4b1). Resident #9's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out 15 which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. Further review of the qMDS dated NJ Exec Order 26.4b1, under section NJ Exec Order 26.4b1 Is the resident's NJ Exec Order 26.4b1) up to date? The response was marked 1, which reflected NJ Exec O A review of the electronic Medical Record (eMR) under NJ Exec Order 26.4b1 reflected Resident #9, last received NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 The paper chart did not show the NJ Exec was offered, education was provided, or a declination had occurred.	F 641	2How the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing will provide education to the Interdisciplinary team who participate in the MDS coding of Section O related to accurate coding of MDS according to the RAI Manual.The Director of Nursing will randomly audit five completed MDSs weekly for 12 weeks and then five random MDSs monthly for an additional 3 months to verify accurate coding of section O of the MDS. One to One education will be provided if opportunities for corrections are as identified as a result of these audits. Modifications to the MDS will be completed as needed. 3What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing, the infection control nurse and the MDS coordinator will discuss weekly the vaccination status of all residents. A form was created to reflect not only the type of vaccination received, and also if resident is up to date according to CDC guidelines. 4How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing will report the results of these audits at the facility	

PRINTED: 08/07/2025
FORM APPROVED
OMB NO. 0938-0391

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F 641	Continued From page 2 On 3/31/25 at 10:48 AM, during an interview with the surveyor, the US FOIA (b)(6) stated that every year, each resident who was NJ Exec O were asked/offered the NJ Exec O when appropriate. For residents who had NJ Exec Order 26.4b1, the resident's family or representative were asked on behalf of the resident for permission to administer the NJ Exec O The resident's offer, education or declination were documented in the paper chart and/or the electronic medical record (eMR). At that time, the surveyor and the US FOIA (b)(6) reviewed Resident #9's NJ Exec Order 26.4b1 record together. The US FOIA (b)(6) stated the resident's record reflected the resident received NJ Exec Order 26.4b1 on NJ Exec Order 26.4b. During the review of the resident's medical record (electronic and paper), the proof of offer, education, and declination were not found. The US FOIA (b)(6) stated she would review the records, look for the documents, and inform the US FOIA (b)(6) On 3/31/25 at 10:57 AM, during an interview with the US FOIA (b)(6)) the surveyor requested the information of the guidelines that the facility followed for the NJ Exec O On 4/1/25 at 8:52 AM, during a meeting with the surveyor and the US FOIA (b)(6) stated that the facility followed the current CDC guidelines and offered NJ Exec Order 26.4 to their residents. The US FOIA (b)(6) provided the surveyor NJ Exec declination for Resident #9 dated on NJ Exec Order 26.4b1 At that time, the surveyor discussed the concern with the US FOIA (b)(6) regarding the qMDS dated NJ Exec Order 26.4b1 that reflected the resident's NJ Exec was current.	F 641	quarterly QAPI Meeting, and is responsible for implementing and sustaining the plan of correction.	

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F 641	Continued From page 3 On 4/1/25 at 9:43 AM, during an interview with the surveyor, the US FOIA (b)(6) stated she inputted information in the MDS while the US FOIA (b)) checked the MDS data for completion and accuracy. The surveyor and the US FOIA (b)(6) reviewed section NJ Exec Order 26 of the qMDS dated NJ Exec Order 26.4b together. At that time, the US FOIA (b)(6) confirmed and acknowledged that Resident #9's NJ Exec was not current, the submitted MDS section NJ Exec Order 26 was inaccurate/incorrect and was signed by the US FOIA (b)(6) On 4/1/25 at 10:12 AM, during an interview with the surveyor, the US FOIA (b)(6) stated that his signature meant he checked the MDS for completion and accuracy. At that time, the US FOIA (b)(6) stated that the data entered for section NJ Exec Order 26 qMDS dated NJ Exec Order 26.4b was a typographical error. On 4/1/25 at 12:27 PM, during a meeting with the survey team, the US FOIA (b)(6), the surveyor discussed the concern regarding the Resident #9's inaccurate MDS for NJ Exec A review of the provided facility policy for Minimum Data Set, dated/revised 7/2023 did not reflect the expectation that the submitted MDS were reviewed for accuracy prior to submission. A review of section Z0400 for the MDS dated NJ Ex Order 26.4(b)(1), revealed that the person signing the MDS certified that the accompanying information accurately reflected the resident assessment information. No further information was provided.	F 641		

