

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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
E 000	Initial Comments	E 000			
F 000	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. INITIAL COMMENTS Survey Date: 11/22/22 Census: 102 Sample: 21 plus 2 closed records	F 000			
F 656 SS=D	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. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656			12/30/22

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

TITLE

(X6) DATE

Electronically Signed

12/16/2022

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.

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 656	Continued From page 1 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person centered care plan for NJ Ex Order 26.4b1 . This deficient practice was identified for 1 of 6 residents, (Resident # 9) reviewed for NJ Ex Order 26.4b1 [REDACTED] This deficient practice was evidenced by the	F 656	F 656 Development / Implement Comprehensive Care Plan How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these residents specified in the Statement of Deficiency (SOD) or CMS-2567		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 656	Continued From page 2 following: On 11/2/22 at 11:51 AM, the surveyor observed Resident #9 out of bed seated in a wheelchair in the dayroom. The resident greeted the surveyor with a smile but was [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The foot rest on the resident's wheelchair had a [REDACTED] NJ Ex Order 26.4b1 [REDACTED] attached to the bottom of the wheelchair. On 11/16/22 at 10:00 AM, the surveyor in the presence of the [REDACTED] US FOIA (b)(6) [REDACTED] and a [REDACTED] US FOIA (b)(6) [REDACTED] observed the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] the residents [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The [REDACTED] US FOIA (b)(6) [REDACTED] described the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] a [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The [REDACTED] US FOIA (b)(6) [REDACTED] further stated that she applied [REDACTED] NJ Ex Order 26.4b1 [REDACTED] and [REDACTED] NJ Ex Order 26.4b1 [REDACTED] as ordered. The [REDACTED] US FOIA (b)(6) [REDACTED] further described the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] to the surveyor and stated that the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] area and that the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] which appeared [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The surveyor reviewed the hybrid medical record for Resident # 9. A review of the resident's Admission Record reflected that the resident was readmitted to the facility on [REDACTED] NJ Ex Order 26.4b1 [REDACTED] with diagnosis which included but not limited to [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. [REDACTED] A review of the quarterly Minimum Data Set	F 656	Review of the care plan for resident #9 revealed resident had [REDACTED] NJ Ex Order 26.4b1 [REDACTED] at the time of the survey [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. As much as the nursing staff were applying [REDACTED] NJ Ex Order 26.4b1 [REDACTED] to the site and the area was [REDACTED] NJ Ex Order 26.4b1 [REDACTED] as per MD order the [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. That said the Care Plan for resident #9 was updated to reflect the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] the resident. How the facility will identify other residents having the potential to be affected by the same deficient practice. Resident Care Coordinators and the Nursing Director have updated the process of keeping the resident roster / matrix current to identify any / all residents with skin impairments (this also includes pressure ulcers). The Interdisciplinary team has reviewed all residents with skin impairments to ensure that each resident centered care plan is appropriate to meet the resident's individual needs in response to the assessment of their current status. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? A review of the Comprehensive Care Plan Policy was presented to the Resident Care Coordinators and members of the		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 656	Continued From page 3 (MDS), an assessment tool used to facilitate the management of care dated [REDACTED] NJ Ex Order 26.4b1, reflected the resident had a brief interview for mental status (BIMS) score of [REDACTED] NJ Ex Order 26.4b1 of 15, indicating that the residents cognition was [REDACTED] NJ Ex Order 26.4b1. Further review of the MDS, Section M indicated that the resident had one or more [REDACTED] NJ Ex Order 26.4b1. The MDS indicated the resident had [REDACTED] NJ Ex Order 26.4b1. A review of the Nursing Re-Admission Assessment dated [REDACTED] NJ Ex Order 26.4b1, indicated that the resident was assessed with [REDACTED] NJ Ex Order 26.4b1. A review of the Order Summary Report for [REDACTED] NJ Ex Order 26.4b1, indicated a physician's order dated [REDACTED] NJ Ex Order 26.4b1 for [REDACTED] NJ Ex Order 26.4b1 apply to [REDACTED] NJ Ex Order 26.4b1. A review of the [REDACTED] NJ Ex Order 26.4b1 assessment dated [REDACTED] NJ Ex Order 26.4b1, indicated that the resident had a [REDACTED] NJ Ex Order 26.4b1 which was [REDACTED] NJ Ex Order 26.4b1. [REDACTED] NJ Ex Order 26.4b1. The assessment notes reflected, "Reclassified from [REDACTED] NJ Ex Order 26.4b1 [REDACTED] NJ Ex Order 26.4b1." A review of the resident's comprehensive person centered care plans revealed a focus area dated [REDACTED] NJ Ex Order 26.4b1 for [REDACTED] NJ Ex Order 26.4b1. [REDACTED] NJ Ex Order 26.4b1. There was no care plan developed to address the resident's [REDACTED] NJ Ex Order 26.4b1 [REDACTED] NJ Ex Order 26.4b1.	F 656	Interdisciplinary Team to ensure full understanding of the process. This training emphasized the importance to appropriately screening potential residents at risk or potential harm so that their care plans can be updated / changed to reflect changes in condition in a timely manner. Review and updating the resident care plans will be reinforce with licensed nursing staff and members of the Interdisciplinary Team. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Interdisciplinary team will continue to utilize the Resident Assessment Instrument (RAI) tool to initiate, revise or modify resident care plans to reflect resident's current status and needs. During care planning meetings the Director of Nursing, RAI Coordinator, or designee will conduct random audits on residents medical records to ensure that care plans reflect resident' current status and addresses specific needs. A Performance Improvement Project (PIP) will be initiated to monitor these audits (monthly) until a full compliance is attained at which time audits will be come quarterly thereafter. Results of these audits will be made available to the Quality Assurance and Performance Improvement (QAPI) Committee to		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 656	Continued From page 4 On 11/15/22 at 11:36 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the NJ Ex Order 26.4b1 assessed the resident's NJ Ex Order 26.4b1 weekly. She further stated that the NJ Ex Order 26.4b1 was not care planned, but should have been. She stated, "I'm responsible for care plans. I missed it. I should have care planned it. I forgot to." She confirmed that the resident was readmitted with the NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1 Review of the facility's undated Care Plans-Comprehensive and Person Centered policy included that measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs will be developed and implemented for each resident...Assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change...The Interdisciplinary Team must review and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MD assessment. Review of the facility's Pressure Ulcer Prevention/Management Program Policy revised 5/08, included that the interdisciplinary team will discuss the evaluation, and a specific individualized plan of care will be developed to address the resident's needs and risk factors in accordance with contemporary standards of practice.	F 656	ensure that policies and protocols are constantly implemented. (QAPI Committee meets every months except July, August, and December). While different deficiencies may have different completion dates within the POC, each individual deficiency is assigned only one completion date. December 30, 2022		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 656	Continued From page 5	F 656			
F 658 SS=D	NJAC 8:39-11.2(e)(2)(f) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was identified that the facility failed to appropriately transcribe a Physician's Order (PO) for the recommendation of NJ Ex Order 26.4b1. This deficient practice was identified for 1 of 1 resident reviewed, (Resident #52) for NJ Ex Order 26.4b1 [REDACTED] Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." On 10/31/22 at 10:43 AM, the surveyor interviewed the US FOIA (b)(6) [REDACTED] regarding residents on the unit that had NJ Ex Order 26.4b1. The US FOIA (b)(6) stated that	F 658	F 658 Services Provided Meet Professional Standards How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these residents specified in the Statement of Deficiency (SOD) or CMS-2567 The Director of Nursing and licensed staff reviewed the record of Resident #52. The attending physician was notified of the deficient practice. Resident's NJ Ex Order 26.4b1 [REDACTED]. Recommendations we communicated to the attending physician and transcribed into the electronic medical record. Licensed staff involved in the deficient practice were counselled and educated on the importance of following up on consultant recommendations regarding physician orders for any treatment used for resident care.		12/30/22

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 658	Continued From page 6 Resident #52 had [REDACTED] that was a [REDACTED] On 11/02/22 at 11:16 AM, the surveyor observed Resident #52 in their room while the Certified Nursing Aide (CNA)#1 was performing care. CNA#1 explained to the surveyor that she would need help from another CNA [REDACTED] the resident. The surveyor observed CNA#2 enter the resident's room. On 11/02/22 at 11:20 AM, the surveyor observed the two CNAs, place a [REDACTED] underneath the resident and attach the [REDACTED] [REDACTED] While the resident was standing, the surveyor observed CNA#1 wash Resident #52's [REDACTED]. The surveyor further observed CNA#1 apply a [REDACTED]. The surveyor observed that the resident's [REDACTED] The surveyor reviewed the hybrid medical record for Resident #52. A review of the resident's Admission Record reflected that the resident resided at the facility for [REDACTED] and had diagnoses which included but were not limited to [REDACTED]. A review of the resident's annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [REDACTED] indicated that the resident's cognitive skills for decision making was [REDACTED]. A review of the resident's [REDACTED] reflected that the resident	F 658	How the facility will identify other residents having the potential to be affected by the same deficient practice. A review of all physician orders and medication administration records has been conducted by the nursing staff to assure that all services, treatments and medications that are ordered are accurate and complete. A list of recommendations from the wound consultant were reviewed to ensure that all orders are transcribed to the current month's medication and treatment administration records. A review of the Physician's Order Policy and Procedure has been presented to all licensed nursing staff (on all shifts) to ensure a full understanding of the policy and procedure. This training emphasized on ensuring that doctor's recommendations will be communicated to the attending physician and transcribed accurately / timely. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The nursing staff will review the standard of practice for physician recommendations and orders. This was followed up by implementation of facility protocols with medication / treatment recapitulation with licensed staff. Nursing staff along with the pharmacy		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 658	Continued From page 7 had an [NJ Ex Order 26.4b1] area on the residents [NJ Ex Order 26.4b1]. The recommendation made by the physician who conducted the [NJ Ex Order 26.4b1] indicated to apply [NJ Ex Order 26.4b1] the affected areas. A further review of the resident's [NJ Ex Order 26.4b1], reflected that the resident had [NJ Ex Order 26.4b1]. The recommendation made by the physician who conducted the [NJ Ex Order 26.4b1] indicated to apply [NJ Ex Order 26.4b1] for changes. A review of the resident's [NJ Ex Order 26.4b1] electronic Treatment Administration Record (eTAR) indicated that the recommendations made by the physician on [NJ Ex Order 26.4b1] who conducted the [NJ Ex Order 26.4b1] was not transcribed to the eTAR from [NJ Ex Order 26.4b1]. A review of the resident's Care Plan revised [NJ Ex Order 26.4b1], reflected a focus area that the resident had potential for [NJ Ex Order 26.4b1] related to [NJ Ex Order 26.4b1]. The goal of the resident's Care Plan was the resident's [NJ Ex Order 26.4b1] would remain [NJ Ex Order 26.4b1] by the next review date. The interventions in the residents Care Plan included to [NJ Ex Order 26.4b1] and to provide [NJ Ex Order 26.4b1].	F 658	consultant will continue to review medical records monthly to ensure accuracy and completeness of the physician's orders, reconciliations, and implementation. Findings will be reported to the Director of Nursing and discussed at schedule QAPI meetings. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? Nursing Administration will conduct random monthly audits to monitor that all protocols are being followed with regards to obtaining physician orders for any recommendations made by a consultant. A Performance Improvement Project (PIP) will be initiated to monitor these audits monthly until full compliance is attained then quarterly thereafter. Results of these audits will be reported to the quarterly Pharmacy and Therapeutics Committee and QAPI team to ensure compliance. While different deficiencies may have different completion dates within the POC, each individual deficiency is assigned only one completion date. December 30, 2022		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 658	Continued From page 8 On 11/15/22 at 11:07 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that the resident had [NJ Ex Order 26.4b1] and was being seen by the physician who assessed resident's [NJ Ex Order 26.4b1]. The surveyor asked the [US FOIA (b)(6)] what treatments were in place for the resident. The [US FOIA (b)(6)] stated that she was [NJ Ex Order 26.4b1] shift. On 11/15/22 at 11:09 AM, the surveyor further reviewed the [NJ Ex Order 26.4b1] eTAR in the presence of the [US FOIA (b)(6)]. A review of the [NJ Ex Order 26.4b1] eTAR reflected that the treatments for the [NJ Ex Order 26.4b1] had not been re-ordered for the resident and were not documented on the [NJ Ex Order 26.4b1] eTAR. The [US FOIA (b)(6)] stated that the resident had been seen by the physician who assessed the [NJ Ex Order 26.4b1], and made recommendations to continue the [NJ Ex Order 26.4b1] for the resident. The [US FOIA (b)(6)] told the surveyor that when facility staff received a recommendation by a physician, they would review the recommendation with the resident's primary care physician prior to carrying out the PO based off of the primary care physician's approval. The [US FOIA (b)(6)] stated that this would be documented in the resident's medical record. The [US FOIA (b)(6)] stated that the PO was not transcribed, however she was applying [NJ Ex Order 26.4b1] for the resident during her shift. The [US FOIA (b)(6)] could not speak to the [NJ Ex Order 26.4b1] during evening shift hours. On 11/15/22 at 11:31 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that the resident had [NJ Ex Order 26.4b1] and was followed by a physician	F 658			

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 658	Continued From page 9 weekly for his/her condition. The [US FOIA (b)(6)] stated that the recommendations made by the physician who conducted the [NJ Ex Order 26.4b1] were not transcribed onto the [NJ Ex Order 26.4b1] eTAR. On 11/17/22 at 10:20 AM, the surveyor observed that the resident's [NJ Ex Order 26.4b1] [REDACTED] On 11/17/22 at 12:36 PM, the surveyor conducted a follow up interview with the [US FOIA (b)(6)] who stated that the nurse working on [NJ Ex Order 26.4b1], should have called Resident #52's primary care physician to review the recommendations and appropriately transcribed them onto the [NJ Ex Order 26.4b1] eTAR. The [US FOIA (b)(6)] further stated that the resident was assessed by the physician, "yesterday" and the [NJ Ex Order 26.4b1]. A review of the facility's undated Physician Orders Policy and Procedure included, "If a consulting physician makes an order recommendation, this recommendation will need to be relayed to the attending physician for approval before recommendations can be carried out." The facility's Physician Orders Policy and Procedure further included that transcribed treatments would be documented onto the TAR.	F 658			
F 755 SS=D	NJAC 8:39-23.2(a) 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	F 755			12/30/22

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 10 §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 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 that the facility failed to provide pharmaceutical services in accordance with professional standards of practice to accurately administer a medication ^{NJ Ex Order 26.4b1} to 1 of 7 residents, (Resident #47) by 1 of 3 nurses observed during the medication administration observation. Reference: New Jersey Statutes Annotated, Title	F 755	F 755 Pharmacy Services / Pharmacist Records How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these residents specified in the Statement of Deficiency (SOD) or CMS-2567		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 11 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." This deficiency was evidenced by the following: On 11/2/22 at 8:42 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that she worked for an agency and that it was [NJ Ex Order 26.4b1] working at the facility. On 11/2/22 at 8:55 AM, during the medication administration observation, the surveyor observed the [US FOIA (b)(6)] preparing to administer medications to Resident #47. The [US FOIA (b)(6)] prepared [NJ Ex Order 26.4b1] medications which included [NJ Ex Order 26.4b1]	F 755	Resident # 47 was assessed with regards to this incident and it was determined that there were [NJ Ex Order 26.4b1] related to the administration of the [NJ Ex Order 26.4b1] medication. As a result of this action the [US FOIA (b)(6)] [NJ Ex Order 26.4b1] with regards to medication administration. This included the importance of following cautionary notices for these medications. As an additional precaution, the facility consultant pharmacist provided a guide for the manner / mode of administration regarding precautionary medications. This guide was attached to each facility medication cart to prevent this sort of misunderstanding in the future. How the facility will identify other residents having the potential to be affected by the same deficient practice. The policy and procedure for Medication Administration was updated to include reviewing and following cautionaries during medication administration. Pharmacy consultant and nursing administrative staff presented a comprehensive review to all licensed nursing staff of the facility's policy and procedure on all shifts to assure full understanding of medication administration including but not limited to checking and following cautionaries prior to administering medication. The pharmacy consultant and nursing		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 12 tablet of [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The [REDACTED] stated that the resident had a [REDACTED] NJ Ex Order 26.4b1 [REDACTED] and she had [REDACTED] the resident's medications. The surveyor observed the [REDACTED] place each medication in a small plastic medication bag, NJ Ex Order 26.4b1 [REDACTED] medications. The surveyor then observed the [REDACTED] proceed to a dining table where Resident #47 was seated in a wheelchair. The [REDACTED] stated that the resident had just finished breakfast and would be placing the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] into applesauce to administer them to the resident. The surveyor asked the [REDACTED] to return to the medication cart to review the medications prior to administration. On 11/2/22 at 9:05 AM, the surveyor, with [REDACTED] US FOIA (b)(6), reviewed the electronic medication administration record (eMAR) which revealed a Physician's Order (PO) dated [REDACTED] NJ Ex Order 26.4b1 [REDACTED] for [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The [REDACTED] stated that there were no instructions noted regarding whether the [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The [REDACTED] added that the resident had a [REDACTED] NJ Ex Order 26.4b1 [REDACTED] which was indicated on the eMAR and was following the diet and [REDACTED] NJ Ex Order 26.4b1 [REDACTED] medications. At that time, the surveyor asked [REDACTED] US FOIA (b)(6) to review the resident's medication label for the [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The surveyor, with [REDACTED] US FOIA (b)(6), reviewed the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] label which had a cautionary warning, "May be broken or allowed to disintegrate in water (Stir well) before swallowing. Rinse down with water. But do not chew all of the remaining particles." The [REDACTED] NJ Ex Order 26.4b1 [REDACTED] stated that when she was preparing the [REDACTED] NJ Ex Order 26.4b1 [REDACTED] she had thought about [REDACTED] NJ Ex Order 26.4b1 [REDACTED] not	F 755	administrative staff conducted medication administration pass to all licensed nursing staff, including agency licensed staff, to assure that competency is demonstrated. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The medication administration policy/procedure were reviewed with licensed staff, including following cautionaries. Pharmacy consultant and/or administrative nursing staff will continue to provide education to ensure that standard of practice are consistently utilized during medication administration. Administrative nursing staff and/or pharmacy consultant will continue to conduct medication pass observation including but not limited to following cautionaries. Licensed nursing staff, including agency staff, will be evaluated as part of the orientation to ensure competency prior to being assign to perform these tasks independently. All findings will be reported to administrator and/or director of nursing. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? Medication pass observation will continue		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 13 NJ Ex Order 26.4b1. The US FOIA further explained that, "nothing states NJ Ex Order 26.4b1." The US FOIA stated that she thought the NJ Ex Order 26.4b1. On 11/2/22 at 9:17 AM, the surveyor attempted to interview Resident #47, but the resident shook his/her head indicating, "no" at that time. On 11/2/22 at 9:18 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she was "somewhat oriented" to the facility's process. The US FOIA explained that she was oriented by another US FOIA (b)(6) to the floor and the medication cart. The US FOIA was unable to speak to whether the facility had provided an orientation or in-service on medication administration. On 11/2/22 at 9:57 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she was familiar with Resident #47. The US FOIA (b)(6) told the surveyor that she thought the resident could NJ Ex Order 26.4b1 as noted on the cautionary warning. The US FOIA (b)(6) stated that the NJ Ex Order 26.4b1. On 11/2/22 at 10:16 AM, the surveyor interviewed the US FOIA (b)(6) who stated that when US FOIA (b)(6) came to work at the facility for the first day, they were given a general orientation to the floor. On 11/2/22 at 1:40 PM, the survey team met with the US FOIA (b)(6) who stated that she would expect the nurses to follow the cautionary warnings such as give with food or NJ Ex Order 26.4b1. The US FOIA (b)(6) added that she was unsure if the facility policy for the Administration of Medication spoke to following cautionary warnings, but she knew there had	F 755	to be conducted by pharmacy consultant and/or nursing administrative staff to assure that licensed nursing staff can demonstrate consistent proficiency and error free during medication pass including following cautionaries. A Performance Improvement Project (PIP) will be initiated to monitor these audits monthly until full compliance then quarterly thereafter. Audit results will be reported and discussed at the Quality Assurance and Performance Improvement (QAPI) committee to assure ongoing compliance. QAPI committee meets every month except July, August and December. While different deficiencies may have different completion dates within the POC, each individual deficiency is assigned only one completion date. December 30, 2022		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 14 been in-services regarding medication administration provided to the nurses. On 11/2/22 at 2:46 PM, the survey team met with the [US FOIA (b) (6)] who stated that the nurses who came from an agency were oriented to the floor before starting their shift. The [US FOIA (b) (6)] added that she was relying on the agency to in-service the nurses on medication administration. On 11/6/22 at 12:45 PM, the surveyor was provided an in-service titled, "Practicing Safe Medication Pass" dated 8/5/22 and 9/9/22 that was performed by the [US FOIA (b)(6)] which revealed a list of medications that should not be crushed which included sustained release tablets and listed the more common prefixes or suffixes that indicated sustained release which included ER. Also provided was the in-service attendance record which revealed that the [US FOIA (b)(6)] was not in attendance. On 11/14/22 at 9:36 AM, the surveyor, in the presence of the survey team, interviewed the [US FOIA (b)(6)] who stated that the nurses were in-serviced on medication administration by the [US FOIA (b)(6)] and the [US FOIA (b)(6)] performed medication observations. The [US FOIA (b)(6)] added that she was responsible for providing mandatory in-services to all staff and kept track that the staff attended the in-services. The [US FOIA (b)(6)] added that she had done in-services regarding safe medication practices. The [US FOIA (b)(6)] stated that nurses who worked for an agency and worked at the facility frequently would attend in-services when they were working. The [US FOIA (b)(6)] was unable to speak to whether she kept track of which agency nurses had attended in-services but kept	F 755			

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 15 sign-in sheets for all in-services. On 11/14/22 at 10:07 AM, the surveyor, in the presence of the survey team, interviewed the [REDACTED] who stated that the primary [REDACTED] for the facility was currently unavailable, but she was able to answer any questions. The [REDACTED] stated that in-services and medication administration observations had been performed. The [REDACTED] added that the nurses were instructed to follow all cautionary warnings for medications. The [REDACTED] added that she thought the nurses would know that an NJ Ex Order 26.4b1 [REDACTED]. The [REDACTED] provided a handout card titled, "Med-Pass Checklist" that was provided to the facility nurses which reflected "Ensure med is crushable." The surveyor reviewed the medical record for Resident #47. A review of the resident's Admission Record indicated diagnoses which included NJ Ex Order 26.4b1 [REDACTED] A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Ex Order 26.4b1 [REDACTED], reflected the resident had a brief interview for mental status (BIMS) score of NJ Ex Order 26.4b1 [REDACTED] of 15, indicating that the resident had NJ Ex Order 26.4b1 [REDACTED]. Further review of the eMAR revealed in the "Diet" section NJ Ex Order 26.4b1 [REDACTED]. On 11/17/22 at 11:48 AM, the surveyor was able to interview Resident #47 who stated that his/her	F 755			

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 16 medications were administered by the nurses and that he/she was NJ Ex Order 26.4b1 the medications. The resident also stated that he/she had no problems with medication administration. The resident was unable to speak to how the medications were administered or if the medications were crushed. On 11/17/22 at 12:30 PM, the survey team met with the US FOIA (b)(6). The US FOIA (b)(6) stated that she was the staff member who oriented the US FOIA (b)(6) to the floor and believed that the nurses should be aware that NJ Ex Order 26.4b1. On 11/18/22 at 8:49 AM, the US FOIA (b)(6) provided the surveyor with a Long-Term Care US FOIA (b)(6) skills form for the US FOIA (b)(6) that was obtained from the agency. The form was an attestation completed by the US FOIA (b)(6) that she was very proficient in medication administration. A review of the facility's policy revised April 2019, for Administration of Medication provided by the US FOIA (b)(6) had no reference to cautionary warnings on the medication label. The policy included that, "The label on each unit dose medication container will be read 3 times: 1-when taking it from the drawer of the cart; 2-before opening the package; and 3-when comparing this package to the medication sheet." A review of the manufacturer's specifications for NJ Ex Order 26.4b1 reflected to "Swallow tablets whole without crushing, chewing or sucking." In addition, the specifications for "Patient Counseling Information" reflected to not crush, chew, or suck the tablets.	F 755			

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 17 Further review of the manufacturer specifications for, "Warnings and Precautions" reflected that NJ Ex Order 26.4b1 reactions and solid dosage forms can produce NJ Ex Order 26.4b1 and the liquid form should be considered in patients with dysphagia, swallowing disorders or severe gastrointestinal motility disorders.	F 755			
F 812 SS=F	NJAC 8:39-11.2(b), 29.2(d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that: a.) the facility failed to store and	F 812	F 812 Food Procurement, Store / Prepare / Serve- Sanitary		12/30/22

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 812	Continued From page 18 serve potentially hazardous foods in a manner to prevent food borne illness in 3 of 3 Bistros, and b.) failed to maintain refrigerator temperatures and store food at the correct temperature for 1 of 3 Bistro refrigerators. This deficient practice was evidenced by the following: On 10/31/2022 at 10:46 AM, in the presence of the first floor US FOIA (b)(6) he surveyor observed the following: The surveyor observed on the first floor Bistro: 1.) The refrigerator had a clear, small bin that housed pre-sliced bologna deli meat wrapped in clear plastic wrap. The pre-sliced bologna was labeled and dated with an expiration date of 10/27/22. 2.) The refrigerator thermometer read 50 degrees Fahrenheit (F). The surveyor observed on the second floor Bistro: 3.) The refrigerator had a clear, small bin that housed pre-sliced ham and bologna deli meat wrapped in clear plastic wrap. The ham was labeled and dated with an expiration date of 10/30/22. The bologna was labeled and dated with an expiration date of 10/29/22. The surveyor observed on the third floor Bistro: 4.) The refrigerator had clear, small bin that housed pre-sliced ham, bologna and sliced yellow cheese deli meat wrapped in clear plastic wrap. The ham was labeled and dated with an expiration date of 10/24/22. The bologna was labeled and dated with an expiration date of	F 812	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these residents specified in the Statement of Deficiency (SOD) or CMS-2567. All bistros were checked and expired meats were discarded. All Guest Service Representative (GSR) were counseled on monitoring refrigerator logs and maintaining the food that were in the bistro refrigerators, including but not limited to discarding outdated items. First floor bistro refrigerator was serviced by facility vendor. Dining services staff were counseled on notifying the Food Service Director for any equipment identified out of compliance or needing repairs. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Dining Service Director conducted audits with staff to ensure that all policies / procedures with regard to the storage and handling of food are being followed. Labeling of all food items will be in keeping with St. Ann's policies and any item identified as "out of date" (beyond the policy of 72 hours) will be discarded. The Dining Service management team conducted rounds to ensure equipment		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 812	Continued From page 19 10/26/22. The yellow cheese was not labeled and dated. On 10/31/2022 at 12:05 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated the [US FOIA (b)(6)], who work in collaboration with the dietary department were supposed to notify the [US FOIA (b)(6)] or [US FOIA (b)(6)] regarding issues with the refrigerators in the Bistros. The [US FOIA (b)(6)] further stated the [US FOIA (b)(6)] was responsible for the refrigerator logs and maintaining the food that was in the Bistro refrigerators. The [US FOIA (b)(6)] explained that the [US FOIA (b)(6)] were inserviced for sanitary uses and cleaning upon hire for five days, then inserviced once monthly with the kitchen staff. On 11/01/2022 at 10:25 AM, the surveyor in the presence of the first floor [US FOIA (b)(6)] and the [US FOIA (b)(6)] observed the following: 5.) On the first floor Bistro, the surveyor observed the refrigerator thermometer read 45 degrees F. A review the facility's undated [US FOIA (b)(6)] Essential Functions and Key Tasks provided by the [US FOIA (b)(6)] included, "Consistently practices key sanitation procedures and policies, especially hand washing, proper food storage and maintaining appropriate temperature of foods." A review the facility's Unit Pantry Management Policy #7 dated 01/01/21, included to, "label, date and discard outdated items per the food storage policy." A review of the facility's Storage of Food and Supplies Policy revised 12/07/20 included to,	F 812	that is not in proper working order is identified and serviced as needed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Dining Service team members have been in-serviced as to the proper way to handle, store, label and serve food items. Any item that is not properly labeled will be taken out of service and will be brought to the attention of the Food Service Manager. Daily temperature logs will be completed by GSRs to ensure that refrigerator temperature are in compliance. Logs will be monitored by the Dining Service Director or designee. Monthly audits will be completed by the Dining Service director or designee and reported to the Administrator for six (6) consecutive months. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? Dining Service Director or designee will monitor refrigerator temperature logs and storage of food items in the dining room bistro weekly for six (6) months and monthly thereafter. Audit finding will be reported to the Quality Assurance and Performance Improvement (QAPI)		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 812	Continued From page 20 "cover, label and date unused portions and open packages. Complete all sections on a Unidine Universal Date Label or use an approved labeling system. Products are good through the close of business day on the date noted on the label." A review of a work order dated 11/2/2022, indicated the refrigerator first floor Bistro was, "running warm."	F 812	committee that meets monthly except July, August and December. While different deficiencies may have different completion dates within the POC, each individual deficiency is assigned only one completion date. December 30, 2022		
F 851 SS=D	NJAC 8:39-17.2(g) Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS	F 851		12/30/22	

