New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			-		С
		308116	B. WING		01/08/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
2ND HOM	E NEWARK OPERATION	S. LLC	BROADWAY		
		NEWAR	K, NJ 07104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
M 000	M 000 Initial Comments		M 000		
	Type of Survey: Com	plaint			
	Complaint#: NJ00134	4218			
	Census: A.M 96 P.M 44				
	Sample Size: 3				
	all of the standards in Administrative Code, for Licensure of Adult facility must submit a a completion date, for that the plan is implen deficiencies may resu	Chapter 8:43F, Standards Day Health Services. The plan of correction, including each deficiency and ensure nented. Failure to correct lt in enforcement action in provisions of New Jersey Title 8, Chapter 43E,			
M 223	8:43F-3.1(b)(1-7) Adn	ninistration	M 223		
	(b) The administrator not limited to, the follo	shall be responsible for, but owing:			
	and procedures, inclu	enforcement of all policies			
	Planning and a managerial, operation components of the facility;	administering the ral, fiscal, and reporting			
	3. Participating in program for participar	the quality improvement t care and staff			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/07/24

New Jersey Department of Health
STATEMENT OF DEFICIENCIES (X

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					c	;
		308116	B. WING		01/0	8/2024
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
2ND HOM	E NEWARK OPERATION	S, LLC 717-727 BF NEWARK,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
M 223	Continued From page	: 1	M 223			
	performance;					
	4. Ensuring that a duties based upon the competencies, and 5. Ensuring the p staff education, and concern accordance with 6. Establishing a relationships and constaff and services propand their caregivers; 7. Verifying that exparticipant is eligible that the adult day heat the participant's entry purposes of this shall be entitled to religible to the performed by the	all personnel are assigned eir education, training, and job descriptions; arovision of staff orientation, angoing staff training in N.J.A.C. 8:43F-6.3; and maintaining liaison amunication between facility eviders and with participants and each Medicaid-eligible to receive services available alth services facility prior to into the program. For the section, the administrator y on any prior authorization and Department for the nice with N.J.A.C. 8:86.				
	This REQUIREMENT by: Complaint#: NJ0013	is not met as evidenced				
		bservation, and pertinent				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY PLETED	
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		308116	B. WING		01	C / 08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
		717-727	BROADWAY			
2ND HOM	E NEWARK OPERATION	S, LLC NEWAF	RK, NJ 07104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
M 223	Continued From page	2	M 223			
IVI ZZJ	infection control, hand spreading infection, fachoking was accurated dated. In addition, the failed to ensure that a duties based upon the competencies, and join deficient practice was 1. On 1/8/24 at 10:14 the Social Worker/Alt (SS/AA) in the room social Worker/Alt (SS/AA) in the room social Worker, and was taff members, and Marketer, to sign an interest of the staff sign the record for the two seps "Infection control, Har spreading of infection Seizures and choking "11/22/23" with times At 10:24 a.m., the sur DON/RN in the presentated she trained the	dwashing, prevention of all prevention, seizures and ely timed and correctly a facility's Administrator all personnel are assigned eir education, training, b descriptions. This is evidenced by the following: a.m., the surveyor observed ernate Administrator specified for the participants requesting Nurse Aide and the in-service attendance record. To be in-service attendance of in-service attendance of in-services topics: and washing, Prevention of and "Fall Prevention," which were back dated for listed as "N/A." To veyor interviewed the ince of the SS/AA, who is the staff back in November	101 223			
	in-services back then have the staff sign the	or the employees to sign the , so she asked the SS/AA to e in-services attendance				
	sheet today [1/8/2024	1].				
	Aide regarding the in- to sign for infection of prevention of spreadi seizures and choking	rveyor interviewed the Nurse services she was preparing ontrol, handwashing, ng infection, fall prevention, in-services, who stated she she was about to sign.				

STATEMENT OF DEPICIONISES NAME PLAN OF CORRECTION DESTRICTATION NUMBER 308116 SUBJURING DESTRICTATION NUMBER 308116 SUBJURING DESTRICTATION NUMBER STREET ADDRESS, CITY, STATE, ZIP CODE 717-727 BROADWAY NEWARK, NJ 07104 PROVIDER OR SUPPLIER SUBJURING SUBJURING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 717-727 BROADWAY NEWARK, NJ 07104 PROVIDER PLAN OF CORRECTION REACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG Continued From page 3 Additionally, the Nurse Aidle stated she was unable to read in English which the in-service attendance sheet was printed in. Review of the documents titled, "INSERVICE" with topics titled "Infection control, Handwashing, Prevention of spreading infection" and "Fall Prevention, Seizures and choking" both dated 11/22/23 revealed two staff members, the Activity Director and a Program Aide, had signed both in-services. Review of the staffing schedule for November 2023 and December 2023 revealed that employees listed above were not on the schedule on the date of this was services. Review of the in-service as Activity Director's date of hire was services. Review of the in-service as Activity Director's date of hire was services. Review of the staffing schedule for November 2023 and December 2023 revealed that employees listed above were not on the schedule on the date of this was services. Review of the temperature logs revealed that the facility had hissing and office in was serviced by the staff preparation of the staff preparation of the review of the facility of the preparation of the preparation of the preparation of the facility of the preparation of the preparation of the facility of the preparation of the facility prevailed by and facility of the facility prevailed by and faci	INEW JEIS	ey Department of Fleat	<u> </u>				
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A BILLIDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE T17.727 BROADWAY NEWARK OPERATIONS, LLC SUMMARY STATEMENT OF DEPCEMENTS (CACH DEPCEMENTS) (CACH DEPCEMENT MUST REPRECISED BY CILL PRETTY TAC SUMMARY STATEMENT OF DEPCEMENTS (CACH DEPCEMENTS) (CACH DEPCEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, STATE, JP CODE 717-77 BROADWAY NEWARK OPERATIONS, LLC 717-77 BROADWAY NEWARK, NJ 07104 M. SLUMMARY STATEMENT OF DEFIDIENCIS (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG Continued From page 4 REPORT, dated 11/22/23, provided by the Dietitian revealed the facility did not have temperature logs from 11/10/23 to 11/22/23 when she conducted an inspection in which she wrote "Nov log stopped @ 11/10-pls [sic] keep up to date" in the comment section of row two with the question-"Are food temps obtained and recorded, and are they safe?" Continued review of an additional document titled, "KITCHEN/FOOD SERVICE INSPECTION REPORT, dated 3/29/23, revealed the Dietitian had notified the facility that food temperatures were not being recorded and/or safe with a comment stating. Tweet do keep up to date in binder that is easily accessible, REGULATION REQUIREMENTS: COLD-HOLD: 41°F OR LOWER HOT-HOLD: 13°F OR HIGHER" mentioned in the comment section of the question number two on the "KITCHEN/FOOD SERVICE INSPECTION REPORT" "Are food temps obtained and recorded, and are they safe?" The Dietitian stated she informed the Administrator on the date of the inspection, 3/39/23, verbally followed by and email of the inspection findings on 3/30/23. Continued interview with the Dietitian revealed that she provided the Administrator with a document titled, "HOW TO CALIBRATE A THERMOMETER" to leach dictary staff how to properly calibrate the thermometer so food temping is accurate. On 1/8/23 at 9:11 a.m., request to the SS/AA and DON/RN, and again at 10/46 a.m., to the FSS,	ANDIEAN	O CONNECTION	IBENTI IOATION NOMBER.	A. BUILDING:		OOWII EETEB	
Continued review of an additional document titled, "KTCHEN/FOOD SERVICE INSPECTION REPORT," dated 3/29/23, revealed the binder that is easily accessible; REGULATION REQUIREMENTS: COLD-HOLD: 41°FOR HOME of the puestion number two on the "KTCHEN/FOOD SERVICE INSPECTION FOR HIGHER was a few and are they safe?" The Dietitian stated she informed the Administrator on the date of the inspection in findings on 3/30/23. Continued Inspection in which she wrote 'Nov log stopped garden's previous of the provided that she provided in the comment section of respective to the previous of the p			308116	B. WING		_	
CALL DATE CALL DATE CALL	NAME OF PI	ROVIDER OR SUPPLIER		, ,	ITE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) M 223 Continued From page 4 REPORT", dated 11/22/23, provided by the Dietitian revealed in inspection in which she wrote "Nov log stopped @ 11/10-pls [sic] keep up to date" in the comment section of row two with the question "Are food temps obtained and recorded, and are they safe?" Continued review of an additional document titled, "KITCHEN/FOOD SERVICE INSPECTION REPORT", dated 3/29/23, revealed the Dietitian had notified the facility that food tempseratures were not being recorded and/or safe with a comment stating "Need to keep up to date in binder that is easily accessible; REGULATION REQUIREMENTS: COLD-HOLD: 41°F OR LOWER HOT-HOLD: 135°F OR HIGHER" mentioned in the comment section of the question number two on the "KITCHEN/FOOD SERVICE INSPECTION REPORT" Are food temps obtained and recorded, and are they safe?" The Dietitian stated she informed the Administrator on the date of the inspection, 3/29/23, revealed the inspection, 3/29/23, revealed that she provided the Administrator with a document titled, "HOW TO CALIBRATE A THERMOMETER" to beach dietary staff how to properly calibrate the thermometer so food temping is accurate. On 1/8/23 at 9:11 a.m., request to the SS/AA and DON/RN, and again at 10:46 a.m., to the FSS,	2ND HOM	E NEWARK OPERATION	IS. LLC				
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days. The facility was unable to produce a dated menu for the past 30 days. The FSS again stated	M 223	REPORT", dated 11/2 Dietitian revealed the temperature logs from she conducted an ins "Nov log stopped @ date" in the comment question "Are food ten and are they safe?" Continued review of a "KITCHEN/FOOD SE REPORT", dated 3/29 had notified the facilit were not being record comment stating "New binder that is easily a REQUIREMENTS: CLOWER HOT-HOLD: mentioned in the comquestion number two SERVICE INSPECTION temps obtained and resafe?" The Dietitian seadministrator on the day 3/29/23, verbally followinspection findings or Continued interview with the she provided the document titled, "HON THERMOMETER" to properly calibrate the temping is accurate. On 1/8/23 at 9:11 a.m DON/RN, and again a the surveyor requested days. The facility was	22/23, provided by the facility did not have in 11/10/23 to 11/22/23 when expection in which she wrote 11/10-pls [sic] keep up to it section of row two with the imps obtained and recorded, an additional document titled, ERVICE INSPECTION 9/23, revealed the Dietitian by that food temperatures ded and/or safe with a led to keep up to date in inccessible; REGULATION OLD-HOLD: 41°F OR in 135°F OR HIGHER" in the ment section of the least of the inspection, owed by and are they stated she informed the date of the inspection, owed by and email of the in 3/30/23. With the Dietitian revealed Administrator with a least of the with a least of the inspection, owed by and email of the in 3/30/23. With the Dietitian revealed Administrator with a least of the menul for the past 30 is unable to produce a dated	M 223			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BOILDING		С
		308116	B. WING		01/08/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
2ND HOM	E NEWARK OPERATION	717-727 E	ROADWAY		
2110 110111	E NEWARK OF ERAFIOR	NEWARK	, NJ 07104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
M 223	Continued From page	÷ 5	M 223		
	delivery service never	gave it to her.			
M 367	On 1/10/24 at 11:19 a document titled, "JOB SERVICE SUPERVIS states" Responsibility dated menus at least ensuring that that san than once for any com G. Keep record of a Ensure that meals are participants Y. Ma Temperature Log." signated 7/21/23. The Administrator failing personnel was trained complete assigned job 8:43F-5.3(b) Participated Care An initial assessment participant on the day include at least perso dietary needs, medical diagnosis. Based on twritten initial plan of complete supplements.	a.m. the surveyor reviewed a B DESCRIPTION: FOOD BOR Position # 501" which dilities: E. Plan written, 14 days in advance, the menu not be used more attinuous seven day period. The all menu changes M. As attractive when served to be attractive when served to a dintain refrigerator and gred by the current FSS and the ded to ensure that all did and competent to be description duties. The anti-Assessment and Plan of the shall be completed for each of admission and shall and hygiene, immediate ations, ambulation and this initial assessment, a are shall be developed anys of the date the initial	M 367		
	by: Complaint#: NJ00134	is not met as evidenced 4218 nd record review, it was			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					C	
		308116	B. WING		01/0	8/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
2ND HOM	E NEWARK OPERATION	S. LLC	ROADWAY			
		NEWARK,	NJ 07104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
M 367	Continued From page	e 6	M 367			
	perform and docume assessment and faile for 1 of 3 sampled parthis deficient practice following: According to surveyor record on 1/8/24 at 0 admitted to the prograwith diagnoses which revealed that the participarter attendance of the programment complete of care. During interview with after the surveyor record on 1/8/28 initial assessment pon/RN stated a copromise of the programment of the programment complete of the	durse (DON/RN) failed to an tan initial nursing d to develop a plan of care ricipants, Participant #3. e was evidenced by the review of the medical 2:30 p.m. Participant #3 was am on NJ ex order 26.4b1 included NJ ex order 26.4b1 eant's medical record cicipant had been in gram since NJ ex order 26.4b1 surveyor did not observe				
	she did not have time	•				
	assessment and deve	omplete an initial nursing elop a written plan of care of the initial assessment of cal record.				
M 539	8:43F-10.5(a) Dietary	Services	M 539			
	The dietary service s provisions of N.J.A.C					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		308116	B. WING		C 01/08/2024
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE	
2ND HOM	E NEWARK OPERATION	IS. LLC	ROADWAY NJ 07104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
M 539	Continued From page		M 539		
	· ·	is not met as evidenced			
	by: Complaint#: NJ00134	4218			
		n and interview, it was acility failed to ensure 1 of 1			
	dietary staff washed t	their hands prior to handling nts. This deficient practice			
		m. while interviewing the isor (FSS) the surveyor, in			
	the presences of the	Social Worker/Alternate			
		a), observed the FSS go arch of temperature logs			
	and in the process wi	pe his/her nose with a			
	disposable tissue whi gloves.	ile wearing disposable			
		veyor requested to watch the			
		leted arrival temperatures rived. The FSS started to			
	complete the arrival to	emperatures of the food			
		tables. The FSS had not			
	she/he went through a	l wash her hands after a hinder and used a			
	disposable tissue to v				
	· ·	nces of the SS/AA the			
		FSS as they uncovered the moving thermometer in a			
	downward motion into				
		that time the surveyor			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		308116	B. WING		C 01/08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
2ND HOM	E NEWARK OPERATION	S. LLC	ROADWAY , NJ 07104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
M 539	nose with a disposab gloves they were curr doff the gloves and whandling clean equiprin addition to handling. After the surveyor intecontamination of the her hands prior to obtoof the food. The facility failed to ewhile handling food a temperatures of the properture of the properture. The New N.J.A.C. 8:24-2.3(f)(1) clean their hands and arms immediately before preparation including clean equipment and single-service and sir After coughing, sneed.	at they had touched their le tissue and the same rently wearing and had not ashed their hands prior to ment to temperature the food g the food. Bervened to stop food the FSS went to wash raining arrival temperatures Insure personal cleanliness and monitoring arrival rarticipants' lunch. Jersey State Sanitary Code -9)-" Food employees shall a exposed portions of their fore engaging in food working with exposed food, utensils, and unwrapped angle-use articles, and: 4. Zing, using a handkerchief or ing tobacco, eating, or pecified in N.J.A.C. After engaging in other	M 539		
M 543	8:43F-10.5(c)(1-5) Di (c) Meals shall be pla in accordance with, b to, the following:	nned, prepared, and served	M 543		
	the nutritional and the	ackgrounds, food habits, and			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 1 2.1.1		152.1111.107.1101.1521.11	A. BUILDING: _		
		308116	B. WING		C 01/08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
2ND HOM	E NEWARK OPERATION	S. LLC	ROADWAY NJ 07104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
M 543	Continued From page	9	M 543		
	of participants;				
	least 14 days in adva The same menu once in any continuou 3. Current menus changes in menus sh food preparation with changes, shall be dietary service for 4. Diets served s diet manual and shall accordance with 5. Food shall be	shall not be used more than us seven-day period; s with portion sizes and any all be posted in the and/or serving area. Menus, e kept on file in the or at least 30 days; hall be consistent with the be served in physicians' orders; prepared by cutting, r blending to meet the needs			
	This REQUIREMENT by: Complaint#: NJ0013	is not met as evidenced			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B WING		С
		308116	B. WING		01/08/2024
NAME OF PROVIDI	ER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
2ND HOME NEV	WARK OPERATION	S. LLC	BROADWAY (, NJ 07104		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
	itinued From page		M 543		
pert dete writt days used day curr post area the state of	ement facility documents and that the facter, dated menus in advance, ensured more than once period for all partited in the food preason. This deficient profollowing: 1/8/24 at 9:11 a.m. ference with the Dising/Registered Notice with the Dising/Registered Notice with the Dising/Registered Notice with the Dising worker/Alternated Surveyor requested last 30 days. In graveyor interview of the menu. The eracy of the menu. The eracy of the menu. The eracy of the menu wery service never in present the survey of the menu. The eracy of the menus of the survey of the survey of the menus of the survey of the menus of the survey o	cility failed to ensure were planned at least 14 uring the same menu not be for any continuous seven cipants, in addition to ny changes in menus be paration and/or serving actice was evidenced by during the entrance irector of urse (DON/RN) and the te Administrator (SS/AA) d a copy of the menu for view the Food Service 0:46 a.m., in the presence veyor, again, requested a e FSS revealed she did not enu because the food gave it to her. The FSS evor with two documents k Cycle Menu" and enu Cycle." ach - 4 Week Cycle Menu" ek Menu Cycle", had five beled a different day of the numbered one through four,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			-		С
		308116	B. WING		01/08/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ITE, ZIP CODE	
2ND HOM	E NEWARK OPERATION	S. LLC	BROADWAY K, NJ 07104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
M 543	Continued From page	: 11	M 543		
	none of the four week listed as a meal option not have a menu with provide to the surveyor being served for lunch The facility failed to en	or to note fried chicken			
M 555	8:43F-10.5(c)(11) Die	tary Services	M 555		
	All meals shall be attriparticipants.	active when served to			
	by: Complaint#: NJ00134 Based on observation determined that the fawere attractive when a This deficient practice following: On 1/8/24 at 10:33 a.I DON the surveyor wa Worker/Alternate Admobserved scrambled expressions.	and interview, it was acility failed to ensure meals served to 2 of 2 participants. was evidenced by the m. after interviewing the s walking back to the Social ninistrator's office when she eggs with diced peppers on the eggs' appearance had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ED		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
					С			
		308116	B. WING		01/08/2024			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE				
2ND HOME NEWARK OPERATIONS, LLC 717-727 BROADWAY NEWARK, NJ 07104								
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE			
M 555	Continued From page	2 12	M 555					
	surveyor observed the included white rice, we chicken. The fried chi brown and black in co of the meal the partici. The facility failed to expression of the means the particity failed to expression.	egetables, lettuce, and fried cken appearance was dark plor. Due to the presentation ipant had declined the meal. Insure meals were attractive ipants based on observation						

STATE FORM: REVISIT REPORT

	• · · · · · · · · · · · · · · · · · · ·				
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	-	
IDENTIFICATION NUMBER	A. Building				
308116 _{Y1}	B. Wing	Y2	3/8/2024	Y3	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
2ND HOME NEWARK OPERATIO	NS, LLC	717-727 BROADWAY			
		NEWARK, NJ 07104			
		•			

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

	Toport Ionni).								
ITEM	Л	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
	M0223 8:43F-3.1(b)(1-7)	Correction Completed 01/30/2024	ID Prefix Reg. # LSC	M0367 8:43F-5.3(b)	Correction Completed 01/30/2024	ID Prefix Reg. # LSC	M0539 8:43F-10.5(a)		Correction Completed 01/30/2024
ID Prefix Reg. # LSC	M0543 8:43F-10.5(c)(1-5	Correction Completed 01/30/2024	ID Prefix Reg. # LSC	M0555 8:43F-10.5(c)(11)	Correction Completed 01/30/2024	ID Prefix Reg. # LSC			Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction
ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC			Correction
REVIEWED STATE AGI REVIEWED CMS RO	ENCY	REVIEWED BY (INITIALS) REVIEWED BY (INITIALS)	DATE DATE	SIGNATURE	E OF SURVEYOR			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/8/2024					RECTED DEFICIENCIES NCIES (CMS-2567) SEN ⁻			YE:	s 🗆 no

Page 1 of 1 EVENT ID: NPHH12