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F 641	Continued From page 4 NJAC 8:39-33.2 (d)	F 641		

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 B. Wing Y2	4/28/2025 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 F0641 Reg. # 483.20(g) LSC	Correction Completed 04/10/2025	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
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

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	
4/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

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E 000	Initial Comments This facility is in Substantial compliance with Appendix Z Emergency Preparedness for all provider and supplier types Interpretive Guidance 483.73. Requirements for Long Term Care (LTC) Facilities.	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 4/3/25 and 4/4/25 and the facility was found to be in non-compliance 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 three story building with a basement. The first floor and basement were built in 1903 and the second and third floor were built in 1986. It is composed of Type II protected construction. The facility is divided into four smoke zones. The generator powers approximately 50 % of the building as per the U.S. FOIA (b) (6) The occupied beds were 37 of 40.	K 000		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or	K 131		5/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 131	Continued From page 1 customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/4/25 in the presence of the US FOIA (b)(6) , it was determined that the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with NFPA 101: 2012 Edition, Section 19.1.3.3* between the Assisted Living (AL) and Long Term Care (LTC) unit (separate licenses). This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:11 AM with the US FOIA and the US FOIA (b)(6) on floor #1 by the elevator revealed that the set of brown doors separating the AL section of the facility from the LTC section were observed to not have any label indicating the fire resistant rating. These doors did not latch when in the closed position. In an interview during the observation, the US FOIA (b)(6) both	K 131	1. Corrective Action A licensed fire door inspection company conducted a facility-wide inspection of all fire doors on April 23, 2025. There were some doors that do not have fire rating tags and those fire ratings will be placed on the applicable doors based upon the analysis of the onsite inspection. The facility will follow the results of the inspection report from the fire door inspection company and make all recommended corrections. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected.	

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K 131	Continued From page 2 confirmed the findings. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 4/4/25 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e)	K 131	3. 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 conduct monthly fire door inspections of all fire doors for proper function and correct fire rating labeling of fire doors and record this inspection on a fire door inspection log. The findings of these inspections will be reported to the Administrator on a monthly basis. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The Director of Maintenance will present the results of these inspections at the facility Safety Meeting and QAPI Meeting quarterly.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/4/25 in the presence of the US FOIA (b)(6)), it was determined	K 281	How the corrective action will be accomplished.	5/10/25

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K 281	Continued From page 3 that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 1 of 4 areas, had the potential to affect 18 residents and was evidenced by the following: An observation at 9:50 AM revealed in the first floor occupied dining room, that 5 wall light switches shut off all 12 ceiling light fixtures. In an interview, the US FOIA (b)(6) both confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 4/4/25 at 12:45 PM. NJAC 8:39-31.2(e)	K 281	The Home's electrical contractor will re-feed wiring to 2 existing center hanging lights so they have constant power on April 28, 2025. How will the facility identify other residents having the potential to be affected by the same deficient practice. All 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 inspect the dining room lighting to ensure constant power to 2 lights. This audit will be conducted weekly X 4 weeks, then bi-weekly for 2 months, and monthly thereafter for 6 months. Results of these inspections will be reported to the Administrator on a monthly basis. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The Director of Maintenance will present the results of these inspections at the facility Safety Meeting and QAPI meeting quarterly.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and	K 341		5/10/25

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K 341	Continued From page 4 components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 4/4/25 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that fire alarm notification by audible and visible signals was provided in enclosed courtyards in accordance with NFPA 101:2012 Edition, Sections 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6, 9.6.4 and NFPA 72:2010 Edition, Sections 18.5, 18.5.2.4 and 24.4.2.20.9. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:28 PM revealed that the enclosed courtyard was not provided with a means to notify occupants of the activation of the fire alarm system. In interviews at the time, the US FOIA (b)(6) confirmed that the courtyard was enclosed and not provided with a means to notify occupants of an activation of the fire alarm system.	K 341	1. Corrective Action A contractor inspected the requirements and proper location for the strobe/horn for the courtyard on April 23, 2025. Strobe/horn needs to be ordered and will be expedited with an anticipated installation date of May 7, 2025. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.	