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 851	Continued From page 21 complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to submit their Payroll Based Journal (PBJ) Report to the Centers for Medicare and Medicaid Services (CMS) within a timely manner. This	F 851	F 851 Payroll Based Journal How the corrective action will be accomplished for those residents found to		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 851	Continued From page 22 deficient practice was identified for one of two PBJ Report submissions reviewed, (Fiscal Year Quarter 3 2022, April 1 - June 30) and was evidenced by the following: A review of the PBJ Staffing Data Report CASPER Report 1705D reflected a triggered area that the facility failed to submit data for the third fiscal year quarter to the CMS. The dates of the third quarter included April 1, 2022, through June 30, 2022. On 11/01/22 at 10:17 AM, the facility's Administrator stated that the PBJ Report for the third quarter was not submitted on time and rejected by CMS because it was late. At that time, the facility's US FOIA (b)(6) provided the survey team with documentation in electronic mail (e-mail) from CMS. A review of the e-mail dated, August 19, 2022 and timed at 7:14 AM from CMS indicated that the third quarter PBJ Report was not accepted because the facility did not submit the report in a timely manner. On 11/16/22 at 12:56 PM, the surveyor interviewed the facility's US FOIA (b)(6) who stated that she worked at the facility for NJ Ex Order 28.4b1 and was familiar with PBJ Reports. The US FOIA (b)(6) further explained that the submission of the PBJ Report was previously submitted by payroll and the facility did away with that position back in August when the third quarter PBJ Report was due. The US FOIA (b)(6) told the surveyor that the third quarter PBJ was rejected because it was submitted a day late, it was an honest mistake, and the report should have been submitted in a timely manner.	F 851	have been affected by the deficient practice; these residents specified in the Statement of Deficiency (SOD) or CMS-2567 Several changes had occurred at Peace Care St. Ann's this past year which resulted in the payroll department being centralized. The responsibility of submitting the Payroll Based Journal (PBJ) was brought back to a central office and the submission deadline for the quarter had been missed by one day (deadline fell on a Sunday and the report was submitted on Monday). Going forward the payroll department is aware of the filing deadlines which will be coordinated with the facility administrator to ensure the deadlines are met. How the facility will identify other residents having the potential to be affected by the same deficient practice. Corporate payroll will coordinate Payroll Based Journal (PBJ) deadlines with the administrator at Peace Care St. Ann's to make sure the deadline is met. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Quarterly filing deadlines have been reviewed with the Corporate Payroll Department to ensure that the PBJ report going forward is submitted in a timely basis. Payroll Based Journal (PBJ) submission report will be submitted to the		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 851	Continued From page 23 NJAC 8:39-41.3(a)	F 851	facility administrator prior to the deadline to ensure timeliness of the submission. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? Filing deadlines for the PBJ report have been reviewed by both the corporate payroll staff and the Administrator at Peace Care St. Ann's to ensure that going forward deadlines are not overlooked, and in an instance when a filing is due over the weekend, staff are aware that the report will be submitted the Friday before the weekend deadline. The Payroll Based Journal submission report will be monitored for the timeliness of the submission by the facility administrator. Results of these audits will be reported quarterly to the Quality Assurance and Performance Improvement committee (QAPI) to ensure that compliance is met. QAPI committee meets every month except July, August and December. While different deficiencies may have different completion dates within the POC, each individual deficiency is assigned only one completion date. December 30, 2022		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030904	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S		STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in CNA staffing for 7 of 14-day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	S 560 Mandatory Access to Care How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these residents specified in the Statement of Deficiency (SOD) or CMS-2567 It continues to be the goal of Peace Care St. Ann's to comply with direct care staff to resident ratios mandated by the State of New Jersey. At Peace Care St. Ann's, the Administrator, Director of Nursing, and Staffing Coordinator meet on a daily basis to discuss staffing for the day (and project	12/30/22

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

TITLE

(X6) DATE

Electronically Signed

12/16/22

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030904	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S		STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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
S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 10/16/2022 through 10/22/2022 and 10/23/2022 through 10/29/2022, revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -10/16/22 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -10/17/22 had 11 CNAs for 97 residents on the day shift, required 12 CNAs. -10/19/22 had 11 CNAs for 97 residents on the day shift, required 12 CNAs. -10/22/22 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -10/23/22 had 10 CNAs for 99 residents on	S 560	out the week). Open positions are identified and contact is made with in-house staff to see what shifts they might be able to pick up to address the need. Those positions not picked up by in-house staff are immediately put out to the several staff support agencies that are currently under contract with Peace Care St. Ann's/Peace Care, Inc. Periodically, staff that are currently working a shift are asked to stay over a few hours and on-coming staff are ask to come in a few hours early to help support the staffing needs. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents at Peace Care St. Ann's have the potential to be adversely affected by the staffing situation. We are currently under contract with several staff support agencies to supplement our open positions on a temporary basis. We also work very closely with our Human Resources Department to advertise open positions and to schedule interviews whenever the opportunity arises. Sign on bonuses, referral bonuses, as well as retention bonuses are being offered - all in attempts of recruiting and retaining staff. Peace Care St. Ann's has also partnered with a local schools and teaching organizations to provide a clinical site for students to train before becoming licensed / certified. Peace Care St. Ann's also offers premium pay to staff for working evening, weekends and holidays.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030904	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S		STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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
S 560	Continued From page 2 the day shift, required 12 CNAs. -10/28/22 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -10/29/22 had 12 CNAs for 101 residents on the day shift, required 13 CNAs. On 11/07/22 at 12:15 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she had been employed for three years at facility in her present position and was responsible for staffing the nursing department. The SC acknowledged the new minimum staffing requirements for nursing homes and added that she staffed the facility daily to meet the requirements, but "the call outs kill us." The SC stated that she would reach out to agencies, other facility CNA's, bonuses offered for overtime, and as a certified CNA herself would help out when needed. The SC stated that she reported directly to the DON and the DON was always aware of the staffing at the facility. On 11/15/22 at 1:19 PM, the facility's Licensed Nursing Home Administrator (LNHA) stated that he met with the DON every morning to discuss staffing and staffing concerns. In addition, the SC would text the LNHA regarding staffing and staffing concerns.	S 560	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? As previously stated Peace Care St. Ann's is currently under contract with several staff support agencies to supplement our open positions on a temporary basis. We also work very closely with our Human Resources Department to advertise open positions and to schedule interviews whenever the opportunity arises. Sign on bonuses, Referral bonuses, as well as Retention bonuses are being offered - all in attempts of recruiting and retaining staff. Peace Care St. Ann's has also partnered with a local teaching organization to provide a clinical site for students to train before becoming licensed / certified. Peace Care St. Ann's also offers an addition to the staff's hourly pay for working weekends and holidays. Peace Care St. Ann's has extended tuition reimbursement as a means to bring entry level staff into nursing positions. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? Daily staffing schedule and resident to staff ratio are reviewed by the Administrator and Director of Nursing to	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030904	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S		STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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
S 560	Continued From page 3	S 560	ensure that required staffing is met to meet the needs of our resident population. Staffing patterns and ratios are identified and outcomes are presented for review by administration and nursing management. Audits related to staffing are presented at QAPI meetings. (QAPI Committee meets monthly except July, August and December). While different deficiencies may have different completion dates within the POC, each individual deficiency is assigned only one completion date. December 30, 2022 (on-going)	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315413	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 3/6/2023
NAME OF FACILITY PEACE CARE ST ANN'S	STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305	

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 F0656	Correction	ID Prefix F0658	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	12/30/2022	LSC	12/30/2022	LSC	12/30/2022
ID Prefix F0812	Correction	ID Prefix F0851	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(q)(1)-(5)	Completed	Reg. #	Completed
LSC	12/30/2022	LSC	12/30/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 11/22/2022

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 030904	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 3/6/2023
NAME OF FACILITY PEACE CARE ST ANN'S	STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305	

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 S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/30/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 11/22/2022		☐ 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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/21/22 and 11/22/22. The facility 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 The facility is a two-story building with a basement, that was built in 90's. It is composed of Type II protected construction. The facility is divided into six smoke zones. The generator does approximately 80% of the building.	K 000			
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 11/21/22, in the presence of the US FOIA (b)(6) , it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice occurred for 8 of 8 fire doors observed, and was evidenced by the following:	K 211	K211 - Means of Egress - General How any corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are residents specified in the Statement of Deficiency (SOD) or CMS 2567		12/24/22

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

TITLE

(X6) DATE

Electronically Signed

12/12/2022

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.

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 211	Continued From page 1 From approximately 10:00 AM to 2:00 PM, the surveyor reviewed all documentation provided from the [REDACTED]. Review of the fire door monthly Maintenance Log indicated that a check for each door was the only indicator on the log and no annual fire door assemblies were noted on the provided log. An interview was conducted with the [REDACTED], during the document review. He stated that currently they could not provide any documentation for the annual fire door assemblies, on the provided monthly log, as identified in the S&C 17-38-LSC documentation. The [REDACTED] was informed of the finding's at the Life Safety Code exit conference held on 11/22/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	Certified fire door-assembly inspector completed an inspection and summary for all stairwell fire doors on 12/22/22 and found all necessary hardware to be in compliance. How the facility will identify other residents having the potential to be affected by the same deficient practice The maintenance team at Peace Care St. Ann's will continue to inspect all fire doors on a monthly basis to ensure compliance with NFPA 80. Fire door inspections will occur annually by certified door vendor. Inspection reports will be monitored and maintained by maintenance director. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Maintenance director will in-service maintenance staff to check fire door latches during environmental rounds. Facilities director or designee will conduct monthly inspections of each of the stairwell fire door. How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 211	Continued From page 2	K 211	systemic change? Monthly inspection audits of all stairwell fire doors will be reviewed by the maintenance director. Findings will be reported to the Safety committee and Quality Assurance and Performance Improvement (QAPI) committee monthly for six (6) months then quarterly thereafter. QAPI committee meets every month except July, August and December. While different deficiencies may have different completion dates with the POC, each individual deficiency is assigned only one completion date. December 24,2022		
K 281 SS=F	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 11/22/22, in the presence of the US FOIA (b)(6) and US FOIA (b)(6), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. This deficient	K 281	K 281 Illumination of Egress How any corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are residents specified in the Statement of Deficiency (SOD) or		12/9/22

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 281	Continued From page 3 practice affected 12 of 24 exit access areas observed and was evidenced by the following: Floor #3 side by side occupied dining rooms were observed to have three electrical wall switches each, that shutoff all the room lights, leaving the means of egress with no lighting. Floor #3 television/day room #1 and #2 were observed to have two electrical wall switches each, that shutoff all the room lights, leaving the means of egress with no lighting. Floor #2 side by side occupied dining rooms were observed to have three electrical wall switches each, that shutoff all the room lights, leaving the means of egress with no lighting. Floor #2 television/day room #1 and #2 were observed to have two electrical wall switches each, that shutoff all the room lights, leaving the means of egress with no lighting. Floor #1 side by side occupied dining rooms were observed to have three electrical wall switches each, that shutoff all the room lights, leaving the means of egress with no lighting. Floor #1 television/day room #1 and #2 were observed to have two electrical wall switches each, that shutoff all the room lights, leaving the means of egress with no lighting. The US FOIA (b)(6) confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the above findings at the Life Safety Code survey exit conference on 11/22/22.	K 281	CMS 2567? The maintenance team at Peace Care St. Ann's has installed light switch covers on all floors in the dining rooms and television/day rooms on 11/24/22. These light switch covers will ensure partial lighting will remain on for illumination of means of egress. How will the facility identify other residents having the potential to be affected by the same deficient practice? The maintenance team at Peace Care St. Ann's will continue to inspect and monitor illumination means of egress lighting during their monthly inspections to ensure that an egress path is lighted at all times. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur? All maintenance staff will be in-service by the maintenance director that lighting in all areas shall be either continuously in operation or capable of automatic operation. In-service included monitoring illumination of means of egress during environmental rounds. Maintenance director or designee will conduct monthly inspections of egress lighting for six (6) consecutive months. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur?		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 281	Continued From page 4 NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	Results of the monthly inspections of the egress lighting will be reported by the maintenance director at the safety committee meeting and at the Quality Assurance and Performance Improvement (QAPI) committee meetings quarterly. QAPI committee meets monthly except July, August and December. While different deficiencies may have different completion dates with the POC, each individual deficiency is assigned only one completion date December 9, 2022		
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 on 11/22/22, in the presence of facility management, it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator transfer switches independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 1 of 1 transfer switches and was evidenced by the following: On 11/22/22 at 1:07 PM, the surveyor in the presence of the US FOIA (b)(6) and	K 291	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are residents specified in the Statement of Deficiency (SOD) or CMS 2567. A licensed electrician installed an emergency light (battery-operated -90 minutes) above emergency transfer switch in the mechanical room on 12/27/22.		12/20/22

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 291	Continued From page 5 US FOIA (b)(6), observed in the boiler room where the generator transfer switch was located, that the ATS-1 was not equipped with battery back-up emergency lighting. There was a light fixture observed in the ceiling area of the transfer switch, but the US FOIA (b)(6) indicated it was not currently working. The US FOIA (b)(6), both confirmed the findings at the time of the observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit on 11/22/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	How the facility will identify other residents having the potential to be affected by the same deficient practice. All other areas were assessed and found that there are emergency lighting, battery operated devices in place. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. During the annual electrical inspection, all emergency lighting will be inspected and tested by licensed electrician. Results will be documented and report will be maintained by the maintenance director. All maintenance staff will be in-serviced by the maintenance director to check and test all emergency lighting during monthly environmental rounds. Maintenance director will conduct tests of all emergency lighting monthly for six (6) consecutive months. How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? Results of the annual and monthly emergency lighting inspections will be reported quarterly to the Quality Assurance and Performance Improvement (QAPI) committee that		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 291	Continued From page 6	K 291	meets monthly except July, August and December.		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and 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 observation and interview on 11/22/22, in the presence of the US FOIA (b)(6), it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 2 of 2 enclosed courtyards in accordance with NFPA 101, 2012	K 341	December 20, 2020 K 341 Fire Alarm Strobes and Horns How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are residents specified in	1/27/23	

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 341	Continued From page 7 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 11/22/22 at 10:38 AM, the surveyor, in the presence of the US FOIA (b)(6), observed in the enclosed courtyards, no evidence of a fire alarm notification (horn/strobe) was located. An interview was conducted during the observation and the surveyor asked the US FOIA (b)(6), if there was a horn/strobe, tied into the fire alarm system within court yard #1 and court yard #2. The US FOIA (b)(6) confirmed that currently there are no horn/strobe devices tied into the fire alarm system in the enclosed courtyard's observed. The US FOIA (b)(6) was notified of the findings at the Life Safety Code exit conference on 11/22/22. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	the Statement of Deficiency (SOD) or CMS 2567? Peace Care St. Ann's requested a time limited waiver. The horns and strobes in the courtyards #1 and #2 were contracted to be installed by authorized fire alarm company with an estimate date for completion of 2/24/23. Interim life safety measures in place until completed. How the facility will identify other residents having the potential to be affected by the same deficient practice? A tour of the campus was conducted by the maintenance director and fire alarm company. Any deficient area identified will have horns and strobes lights installed. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? All maintenance staff will be in-serviced by the maintenance director to check and test all horns and strobes during environmental rounds. Any deficient areas will be reported to maintenance director. Maintenance director will check all horns and strobes throughout the campus monthly for six (6) consecutive months. How will the facility monitor its corrective action to ensure that the deficient practice		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 341	Continued From page 8	K 341	is being corrected and will not recur, i.e., what program will be put in place to monitor the continued effectiveness of the systemic changes? The maintenance team will continue to monitor the fire alarms and strobes along with all other existing fire horns and strobes. Results of the audit will be reported to safety meetings and to the Quality Assurance and Performance Improvement (QAPI) committee monthly for six (6) months then quarterly thereafter. QAPI meets monthly except July, August and December. While different deficiencies may have different completion dates with the POC, each individual deficiency is assigned only on completion date. January 27, 2023		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area	K 351			1/20/23

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 351	Continued From page 9 of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 11/21/22, in the presence of the facility US FOIA (b)(6), it was determined that the facility failed to provide automatic fire sprinkler protection to all areas in accordance with NFPA 13. At 10:10 AM, the surveyor observed in the Nurse Station Supervisor office that 4 of 4 closets; 3 of 3 kitchens, and two refrigerators and one freezer did not have any fire sprinkler protection. 1). The left-side closet approximately 3' x 2' contained 6-portable oxygen cylinders and was observed to not have any fire sprinkler coverage. 2). The middle closet approximately 4' x 2' contained combustible cardboard boxes and was observed to not have any fire sprinkler coverage. 3). The right-side closet approximately 6' x 2' contained combustible cardboard boxes and was observed to not have any fire sprinkler coverage. 4). The locked Omnicell closet approximately 7' x 3' was observed to not have any fire sprinkler coverage. 5). At 12:15 PM, the surveyor observed that the Kitchen two walkin refrigerators and one walkin Freezer were observed to not have any fire	K 351	K 351 Sprinkler Head How any corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are residents specified in the Statement of Deficiency (SOD) or CMS 2567 Automatic fire sprinkler protection were installed in the affected areas. Installations were completed by 1/19/23. How the facility will identify other residents having the potential to be affected by the same deficient practice. All confined locations were checked to assure that all have automatic fire sprinkler protection. The maintenance team at Peace Care St. Ann's will continue to monitor the sprinkler system for any areas that may require coverage by the sprinkler system and make the necessary additions. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 351	Continued From page 10 sprinkler coverage. One of the refrigerators was observed to not be working and was used as a storage unit. An interview was conducted with the [US FOIA (b)(6)] [REDACTED] during the observations and he confirmed the above findings. The [US FOIA (b)(6)] was informed of the findings at the life safety code exit conference on 11/22/22. NFPA 13, 25 NJAC 8:39-31.1(c) NJAC 8:39-31.2(e)	K 351	During the annual fire sprinkler inspections, all sprinkler heads will be checked to assure compliance. Results will be documented. Maintenance director or designee will conduct monthly rounds to assure that sprinkler heads are not blocked and heads are intact. All maintenance staff will be in-serviced by the maintenance director to check all confined spaces and sprinkler heads during monthly environmental rounds. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? Results of the monthly rounds will be monitored by the maintenance director and reported at the Quality Assurance and Performance Improvement (QAPI) meetings that meet monthly except July, August and December. While different deficiencies may have different completion dates with the POC, each individual deficiency is assigned only one completion date. January 20, 2023		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101	K 363		12/28/22	

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 11 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other 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:	K 363			

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 12 Based on observation and interview on 11/22/22, in the presence of th US FOIA (b)(6) 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 of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was further identified in 3 of 40 resident room doors observed and was evidenced by the following: During the building tour from 9:15 AM to 3:00 PM, the surveyor, in the presence of the US FOIA (b)(6) toured the facility and observed the following: 1). Resident Room # 130 top section of the wooden door was warped, preventing the door from being smoke resistant. 2). Resident Room # 233 top section of the wooden door was warped, preventing the door from being smoke resistant. 3). Resident Room # 310 would not latch, due to a hardware malfunction. At the time of observations, the surveyor interviewed the US FOIA (b)(6) who confirmed the above findings. The US FOIA (b)(6) was informed of the findings at	K 363	K 363 Corridor / Smoke Passage Doors How any corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are residents specified in the Statement of Deficiency (SOD) or CMS 2567 Resident room door#130 and door#233 hinges were repaired to ensure that wooden door was not warped. Resident room door#310 tension was adjusted to ensure proper latching. How the facility will identify other residents having the potential to be affected by the same deficient practice. All corridor / smoke doors were checked to ensure integrity and proper clearance along with proper latching and closure on 11/23/22. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The maintenance team at Peacecare St. Ann's will continue to monitor monthly all corridor / smoke doors to ensure for proper latching and closure. All findings will be documented in the Maintenance Repair Log. All maintenance staff will be in-serviced by the maintenance director to check integrity of all corridor door for proper		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 13 the Life Safety Code Exit Conference on 11/22/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	latching. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? Monthly audits will be conducted by the maintenance director for six (6) consecutive months then quarterly thereafter. Results of these audits will be reported to Quality Assurance and Performance Improvement (QAPI) committee that meets monthly except July, August and December. While different deficiencies may have different completion dates with the POC, each individual deficiency is assigned only one completion date.		
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel	K 531	December 28,2022	12/20/22	

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 531	Continued From page 14 distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 11/21/22, in the presence of US FOIA (b)(6) it was determined that the facility failed to test and inspect the elevator annually with the local Department of Community Affairs Division of Codes and Standards Elevator Safety Division. This deficient practice was evidenced by the following: A review of the facility's elevator inspection certificate, revealed that 2 of 2 hydraulic elevator devices were last inspected 1/21/21, from the Jersey City Elevator Safety Division. The current date of 11/22/22, indicated that the annual inspection date was over 10-months past due. In an interview, at 11:30 AM, the facility's US FOIA (b)(6) provided an email trail that indicated he was trying to get the elevator's inspected, but the email's indicated that the Jersey City Elevator Safety Division was behind on there inspections, due to a "manpower" shortage. The US FOIA (b)(6) was informed of this issue at the Life Safety Code exit conference on 11/22/22.	K 531	K 532 Elevator Inspection How any corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are residents specified in the Statement of Deficiency (SOD) or CMS 2567 As stated to the Life Safety Surveyor, numerous attempts have been made to contact the Jersey City Code Enforcement Department to have the elevators at Peace Care St. Ann's certified. Our maintenance team presented numerous email attempts as well as phone calls made to the city which went unanswered however we continue to ask the city to schedule the inspections. To ensure that our elevators are in safe working order, Peace Care St. Ann's, at facility's expense, contacted our elevator service company to come onsite to conduct additional inspections. How the facility will identify other residents having the potential to be affected by the		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 531	Continued From page 15 NJAC 8:39-31.2(e)	K 531	same deficient practice. Peacecare St. Ann's will continue to reach out to the Jersey City Code Enforcement Department to perform our annual inspections however until such time as they arrive onsite to perform the inspection Peacecare St. Ann's will continue to have our current elevator service company inspectors certify the working order of the elevators. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Maintenance director will begin to schedule the necessary inspection with the Jersey City Code Enforcement Department at least 2 to 3 months prior to expiration date and will continue to follow-up until inspection has been scheduled. How will the facility monitor the corrective action to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness o the systemic change? Updates on scheduling the elevator inspections will be provided by the maintenance director at the Quality Assurance and Performance Improvement (QAPI) committee meetings. QAPI committee meets monthly except July, August and December.		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 531	Continued From page 16	K 531	While different deficiencies may have different completion dates with the POC, each individual deficiency is assigned only one completion date.		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 11/21/22, in the presence of the [US FOIA (b)(6)] [REDACTED] it was determined that the facility failed to conduct in-house fire drills with varying activation types and simulation of emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was evidenced by the following: Based on document review and interview on 11/21/22, with the [US FOIA (b)(6)] [REDACTED], the facility fire drill reports revealed method for the simulation of emergency fire conditions were not varied:	K 712	December 20, 2022 K 712 Fire Drills How any corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are residents specified in the Statement of Deficiency (SOD) or CMS 2567 The maintenance team at Peace CVare St. Ann's have been instructed on how to change the current "Fire Drill Form" to be more descriptive in what is being reported at the time of the fire drill. Drills will now include alarm was activated, training	12/9/22	

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 712	Continued From page 17 Date Type of alarm transmission: Pull, Smoke or Page - 10/26/22 Description of Drill/Alarm: Blank - 09/23/22 Description of Drill/Alarm: Blank - 08/29/22 Description of Drill/Alarm: Blank - 07/19/22 Description of Drill/Alarm: Blank - 06/23/22 Description of Drill/Alarm: Blank - 05/19/22 Description of Drill/Alarm: Blank - 04/30/22 Description of Drill/Alarm: Blank - 03/30/22 Description of Drill/Alarm: Blank - 02/21/22 Description of Drill/Alarm: Blank - 01/24/22 Description of Drill/Alarm: Blank - 12/01/21 Description of Drill/Alarm: Blank - 11/10/21 Description of Drill/Alarm: Blank The findings were verified by the US FOIA (b)(6) at the time of the observation's. He indicated that currently the fire drills were not descriptive as to the type of device used to activate the fire alarm system, (pull, page and smoke) including the location and type of fire simulation used to train staff members on the above dates. The US FOIA (b)(6) was informed of the finding, at the Life Safety Code exit conference on 11/22/22.	K 712	provided, equipment used, and page notification to name but a few. How the facility will identify other residents having the potential to be affected by the same deficient practice. Peace Care St. Ann's recognizes the importance of continuing to conduct our monthly fire drills. All residents at St. Ann's (and the staff) could be affected by a fire / smoke situation in the facility and therefore it is important that the staff are properly trained. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Peace Care St. Ann's will modify the current fire drill report to encompass several areas of importance. The form will now note how the fire alarm was activated, the location of the simulated fire, type of fire situation, staff responding, equipment used, time of incident (beginning), time of incident (ending) to be more comprehensive. These findings will be reported to the QAPI committee on a quarterly basis. How will the facility monitor it corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? Peace Care St. Ann's has modified it's		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 712	Continued From page 18 NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712	current "Fire Drill Form" and will continue to hold monthly fire drill which will be discussed and evaluated by our QAPI committee that meets monthly except July, August and December. While different deficiencies may have different completion dates with the POC, each individual deficiency is assigned only one completion date. December 9, 2022		
K 918 SS=E	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 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	K 918		12/28/22	

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 918	Continued From page 19 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, interview, and review of facility documents on 11/22/22, in the presence of the US FOIA (b)(6) [REDACTED] it was determined that the facility failed to a.) 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 for emergency electrical generator systems and b.) ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. c.) The facility monthly load test document did not provide any times indicating how long the monthly test was conducted as per NFPA 110. This deficient practice was evidenced for 1-generator log provided by the [REDACTED] by the following: 1). At 9:30 AM, a review of the generator records for the previous twelve months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the monthly load test	K 918	K 918 Electrical Systems and Testing How any corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are residents specified in the Statement of Deficiency (SOD) or CMS 2567 The maintenance team at Peace Care St. Ann's has revised the current Generator Log to include transfer time duration and the time under load for each of the monthly test as per NFPA 110. In addition to the changes to the reporting process Peace Care St. Ann's has also installed two (2) remote shut off switches to shut the generator down in the event of an emergency.(only 1 is required). How the facility will identify other residents having the potential to be affected by the same deficient practice. Peace Care St. Ann's recognizes the importance of having an emergency		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 918	Continued From page 20 document provided by the [US FOIA] indicated no transfer time was being logged. An interview was conducted with the [US FOIA] during the document review and he stated that no transfer time was being documented currently on the log provided. 2). At 12:40 PM, the surveyor, and [US FOIA], observed that the facility's generator did have a remote shutoff. An interview was conducted during the observation with the [US FOIA] who confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation located (remote) of the enclosure housing the prime mover. The current manual stop station was located on the generator cabinet and not remote. 3.) At 12:48 PM, the surveyor and [US FOIA] reviewed and confirmed there was no times indicated on the completed monthly load test log. An interview was conducted during the observation with the [US FOIA], who confirmed that the generator log did not provide a time as to how long the generator was exercised under load each month. The [US FOIA (b)(6)] was informed of the findings at the Life Safety Code Exit Conference on 11/22/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	back-up generator that is in proper working order. Having equipment that is not properly maintained or in proper working order affects our ability to care for each of our residents at Peace Care St. Ann's. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur? Peace Care St. Ann's has revised the "Generator Log" form to record the particulars of each time the generator is run. This data will reflect the amount of time the generator is run, time the facility is carried "under load" and other operational statistics to ensure the generator is in proper running order. Two (2) remote disconnect switches were installed to shut the generator down in the event of an emergency to comply with NFAP 110. Maintenance director will monitor weekly logs for start and end times of the generator testing in addition to monthly load testing assurance of transfer time, no more than 10 seconds, including testing functionality of the emergency stop button. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put in place to monitor the continued effectiveness of the systemic change. Peacecare St. Ann's has revised the		

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315413	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER PEACE CARE ST ANN'S			STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305		
(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 918	Continued From page 21 NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918	"Generator Log" form to reflect operational data and generator capability during each run cycle. The information from this form will be communicated to the QAPI Committee quarterly to determine the effectiveness of the generator and to diagnose any potential issues that might develop as a result of the generator's operation. While different deficiencies may have different completion dates with the POC, each individual deficiency is assigned only one completion date. December 28, 2022		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315413	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 3/6/2023
NAME OF FACILITY PEACE CARE ST ANN'S	STREET ADDRESS, CITY, STATE, ZIP CODE 198 OLD BERGEN ROAD JERSEY CITY, NJ 07305	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	12/24/2022	LSC K0281	12/09/2022	LSC K0291	12/20/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0341	01/27/2023	LSC K0351	01/20/2023	LSC K0363	12/28/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	12/20/2022	LSC K0712	12/09/2022	LSC K0918	12/28/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 11/22/2022		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			