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K 341	Continued From page 5 The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference on 4/4/25 at 12:45 PM. N.J.A.C 8:39-31.2(e) NFPA 72	K 341	The Maintenance Director or designee will conduct monthly monitoring of the strobe/horn for the courtyard. The findings of these inspections will be reported to the Administrator on a monthly basis. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The Director of Maintenance will present the results of these inspections at the facility Safety Meeting and QAPI Meeting quarterly.	
K 363 SS=E	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	K 363		5/10/25

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	315392	A. BUILDING 03 B. WING	04/04/2025

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
K 363	Continued From page 6 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 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 observation and interview on 4/4/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101: 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 4 of 16 resident rooms observed, had the potential to affect 30 residents and was evidenced by the following: Observations from 9:15 AM to 12:45 PM in the presence of the US FOIA (b)(6) revealed resident room doors did not operate properly as follows: - Room #N-111 - the door when closed, was observed to have a gap at the top of the door and frame that would not provide the required smoke barrier to the exit/egress corridor.	K 363	How the corrective action will be accomplished. Identified doors were immediately inspected and repaired on the same day. How the facility will identify other residents having the potential to be affected by the same deficient practice. A new Door Check Log has been created. All maintenance staff were educated on the new log and how to complete it. They were also instructed to notify the Maintenance supervisor and Administrator of any issues that cannot not be repaired. All resident room doors were immediately inspected and any corrective repairs were made. What measures will be put into place or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING 03 B. WING ______	04/04/2025

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

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K 363	Continued From page 7 - Room #N-115 - the door would not properly close into its frame. - Room #N-116 - the door would not latch into its frame. - Room #N-117 - the door when closed was observed to have a gap at the top of the door and frame gap that would not provide the required smoke barrier to the exit/egress corridor. In an interview at 12:00 PM, the US FOIA (b)(6) [redacted] confirmed the above findings. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 4/4/25 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	systemic changes will be made to ensure that the deficient practice will not recur. The Maintenance Director or designee will conduct weekly X 4 weeks inspections of all doors using the Door Check Log, then bi-weekly for 2 months, and monthly thereafter for 6 months. The findings will be reported immediately to the Administrator. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The Maintenance Director will present the results of these inspections at the Facility Safety Committee 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 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	K 918		5/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING 03 B. WING	04/04/2025

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 8 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 record review and interview on 4/3/25 in the presence of the US FOIA (b)(6) , it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame in accordance with NFPA 99: 2012 Edition for emergency electrical generator systems. This deficient practice was evidenced for 1 of 1 generators, had the potential to affect all residents in the facility, and was evidenced by the following: A review of the generator records at 9:44 AM for the previous twelve (12) months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds for 9 of 12 load tests. The US FOIA was	K 918	How the corrective action will be accomplished. A new Emergency Generator Monthly Test Log was created to include the transfer time on the log. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315392	A. BUILDING 03 B. WING ______	04/04/2025

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 9 performing monthly generator load testing, but did not provide transfer times on the following log dates: The facility's generator testing was performed on 4/2/25, 3/25/25, 2/28/25. 1/16/25, 12/24/24, 11/27/24, 10/21/24. Months 9, 8, & 7, (were not load tested due to smoke conditions from the Canada forest fires), 6/25/24 and 5/2/24. An interview was conducted with the US FOIA (b)(6) during document review, where they both stated the transfer times were not being documented. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/4/25 at 12:45 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	The Maintenance Director or Designee will utilize the new Generator Test Log and submit to the Administrator on a monthly basis. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The Director of Maintenance will report the results of the monthly generator testing 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	5/12/2025 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 K0131	Correction Completed 05/10/2025	ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 05/10/2025	ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 05/10/2025
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 05/10/2025	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 05/10/2025	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	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	
4/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO