STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE JERSEY CITY, NJ 07306**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #s NJ 170090, 173767, 178004 STANDARD SURVEY: 10/31-11/7/24 CENSUS: 124 SAMPLE SIZE: 25+2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that [NJ Ex Order 26.4(b)(1)] care was provided to dependent residents in a timely manner for 3 of 6 residents (Resident #22, #109, and #87) observed for [NJ Exec Order 26.4b1] care on 1 of 3 units, the [NJ Exec] floor Unit. This deficient practice was evidenced by the following: a. On 11/4/24 at 11:55 AM, the surveyor interviewed the Certified Nursing Assistant (CNA	F 677	F 677 Corrective Action taken for those residents to have been affected by the deficient practice: Grievance was completed for Resident 3# 22 and Resident # 87 Resident # 22 - Care Plan was updated to include [NJ Exec Order 26.4b1] care Resident # 109 - Care Plan was updated to include [NJ Exec Order 26.4b1] care Resident #87 - Care Plan was updated to	11/22/24

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

Electronically Signed | 11/25/2024

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

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F 677	Continued From page 1 #1) on the [redacted] floor unit. CNA #1 stated that she had 8 residents on her assignment and was also helping another aide with some of their residents. On 11/4/24 at 12:00 PM, the surveyor and CNA #1 entered Resident #22's room and observed the resident in bed. CNA #1 stated that she had not provided care to Resident #22 yet as she was very busy all morning. The CNA [redacted] Resident #22's [redacted] which was [redacted] with [redacted] At that time when CNA #1 [redacted] the [redacted] another [redacted] was observed which was also [redacted] with [redacted] CNA #1 acknowledged the two [redacted] were [redacted] with [redacted] and stated that no residents should be wearing two [redacted] CNA #1 stated that it was the night CNA who [redacted] the resident. A review of Resident #22's Admission Record reflected the Resident was admitted to the facility with diagnoses which included but were not limited to [redacted] A review of Resident #22's quarterly Minimum Data Set (MDS) an assessment tool dated [redacted] revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of "[redacted] out of 15" which indicated Resident #22 had a [redacted]. The MDS further assessed Resident #22 required [redacted] from staff for [redacted] and was always [redacted] of [redacted] and [redacted] The surveyor reviewed Resident #22's Individual Care Plans (ICPs) which revealed there were no care plans initiated that focused on the resident's [redacted] and [redacted].	F 677	include [redacted] care Action to identify other residnets that may have been affected by the deficient practice: A review was conducted for all residents in house to identify those who require incontinency care. For those identified care plans were updated. The measures the facility will take to ensure the problem will be corrected and will not reoccur: Certified Nursing Assistants were in-serviced on proper incontinency care including 2 hour rounding. It was further emphysized that double diapering is not in keeping with proper care protocols. Random audits will be conducted and findings will be reported to the QAPI committee for the next 2 Quarters. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: DON and / or her designee will conduct bi-weekly audits for the next 2 months followed by monthly audits for 1 month. The findings will be reported to the QAPI Committee. Adverse finding will be immediately addressed. Goal set for incontinency care compliance will be 100% compliance Completion Date:	

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F 677	Continued From page 2	F 677	11/22/24	

b. On 11/4/24 at 12:15 PM, the surveyor and CNA #1 observed Resident #109 in bed. CNA #1 stated that she had not provided care for Resident 109 until this time. The CNA NJ Exec Order 26.4b the resident's NJ Exec Order 26.4b1 which was NJ Exec Order 26.4b1 with NJ Exec Order CNA #1 acknowledged that she should have provided NJ Exec Order 26.4b1 care for Resident #109 every two hours but stated that she had been too busy.

A review of Resident #109's Admission Record reflected the Resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1

A review of Resident #109's quarterly MDS dated NJ Exec Order 26.4b revealed Resident #109 had a BIMS score of "NJ out of 15" which indicated Resident #109 had a NJ Exec Order 26.4b1 . The MDS further assessed that the resident required NJ Exec Order 26.4b1 from staff for NJ Exec Order 26.4b and he/she was always NJ Exec Order 26.4b1 of NJ Exec Order and NJ Exec Order 26.4b

The surveyor reviewed Resident #109's ICPs which revealed there were no care plans initiated that focused on the resident's NJ Exec Order 2 and NJ Exec Order 26.4

c. On 11/4/24 at 12:30 PM, the surveyor observed Resident #87 in bed. The resident stated that she/he had not been NJ Exec Order 26.4b or NJ Exec Order 26 all

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F 677	Continued From page 3 morning and further stated that she/he wanted to get [NJ Exec Order 26.4] up and [NJ Exec Order 26.4b1] On 11/4/24 at 12:35 PM, the surveyor interviewed CNA #2 who stated that Resident #87 was on her assignment. CNA #2 confirmed she had 10 Residents on her assignment and had not yet provided care to Resident #87. At that time, CNA #2 and the surveyor entered Resident #87's room. CNA #2 [NJ Exec Order 26.4b] Resident #87's NJ Exec Order 26.4b1 which was [NJ Exec O] and both the surveyor and CNA #2 observed the resident had a NJ Exec Order 26.4b1 within the [NJ Exec Order 26.4b1] CNA #2 stated that she doesn't use [NJ Exec Order 26.] , that it was the night CNA that put it there. A review of Resident #87's Admission Record reflected Resident #87 was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 A review of Resident #87's Admission MDS dated [NJ Exec Order 26.] revealed Resident #87 had a BIMS score of "[NJ Ex] out of 15" which indicated Resident #87 had a NJ Exec Order 26.4b1 . The MDS further revealed that the resident required NJ Exec Order 26.4b1 from staff for [NJ Exec Order 26.4b1] , and he/she was always [NJ Exec Order 26.4b1] of [NJ Exec Order] and [NJ Exec Order 26.4] The surveyor reviewed Resident #87's ICPs which revealed there were no care plans initiated that focused on the resident's [NJ Exec Order] and [NJ Exec Order 26.4] . On 11/4/24 at 1:34 PM, the survey team met with the US FOIA (b)(6) to discuss the above	F 677		

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F 677	Continued From page 4 observations and concerns. The [US FOIA (b)] confirmed that [NJ Exec Order 26.4b1] should be done every two hours and that no resident should have two [NJ Exec Order 26.4b1]. The [US FOIA (b)] further stated that [NJ Exec Order 26.4b1] should be used only if the resident requests. On 11/6/24 at 2:15 PM, the surveyor interviewed the [US FOIA (b)] who stated that all residents who were [NJ Exec Order 26.4b1] should have a care plan in place since [NJ Exec Order 26.4b1] care was part of the resident's care. The surveyor attempted a phone interview with the 12:00 AM-8:00 AM, CNA who was assigned to Resident #22, #109 and #87. The surveyor left a voice message with no return call.	F 677		
F 695 SS=D	NJAC 8:39-27.1 (a), 27.2 (h) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer [NJ Exec Order 26.4b1] according to the physician's order for 1 of 1 resident, (Resident #6).	F 695	F 695 Corrective Action taken for those residents to have been affected by the deficient practice:	11/22/24

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F 695	Continued From page 5 This deficient practice was evidenced by the following: 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 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." On 10/31/24 at 12:25 PM, the surveyor observed Resident #6 in bed on a NJ Exec Order 26.4b1 with his/her eyes closed and the NJ Exec Order 26.4b1 [redacted]. The surveyor observed the NJ Exec Order 26.4b1 [redacted]. The surveyor observed Resident #6 wearing a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted] on and the	F 695	Resident # 6 medication error report was completed and submitted to MD, family was notified Action to identify other residnets that may have been affected by the deficient practice: A comprehensive audit was conducted to determine which residents have orders for oxygen. Staff viewed each resident with oxygen orders to ensure that the proper liter flow was being administered in keeping with the MD's orders. The measures the facility will take to ensure the problem will be corrected and will not reoccur: Staff in-services were conducted to ensure that rounds are made before as well as during the shift to ensure that the proper oxygen liter flow is being followed. Finding will be reported to the QAPI Committee Quality Assurance plan to monitor facility performance to make sure corrections are achieved: DON and / or her designee will conduct bi-weekly audits for the next 2 months followed by monthly audits for 1 month. The findings will be reported to the QAPI Committee. Adverse finding will be immediately addressed. Goal set for proper oxygen administration will be 100%	

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F 695	Continued From page 6 [redacted] was set at NJ Exec Order 26.4b1 A review of Resident #6's Admission record revealed Resident #6 was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]). A review of Resident #6's annual Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed Resident #6 had NJ Exec Order 26.4b1 [redacted], was NJ Exec Order 26.4b1 [redacted] and was NJ Exec Order 26.4b1 others. The MDS further assessed that Resident #6 was [redacted] on staff for Activities of Daily Living (ADLs), had a NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 [redacted]. A review of the Individual Care Plan (ICP) initiated on [redacted] reflected a focus area: resident has NJ Exec Order 26.4b1 with interventions that included but were not limited to [redacted]. A Review of the NJ Exec Order 26.4b1 Order Summary Report (OSR) revealed an active physician order (PO) with an order date of [redacted] for [redacted] every shift for NJ Exec Order 26.4b1 [redacted] On 11/1/24 at 1:07 PM, the surveyor observed Resident #6 in bed with the head of the bed elevated, the NJ Exec Order 26.4b1 [redacted]. The surveyor observed Resident #6 wearing a [redacted] on and the gauge was set at [redacted].	F 695	compliance Completion Date: 11/22/24	

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F 695	Continued From page 7 On 11/1/24 at 1:10 PM, the surveyor asked the US FOIA (b)(6) to accompany her to Resident #6's room. The surveyor and the US FOIA (b) entered Resident #6's room, and both observed the resident in the bed with the head of the bed elevated, and a NJ Exec Order 26.4b1 The resident was NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 was on with the NJ Exec Order 2 set at NJ Exec Order 26 The US FOIA (b) confirmed the NJ Exec Order 26.4b1 was on and the NJ Exec Order 2 was set at NJ Exec Order 2. On that same day at the same time, the surveyor and the US FOIA (b) together reviewed the electronic medical record (EMR) for the resident's order for NJ Exec Order 26.4 The US FOIA (b) stated that the resident's PO was for NJ NJ Exec Order 26.4b1 and acknowledged the PO should have been followed. On 11/1/24 at 1:29 PM, the surveyor discussed the above observations and concerns with the US FOIA (b)(6) who confirmed the PO should have been followed for the administration of NJ Exec Order 26.4b A review of the facility's "Oxygen Therapy" policy and procedure dated 5/24 indicated ...The purpose of oxygen therapy is to administer oxygen in cases where insufficient oxygen is carried to the tissues by the blood ...oxygen therapy is administered only as ordered by a physician ...the physician's order will specify the rate of oxygen flow.	F 695		
F 725 SS=D	NJAC 8:39 27.1 (a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		12/2/24

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F 725	Continued From page 8 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER	F 725	F 725 Corrective Action taken for those residents to have been affected by the deficient practice: PeaceCare St. Joseph's goes to great lengths to ensure that we staff our	

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F 725	Continued From page 9 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide (CNA) to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.	F 725	organization in keeping with Federal & State state requlation. We make every effort to replace staff that call out at the last moment and continue to emphysize how important it is to not only our residents but their co-workers to call out with proper notice. That said we will continue to partner with our Per-Diem staff to cover last minute call outs as well as utilize external staffing agencies when necessary. Action to identify other residents that may have been affected by the deficient practice: The management team of PeaceCare St. Joseph's meets, on a daily basis, to ensure we meet our staffing requirements. We will continue to utilize our Per Diem staff as well as external staffing agencies to suppliment our staffing needs as well as speak to our professional affiliations to see what is best practice to maintain / recruit team members. Meeting with staff during our monthly meetings is also a foreum to discuss staffing with team members to let them know what trends are occurring and what step we are taking to address staffing shortfalls. The measures the facility will take to ensure the problem will be corrected and will not reoccur: The Administrative team of PeaceCare St. Joseph's meets routinely (on a daily	

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F 725	Continued From page 10 c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports (AAS-11 and AAS-12) for the 11/07/2024 Standard survey at Peace Care St. Joseph's revealed the following. There were no deficient practices identified for Registered Nurse staffing as submitted for the 2 weeks of AAS-12 staffing from 10/13/2024 to 10/26/2024. The facility was deficient in CNA staffing for	F 725	basis) to discuss and plan how to meet the staffing requirements. We will continue to utilize our Per Diem staff as well as external staffing agencies to suppliment our staffing needs as well as speak to our professional affiliations to see what is best practice to maintain / recruit team members. Meeting with staff during our monthly meetings is another foreum to discuss staffing with team members to let them know what trends are occurring and what steps we are taking to address staffing shortfalls. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: The Administrative team of PeaceCare St. Jospeh's will continue to monitor our staffing patterns on a daily basis to ensure staffing standards are being met. We are not only striving to meet / exceed expectations on staffing requirements but we are also looking to eliminate the need to utilize agency staff. Completion Date: 12/2/24	

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(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 725	Continued From page 11 residents on 4 of 14 day shifts for the 2 weeks of AAS-11 staffing from 10/13/2024 to 10/26/2024, as follows: -10/13/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -10/18/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -10/19/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -10/20/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. On 11/4/24 at 12:30 PM, the surveyor observed Resident #87 in bed. The resident stated that she/he had not been changed or bathed all morning and further stated that she/he wanted to get washed up and changed. On 11/4/24 at 12:35 PM, the surveyor interviewed the US FOIA (b) who stated that Resident #87 was on her assignment. The US FOIA (b) confirmed that she had 10 Residents on her assignment and had not yet provided care to Resident #87. At that time, the US FOIA (b) and the surveyor entered Resident #87's room. The US FOIA (b) NJ Exec Order 26.4b Resident #87's NJ Exec Order 26.4b1, and both the surveyor and the US FOIA (b) observed the resident had a NJ Exec Order 26.4b1 within the NJ Exec Order 26.4b1 The US FOIA (b) stated that she doesn't use NJ Exec Order 26.4b1 on resident. She stated that it was the night US FOIA (b) who put it there. On 11/4/24 at 1:34 PM, in the presence of the survey team, the US FOIA (b)(6)) stated that NJ Exec Order 26.4b1 care should be provided to the residents every 2 hours. The surveyor informed the US FOIA (b)(6)	F 725		

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	315452	A. BUILDING _____ B. WING _____	C 11/07/2024

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F 725	Continued From page 12 US FOIA (b)(6) of the staffing ratio concerns on 11/7/24 at 1:00 PM. No further information was provided to the surveyor by the facility administration. Refer to F677D	F 725		
F 755 SS=E	NJAC 8:39-5.1(a); 27.1(a); 27.2(d); 27.2(h) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). 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	F 755		11/25/24

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F 755	Continued From page 13 §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, record review and review of other facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure, a.) consistent maintenance of the system of record keeping of the Drug Enforcement Agency (DEA) order Form-222 (a federal narcotic requisition form), that enabled accurate reconciliation of controlled-dangerous substances (narcotic medications, that due to their high potential for abuse, are tracked with a degree of detail and attention) that was ordered and received, b) the development and implementation of policy and procedure for DEA order Form-222, c) removal and disposition of a discharged Resident's medication from the active inventory, and d.) properly label an opened NJ Exec Order 26.4b1 . The deficient practice was identified for five (5) of 12 DEA Form-222s reviewed, one (1) of two (2) medication storage rooms, one (1) of three (3) medication carts inspected during the medication storage and labeling observation. The evidence was as follows: Reference: 21 CFR 1305 Part 1. Purchaser Information 6. ...Purchaser must make a copy of the order form for its records before mailing the original to the supplier.	F 755	F 755 Corrective Action taken for those residents to have been affected by the deficient practice: A comprehensive inspection was conducted on all nurisng units to reconcile / remove any and all medications that were expired and awaiting return to the Pharmacy. A new policy was implemented to ensure that all medications falling into this catagory are removed from the nursing units / medication rooms. It was further discovered that the DEA 222 forms were not being properly accounted for (forms were being used out of sequence) and several "voided" forms should have been returned to the DEA for proper reconciliation. New standards were put into place to tighten up accountability going forward so that this sort of concern does not occur in the future. Staff were inserviced as to the proper manner to use the DEA 222 form so that form as uesd in the proper manner. Action to identify other residents that may have been affected by the deficient practice: While all residents have the potential to	

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F 755	Continued From page 14 Part 5 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item. 21 CFR 1305.16 6. Lost or stolen order forms must be documented and reported to your local DEA office. 21 CFR 1305.18 7. Unused order forms should be voided and returned to Drug Enforcement Administration ... 1.) On 11/6/24 at 12:11 PM, the surveyor and the newly appointed U.S. FOIA (b) (6)) reviewed the DEA Form-222 together. The U.S. FOIA (b) informed the surveyor that the U.S. FOIA (b) (6) was at the facility the day before to organize the facility's record keeping file for the DEA Form-222. A review of the DEA Form-222 from September 2023 revealed the following: -231381123 and 231381124 were missing. -240365257 had the incorrect address. -240365258 and 240365259 were at that time, missing, (which was later found), unexecuted (not used), not voided and had the incorrect address. Further review of the DEA Form-222 revealed the staff did not consistently complete Part 5, as instructed on the front of DEA Form-222 (for the accurate reconciliation and accountability of the ordered narcotic medication against the received narcotic medication from the supplier). The discrepancies were identified on the following	F 755	be affected by this, no negitive outcomes had occurred. New policies in place will tighten up on these practices to prevent the potential for future concerns. Staff were inserviced as to best practiced with regards to the utilization of the DEA 222 form The measures the facility will take to ensure the problem will be corrected and will not reoccur: The Director of Nursing at PeaceCare St. Joseph' has contacted the provider Pharmacy and arranged for a QA meeting to discuss labeling of supplies and the removal of discharged / expired residents. A log for all nurses to monitor and sign daily for expired medical supplies to ensure for compliance. The Night Supervisor will also be responsible for checking the medication carts / cabinets on a daily basis to ensure that nedications are being properly stored and that no expired supplies are being stored. The DON reviewed instructions for DEA Form 222 with the pharmacist. Pharmacy consultant with conduct, as part of their monthly audit, an inservice regarding proper sequential usage of the DEA 222 form and to ensure that those forms that are expired are properly return to the DEA for reconciliation. Quality Assurance plan to monitor facility	

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F 755	Continued From page 15 forms: -231381125 the number received, and the date received were blank and had no packing slip (facility signed invoiced quantities received from the supplier). -240531774 the number received, and the date received were blank. Part 1 of the requirement for this form was to enumerate the total quantity ordered. This line item was also blank. -231381120 the number received, and the date received were blank and had no packing slip. -231381119 the number received, and the date received were blank and had no packing slip. On 11/6/24 at 3:06 PM, in the presence of the survey team, the US FOIA (b)(6) [redacted], the surveyor discussed the concerns regarding the inconsistencies in reconciliation, accountability for the narcotic medications ordered and received utilizing the DEA Form-222. On 11/7/24 at 10:07 AM, in the presence of the survey team, the US FOIA (b)(6) stated that when the previous US FOIA (b) had left (no longer employed in the facility) he took all the unused DEA Form-222 for safe keeping. The US FOIA (b)(6) also stated that the US FOIA (b) was responsible for ensuring the tracking and accountability of the narcotic medication ordered and received. At that time, the US FOIA (b)(6) provided the surveyor the unused/unexecuted DEA-Form 222 (240365258 and 240365259), acknowledged that those forms had the incorrect address and voided the forms. At that time, the new US FOIA (b) informed the US FOIA (b)(6) that the same forms had to be returned to the DEA. On 11/7/24 at 10:10 AM, in the presence of the survey team, the US FOIA (b) confirmed and	F 755	performance to make sure corrections are achieved: An enviornmental rounding tool was developed and will include the checking of the medicall supply room, medication cabinets, medication carts, and DEA Form 222 utilization. The DON or designee will conduct weekly audits for the next 4 weeks, bi-weekely audits for the following 2 weeks, and then monthly for the remaining 6 months. All findings will be addressed and reported to the QAPI Committee for further discussion. Completion Date: 11/25/24	

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acknowledged that there were errors, and the evidence of the tracking and accountability was not present. The [US FOIA (b)] stated that moving forward she would track all the DEA-Form 222 and its associated requirements.

2.) At that time, the surveyor requested for the facility's policy and procedures for controlled dangerous substance/ narcotic medications for the discrepancies identified with the DEA Form-222 (the process the facility follows for resolving discrepancies, process for accurate ordering, receiving, administering of narcotic medications, and when drug diversion was found).

On 11/7/24 at 12:01 PM, in the presence of the survey team, the [US FOIA (b)] stated that there were no other policies for the tracking, ordering, and receiving, identification of diversion of controlled dangerous substance/narcotic medications in relation to the DEA Form-222.

3.) On 11/6/24 at 9:43 AM, in the presence of the [US FOIA (b)(6)] the surveyor began the medication room observation located on the First floor. At that time, the surveyor and the [US FOIA (b)(6)] observed 2 clear plastic bags, that had a pharmacy label for Resident #179 and reflected the following:
Rx [NJ Exec Order 26.4b1] contained 2 bottles of [NJ Exec Order 26.4b1] [redacted]) dated [NJ Exec Order 26.4b].
Rx [NJ Exec Order 26.4b1] contained 1 bottle of [NJ Exec Order 26.4] dated [NJ Exec Order 26.4b].

At that time, the [US FOIA (b)(6)] stated that Resident #179

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was discharged last week, and the resident's medication should have been removed from the active inventory to prevent medication administration errors. All nurses on all shifts were responsible to ensure discontinued medications and discharged residents' medication were removed from active inventory, returned to the pharmacy, or disposed. The US FOIA (b)(6) stated that she would remove the medication, return to the pharmacy, and inform her supervisor.

4.) On 11/6/24 at 10:39 AM, in the presence of the US FOIA the surveyor began the medication cart observation located on the Third floor. At that time, the surveyor and the US FOIA observed an opened bottle of the NJ Exec Order 26.4b1 that was opened and not dated. The US FOIA stated that the NJ Exec Order 26.4b1 should have been dated immediately after it was opened to know the use by date. The US FOIA stated she would dispose of the undated, opened NJ Exec Order 26.4b1 and replace it with a new one.

According to the NJ Exec Order 26.4b1 manufacturer's package insert, under storage and handling, reflected instructions that included, to use within 6 months of first opening or the expiration date on the label, whichever comes first.

On 11/6/24 at 3:06 PM, in the presence of the survey team, the US FOIA (b)(6), the surveyor discussed the concern regarding the discharged resident's NJ Exec Order 26.4 and the opened and undated NJ Exec Order 26.4b1. At that time, the US FOIA (b) acknowledged the concerns and informed the surveyor that she was made aware of the observation by the nurses. The US FOIA (b) confirmed the NJ Exec Order 26.4 should have been

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F 755	Continued From page 18 removed and the [NJ Exec Order 26.4b] should have been dated. A review of the facility policy provided; Medication Storage dated/revised 1/1/24 included the following: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and /or medication rooms according to the manufacturer's recommendations ... Policy Explanation and Compliance Guidelines 2.Narcotics and Controlled Substances: c. Any discrepancies which cannot be resolved mist be reported immediately as follows: i. Notify the DON, charge nurse, or designee and the pharmacy. ii Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted ... 8. Unused Medications: all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medication with worn, illegible, or missing labels. These medications are destroyed in accordance with our destruction of unused drug policy. No further information was provided.	F 755		
F 868 SS=E	NJAC 8:39-29.4 (c)(g)(h)(k),29.7(c) QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance.	F 868		11/22/24

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F 868	Continued From page 19 §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on interview and record review, it was determined that the facility failed to assure that	F 868	F 868 Corrective Action taken for those residents to have been affected by the	

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F 868	Continued From page 20 the required staff attended the quarterly Quality Assurance (QA) meetings. This was identified for 4 of 4 quarterly QA meetings reviewed. This deficient practice was evidenced by the following: On 10/31/24 at 10:00 AM, upon entrance conference, the surveyor requested to review the QA meeting sign in sheets for the last few quarters of QA meetings held. On 11/4/24 at 10:30AM, the surveyor received QA meeting sign in sheets dated, 10/17/24, 7/18/24, 4/18/24 and 1/18/24, which revealed that the US FOIA (b)(6) was not in attendance for any of those scheduled meetings. At 10:35 AM, the surveyor interviewed the Administrator who stated that if the US FOIA is in the building during the QA meeting, then, she will attend and could not explain why she was not in attendance for those 4 QA meetings. The surveyor reviewed the Infection Preventionist policy and procedure, dated 2/2024, which revealed that the facility's US FOIA must have time necessary to participate in required committees such as QAA. The surveyor reviewed the Quality Assurance and Performance Improvement policy and procedure, dated 3/2024, which revealed the QA committee shall consist of a minimum of ... "The Infection Preventionist." N.J.A.C. 8:39-33.1 (b)	F 868	deficient practice: Going forward all future QAPI meetings will be scheduled so that the Infection Preventionist will be in attendance rather than just having their report submitted. Action to identify other residents that may have been affected by the deficient practice: As much as all residents have the poteintial for being affected by this no actual harm had occurred as the report submitted by the Infection Perventionsit was entered into the record. PeaceCare St. Joseph's is fortunate to have several other members of our team with IP credentials to assist the Infection Preventionist to that infection control matters do not go unaddressed. The mistake that was made was during the change of staff members in the past few months whereby I neglected to account for the role changes and the new IP needing to sign in as being a member of the committee. Going forward this concern will not be overlooked. The measures the facility will take to ensure the problem will be corrected and will not reoccur: The policies of PeaceCare St. Joseph's have been reviewed and as much as the detail of having the Infection Preventionist's presence is clearly noted it was a detail that was overlooked - it will	

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F 868	Continued From page 21	F 868	not be overlooked in the future. She will be in attendance, her report will be discussed and submitted along with every other member of the QAPI committee. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: The Administrator will be responsible for taking attendance and making sure all committee members, with their reports, are accounted for going forward. Completion Date: 11/22/24	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		11/22/24

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F 880	Continued From page 22 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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(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 880	Continued From page 23 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to a) maintain infection control standards and procedures during [NJ Exec Order 2] care treatments for 2 of 5 residents (Resident #181, #6) reviewed for care and services for [NJ Exec Order 26.4b1] b) provide a safe and sanitary environment to prevent the potential spread of [NJ Exec Order 26.4b] and [NJ Exec Order 26.4b1]n to both residents and staff by sharing personal care items between residents and a linen cart which contained linen for multipe residents was brought into a Resident room (Room [NJ Exec O] and then back out into the hallway, observed for 1 of 3 CNAs (CNA #1) on 1 of 4 nursing units, ([NJ Exec]-floor unit) and c) failed to practice acceptable hand hygiene as recommended by the CDC. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to	F 880	F 880 Corrective Action taken for those residents to have been affected by the deficient practice: RN #1 & LPN #1 were counceled and inserviced regarding the proper manner in which [NJ Exec Order 2] care should be provided. This includes hand hygiene, methods of [NJ Exec Order 26.4] the [NJ Exec Order 26] as well as [NJ Exec Order 26.4b1] of a [NJ Exec Order 26.4b1]. Clinincal competencies were conducted by the facility Infection Perventionist to ensure the proper procedures are being followed. CNA #2 was counseled and educated by the facility Infection Preventionist regarding the policy of hand hygiene. Action to identify other residents that may have been affected by the deficient practice: The Director of Nursing and the Infection Preventionist conducted a comprehensive review with all nursing staff regarding infection control (including hand hygiene and the proper manner to handle clean linen) to assure a full understanding of	

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F 880	Continued From page 24 a clean body site on the same patient ... After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. The surveyor observed Resident #181 on 11/1/24 at 9:30 AM sitting up in bed eating breakfast. A review of the electronic medical record revealed the following. The resident's Admission Record noted the resident was admitted with NJ Exec Order 26.4b1 The NJ Exec Order 26.4 Admission Minimum Data Set assessment tool (MDS) indicated the resident was NJ Exec Order 26.4b1 as referenced by a score of NJ Exe on the Brief Interview for Mental Status (BIMS) in Section NJ E Section NJ E indicated the resident was at risk for NJ Exec Order 26.4b1 . The NJ Exec Order 26.4b1 included documentation regarding a NJ Exec Order 26.4b1 . The NJ Exec Orde was noted to have initially been identified as a NJ Exec Order 26.4b1 which was currently 'NJ Exec Order 26.4b1 ." The treatment recommendation (which was reflected in the NJ Exec Order 26.4b1 physician's order summary) was for the following treatment to be performed twice daily and as needed - NJ Exec Order 26.4 pat NJ Exec O apply NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order , and NJ Exec Orde with a NJ Exec Order 26.4b1 . The surveyor observed the NJ Exec Order 26.4b1 treatment on 11/6/24 at 11:24 AM. The treatment	F 880	infection prevention / control procedures.. The measures the facility will take to ensure the problem will be corrected and will not reoccur: Nursing management will continue to conduct daily observations for medication pass, wound care, hand hygiene, and infection protocols during daily rounds. Clinical competenties will begin during a new employees orientation process and will continue with daily random observations to ensure that staff are capable of preforming these tasks independently. The findings of these observations will be reported to the QAPI Committee - 100% compliance is expected. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: Medication pass, wound care, hand hygiene observations / audits (as well as proper handling of linen) will be conducted by nursing admininstration to assure that nursing staff can demonstrate consistant proficiency in infection control protocols. QAPI iniatitive will monitor and report on these audits for a period of 6 months or such time that 100% compliance is achieved.	

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F 880	Continued From page 25 was performed by RN #1 who was assisted by RN #2. After reviewing the physician's treatment order, RN #1 proceeded to the resident's bathroom to perform hand washing. RN #1 wet her hands, applied soap, and lathered outside of running water for 10 seconds. RN #1 turned off the faucet handle with bare wet hands. RN #1 set up the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 supplies on the sanitized over bed table and proceeded to Resident #181's bedside to begin the treatment. RN #1 removed the NJ Exec Order 26.4b1 from the resident's NJ Exec Order 26.4b1, removed her gloves, and proceeded to the bathroom to perform hand washing. RN #1 lathered outside of running water for 5 seconds, rinsed and dried her hands, and closed the faucet with a wet paper towel. RN #1 applied clean gloves and cleansed the NJ Exec Order 2 by NJ Exec Order 2 in a NJ Exec Order 26.4b1 from NJ Exec Order the NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 The NJ Exec Order 26 g was NJ Exec Order 26.4b1 from NJ Exec Order to the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . RN #1 wearing the same gloves (now considered soiled) NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1. RN #1 wearing the same soiled gloves NJ Exec Order 26 and NJ Exec Order 26.4b1 . RN #1 placed the area of the NJ Exec Order 26.4b1 which had been touched by soiled gloves into the NJ Exec Order 26.4b1	F 880	Completion Date: 11/22/24	

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F 880	Continued From page 26	F 880		

The NJ Exec Order 26.4b1 was placed over the [redacted] while RN #1 wore soiled gloves.

RN#1 reached into her uniform pocket with soiled gloves to obtain a pen. She wrote the date and her initials on the NJ Exec Order 26.4b1 which had already been applied to the resident's [redacted]

RN #1 placed the pen which she had handled with soiled gloves back into the uniform pocket.

The surveyor interviewed RN #1 after she had completed the treatment.

RN #1 stated the facility policy for handwashing required to lather outside of running water for at least 20 seconds. She stated the [redacted] should be cleansed from in to out only. She stated she knew she NJ Exec Order 26.4b1 [redacted]. She acknowledged she should have dated the [redacted] prior to placing it on the resident's [redacted]

The surveyor discussed the treatment observation with the US FOIA (b)(6) [redacted] and the US FOIA (b)(6) [redacted] on 11/06/24 at 3 PM . The [redacted] stated the resident was an agency nurse and he would contact the nursing agency to see if there was education done for hand hygiene and [redacted]

On 11/07/24 at 10:17 AM the [redacted] stated he was unable to obtain nurse education for RN #1 from the nursing agency. At that same time the [redacted] provided a photocopy of a remedial treatment observation and handwashing evaluation performed with RN #1 on [redacted]. The documents indicated hands should be lathered

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F 880	Continued From page 27	F 880		

outside of running water for 20 seconds before rinsing. A new paper towel should be used to turn off faucets. Gloves should be discarded when soiled. The method for cleaning the [NJ Exec Order 2] was not addressed, nor was the correct method for documenting on the NJ Exec Order 26.4b1 [redacted]

2. The surveyor observed Resident #6 on 10/31/24 at 12:25 PM, in bed on a [NJ Exec Order 26.4b1] [redacted] with their eyes closed, and the [NJ Exec Order 26.4] [redacted] The surveyor observed the [NJ Exec O] [redacted] and the NJ Exec Order 26.4b1 on with the [NJ Exec Order] set on [NJ] [redacted].

A review of Resident #6's medical record revealed the following.

The resident's Admission Record noted the resident was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]

A review of the NJ Exec Order 26.4b1 Physician Order Summary (POS) included a physician's order dated [NJ Exec Order 26] to NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1, [NJ Exec Ord] the [NJ Exec Order 26.4b1] with NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 [NJ Exec Order 26.4b] apply [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] to the NJ Exec Order 26.4b1 every day and evening shift and when needed.

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F 880	Continued From page 28 A review of the quarterly Minimum Data Set (MDS) dated [redacted], an assessment tool, indicated that Resident #6 had [redacted], was [redacted] and was [redacted]. The MDS further assessed that Resident #6 was [redacted] on staff for [redacted], had a [redacted], and received [redacted]. A review of the Individual Care Plan with a focus area indicated the Resident had an [redacted] to their [redacted] upon admission with interventions which included but were not limited to [redacted] weekly if needed, [redacted] assessment by nurse, [redacted], [redacted] every 2 hours and to keep [redacted] and [redacted]. The surveyor observed the [redacted] treatment on 11/4/24 at 11:10 AM. The treatment was performed by the [redacted] who was assisted by the Certified Nursing Assistant (CNA #1). After reviewing the physician's treatment order, the [redacted] proceeded to the resident's bathroom and performed hand washing. The [redacted] set up the [redacted] and [redacted] on the sanitized over-bed table and proceeded to Resident #6's bedside to begin the treatment. The supplies included a [redacted], a [redacted], a bottle of [redacted], [redacted], a [redacted], and [redacted]. All supplies were contained in a plastic bag.	F 880		

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The [US FOIA (b)] donned a disposable gown and gloves and removed the [NJ Exec Order 26.4b1] from the resident's [NJ Exec Order 26.4b1]. The [US FOIA (b)] described the [NJ Exec Order 26.4b] as having a [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1]. The [US FOIA (b)] removed her gloves and washed her hands.

The [US FOIA (b)] applied clean gloves, reached into the package of [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] and in a [NJ Exec Order 26.4b1] cleansed the [NJ Exec Order 26.4b1]. The [US FOIA (b)] discarded the [NJ Exec Order 26.4b1] and using the same gloves, reached into the [NJ Exec Order 26.4b1] and removed another [NJ Exec Order 26.4b1]. The [US FOIA (b)] wet the [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] the [NJ Exec Order 26.4b1] and then using the same [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1] of the [NJ Exec Order 26.4b1]. The [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4b1] by [NJ Exec Order 26.4b1] from the [NJ Exec Order 26.4b1] of the [NJ Exec Order 26.4b1] into the [NJ Exec Order 26.4b1].

The [US FOIA (b)] removed the gloves, sanitized her hands using Alcohol Based Hand Rub (ABHR), poured [NJ Exec Order 26.4b1] onto a [NJ Exec Order 26.4b1] placed it inside the [NJ Exec Order 26.4b1], and placed the dated, [NJ Exec Order 26.4b1] over the [NJ Exec Order 26.4b1] onto the [NJ Exec Order 26.4b1] without [NJ Exec Order 26.4b1]. The [US FOIA (b)] applied the [NJ Exec Order 26.4b1] to the portion of the [NJ Exec Order 26.4b1] that was not covered and then [NJ Exec Order 26.4b1] with another [NJ Exec Order 26.4b1].

The [US FOIA (b)] brought all of the supplies out of the room and put them back into the treatment cart.

The surveyor discussed the breaks in technique with the [US FOIA (b)] on 11/4/24 at 11:45 AM. The [US FOIA (b)] stated that the [NJ Exec Order 26.4b1] should be [NJ Exec Order 26.4b1] from the center of the [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4b1]. The

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F 880	Continued From page 30 US FOIA (b) acknowledged that she should have only brought the supplies needed for the treatment into the resident's room and should have discarded the bag of NJ Exec Order 26.4b1 NJ Exec Ord and the contaminated bottle of NJ Exec Ord The US FOIA (b) confirmed that she should have applied the NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 before she applied the NJ Exec Order 26.4b1. The surveyor interviewed the US FOIA (b)(6) on 11/4/24 at 12:55 PM, who confirmed the supplies brought into the resident's room should have been discarded, not put back into the treatment cart. On 11/4/24 at 1:34 PM, the surveyor discussed the observations and concerns with the US FOIA (b)(6) and US FOIA (b)(6) The US FOIA (b) confirmed only supplies needed for the NJ Exec Order 2 treatment should be brought into the resident's room. A review of the Treatment Observation Protocol included...Treatment Procedure...understands steps of NJ Exec Order 2 care procedure; follow treatment order as written...NJ Exec Order 26.4b1 as per MD order and NJ Exec Order 26.4b1. Preparing Treatment...NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 are kept out of resident rooms...place amount needed on NJ Exec Order 26.4b1...place used supplies in receptacles... 3. On 11/4/24 at 12:00 PM, the surveyor observed CNA #1 obtained a bag of personal care supplies from the resident in room NJ Exec bed 1 and used the same personal care items for the resident in NJ Exec bed 2 (Resident #22). At that same time, the surveyor observed the linen cart that contained	F 880		

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F 880	Continued From page 31 linens for multiple residents on the [NJ Exec] floor unit was inside room [NJ Exec] After the CNA had provided care for Resident #22, CNA #1 put the bag of personal care items she had used for both residents in room [NJ Exec] onto the linen cart and pushed the cart out into the hallway. At that time, CNA #1 acknowledged she should not have shared the personal care items between residents and that the items should be kept in each resident's room. CNA #1 confirmed that only the linen needed for each resident should be brought into the room not the entire linen cart for infection control reasons. On 11/4/24 at 12:50 PM, the surveyor interviewed the US FOIA (b)(6) the [NJ Exec]-floor unit who stated that linen carts should remain outside of rooms, only linen needed for each resident should be brought into the room, and personal care items should be used for only one resident, not shared between residents. On 11/4/24 at 1:34 PM, the surveyor discussed the above observations and concerns with the US FOIA (b)(6). 4. On 11/4/24 at 12:40 PM, the surveyor observed CNA #2 entered the bathroom in Resident room [NJ Exec] The surveyor observed CNA #2 applied soap to her hands and immediately placed her hands under the stream of running water without first lathering her hands outside of the running water. At that same time, the surveyor interviewed CNA #2 who acknowledged that she should have applied soap and then lathered her hands for 20 seconds outside the stream of water.	F 880		

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F 880	Continued From page 32 On 11/4/24 at 1:34 PM, the surveyor discussed the above observations and concerns with the US FOIA (b)(6) .	F 880		
F 883 SS=E	NJAC 8:39 19.4 (a) (n) Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883		11/22/24

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F 883	Continued From page 33 that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure [redacted] was offered according to the current Centers for Disease and Control Prevention (CDC) and the [redacted] recommendations for Residents #23, #36 and #83. This deficient practice was identified for three (3) of five (5) residents reviewed for [redacted] status. The deficient practice was evidenced by the following:	F 883	F 883 Corrective Action taken for those residents to have been affected by the deficient practice: Residents # 23, 36, and 83 (along with their responsible parties) were contacted by our Infection Perventionist, consents were obtained and [redacted] were offered to these individuals. After discussing the Risk v Benefit of the [redacted] (and the consents being obatined) the primary care physician was contacted and orders were	

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F 883	Continued From page 34 Reference: A review of the CDC's Advisory Committee on Immunization Practices (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 9/12/24, included the following. The CDC recommends a single dose of PCV21 (pneumococcal 21-valent conjugate vaccine; Capvaxive), PCV20 (pneumococcal 20-valent conjugate vaccine), or PCV15 (pneumococcal 15-valent conjugate vaccine) greater than or equal to 1 year after the last PPSV23 (pneumococcal 23-valent polysaccharide vaccine; Pneumovax23) dose. Reference [previous guidelines] A review of the CDC's Advisory Committee on Immunization Practices (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 3/15/23, included the following: The CDC recommends a single dose of PCV20 or PCV15 greater than or equal to 1 year after PPSV23. On 11/4/24 at 1:13 PM, during an interview with a surveyor, the US FOIA (b)(6) tated that the NJ Exec Order 26.4b1 offered at the facility was the NJ Exec Order 26 and that she was aware of the new guidelines for the NJ Exec Order 26.4b1 . At that time, the US FOIA (b)(6) stated that the facility had not offered the newest NJ Exec Order 26.4b1 to residents who had previously received the NJ Exec Order 26.4b 1.) On 10/31/24 at 11:13 AM, the surveyor observed Resident #23 seated in a wheelchair, NJ Exec Order 26 and NJ Exec Order 26.4b1 The resident informed the surveyor of their diagnosis of NJ Exec Order 26.4b1 and how they have worked hard during NJ Exec Order 26.4b1 treatment to achieve the NJ Exec Order 26.4 they currently have.	F 883	obtained for the NJ Exec Order 26.4 to be administrered. Action to identify other residents that may have been affected by the deficient practice: An audit of all residents at PeaceCare St. Jospeh's was conducted and it was determined that these residents were the only individuals who had not been included in the vaccination clinincs The measures the facility will take to ensure the problem will be corrected and will not reoccur: Going forward consent orders will be obtained for all residents (new as well as existing) who wish to be vaccintated. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: The Infection Prevenionist will conduct weekly audits for 4 weeks to ensure compliance with all new admissions and existing residents Completion Date: 11/22/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE JERSEY CITY, NJ 07306**

(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 883	Continued From page 35 The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #23. According to the Admission Record (AR; an admission summary) reflected Resident #23 was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted] Resident # 23's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out 15 which indicated the resident's NJ Exec Order 26.4b1 Further review of the qMDS dated [redacted], under section NJ Exec Order 26.4b1 Is the resident's NJ Exec Order 26.4b1 [redacted] to date? The response was marked [redacted] which reflected [redacted] A review of the electronic Medical Record (eMR) reflected Resident #23 had received NJ Exec Order 26.4b1 A review of the paper-based chart for Resident #23 did not reveal documentation that the NJ Exec Order 26.4b1 was offered, or was declined, and that education was provided to the resident in [redacted] 2. On 10/31/24 at 10:48 AM, the surveyor observed Resident #36 in bed with [redacted] via a [redacted]	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE JERSEY CITY, NJ 07306**

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F 883		F 883		

Continued From page 36

NJ Exec Order 26.4b1 and the [redacted] of the bed was [redacted]

According to the AR Resident #36 was admitted to the facility with diagnoses which included but were NJ Exec Order 26.4b1 [redacted]

Resident # 36's most recent Annual Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a BIMS score of [redacted] out 15 which indicated the resident's [redacted]

Further review of the AMDS dated [redacted] under section [redacted] Is the resident's NJ Exec Order 26.4b1 [redacted] to date? The response was marked [redacted] which reflected [redacted]

A review of the eMR reflected Resident #36 had received NJ Exec Order 26.4b1

A review of the paper-based chart did not reveal documentation that the NJ Exec Order 26.4b1 was offered, or was declined, and that education was provided to the resident in [redacted]

3. On 10/31/24 at 11:45 AM, the surveyor observed Resident #83 [redacted] on the [redacted]

According to the AR Resident #83 was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

(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 883	Continued From page 37 Resident #83's most recent quarterly MDS dated [redacted] reflected the resident had a BIMs score of "[redacted] out of 15" which indicated a [redacted] Further review of the qMDS , under section [redacted] Is the resident's [redacted] to date? The response was marked [redacted] which reflected [redacted] Under section [redacted] If [redacted] not received state the reason ...the box was left blank. A review of the eMR reflected Resident #83 had received [redacted] On 11/6/24 at 3:06 PM, the surveyor requested any documentation showing that the resident was offered and or had declined the [redacted] On 11/6/24 at 3:06 PM, in the presence of the survey team, the [redacted] and the [redacted] the surveyor discussed the concern regarding Resident #23, #36 and #83 who were not offered [redacted] according to the current Centers for Disease and Control Prevention (CDC) and the [redacted] recommendations. On 11/7/27 at 10:10 AM, in the presence of the survey team, and the [redacted] confirmed that there was no further information that could be provided regarding the concerns for the [redacted]. A review of the undated facility policy for	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE JERSEY CITY, NJ 07306**

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F 883	Continued From page 38 Pneumococcal Vaccine included: It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations (policy references included CDC dated 10/26/24). No further information was provided. N.J.A.C. 8:39-19.4 (i)	F 883		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030905	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

(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 WAS 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the	S 560	S 560 Corrective Action taken for those residents to have been affected by the deficient practice: All residents are afected by staff calling out for scheduled shifts. we staff our	12/2/24

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

Electronically Signed | 11/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030905	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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S 560	Continued From page 1 Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth	S 560	organization in keeping with Federal & State state requlation. We make every effort to replace staff that call out at the last moment and continue to emphysize how important it is to not only our residents but their co-workers to call out with proper notice. That said we will continue to partner with our Per-Diem staff to cover last minute call outs as well as utilize external staffing agencies when necessary. Action to identify other residents that may have been affected by the deficient practice: The management team of PeaceCare St. Joseph's meets, on a daily basis, to ensure we meet our staffing requirements. We will continue to utilize our Per Diem staff as well as external staffing agencies to suppliment our staffing needs as well as speak to our professional affiliations to see what is best practice to maintain / recruit team members. Meeting with staff during our monthly meetings is also a foreum to discuss staffing with team members to let them know what trends are occurring and what step we are taking to address staffing shortfalls. The measures the facility will take to ensure the problem will be corrected and will not reoccur: The Administrative team of PeaceCare St. Joseph's meets routinely (on a daily basis) to discuss and plan how to meet the staffing requirements. We will continue to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030905	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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S 560	Continued From page 2 place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports (AAS-11 and AAS-12) for the 11/07/2024 Standard survey at Peace Care St. Joseph's revealed the following. There were no deficient practices identified for RN staffing as submitted for the 2 weeks of AAS-12 staffing from 10/13/2024 to 10/26/2024, The facility was deficient in CNA staffing for residents on 4 of 14 day shifts for the 2 weeks of AAS-11 staffing from 10/13/2024 to 10/26/2024, as follows: -10/13/24 had 14 CNAs for 123 residents on the	S 560	utilize our Per Diem staff as well as external staffing agencies to suppliment our staffing needs as well as speak to our professional affiliations to see what is best practice to maintain / recruit team members. Meeting with staff during our monthly meetings is another foreum to discuss staffing with team members to let them know what trends are occurring and what steps we are taking to address staffing shortfalls. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: The Administrative team of PeaceCare St. Jospeh's will continue to monitor our staffing patterns on a daily basis to ensure staffing standards are being met. We are not only striving to meet / exceed expectations on staffing requirements but we are also looking to eliminate the need to utilize agency staff.Reports of staffing trends will be reported to QAPI committee on a quaterly basis. Completion Date: 12/2/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030905	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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S 560	Continued From page 3 day shift, required at least 15 CNAs. -10/18/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -10/19/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -10/20/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. The surveyor informed the Director of Nursing and Licensed Nursing Home Administrator of the staffing ratio concerns on 11/7/24 at 1:00 PM. No further information was provided to the surveyor by the facility administration.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315452 Y1	A. Building B. Wing Y2	1/23/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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 F0677	Correction	ID Prefix F0695	Correction	ID Prefix F0725	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	11/22/2024	LSC	11/22/2024	LSC	12/02/2024
ID Prefix F0755	Correction	ID Prefix F0868	Correction	ID Prefix F0880	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	11/25/2024	LSC	11/22/2024	LSC	11/22/2024
ID Prefix F0883	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(d)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/22/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/7/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030905 Y1	A. Building B. Wing Y2	1/23/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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	12/02/2024	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/7/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING **01** B. WING _____	**11/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE** **JERSEY CITY, NJ 07306**

(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 Peace Care St Joseph's is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 11/06/2024 to 11/07/2024 and Peace Care St Joseph's 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 Occupancies. Peace Care St Joseph's is a four-story building consisting of multi-phase construction that was built in 1899, 1915 & 2001. It is composed of Type I & II construction. The facility is divided into 20 smoke zones.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		11/26/24

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

Electronically Signed | 12/04/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING **01** B. WING _____	**11/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE** **JERSEY CITY, NJ 07306**

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K 222	Continued From page 1 only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

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	315452	A. BUILDING **01** B. WING _____	**11/07/2024**

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K 222	Continued From page 2 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/06/2024 and 11/07/2024 in the presence of the US FOIA (b)(6) and US FOIA (b)(6) it was determined that the facility failed to provide A) The required correct sign on an exit door and B) Maintain three of 11 designated exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1,19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice had the potential to affect 31 of 124 residents and was evidence by the following: A) Observation on 11/06/2024 from 2:15 PM to 3:36 PM with US FOIA on the Fourth Floor revealed the following: Stairway exit discharge doors D and E had thumb turn locks on the egress side of both doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The US FOIA confirmed the findings at the times of observations.	K 222	K-222 - Egrees Doors SS=F Corrective Action taken for those alleged to have been affected by the deficient practice: The improper signage on the exit door to stairwell C was immediately removed and changed from a "pull" sign to that of a push sign indicating that the door will swing open into the stairwell. The Maintenance Director removed the Thumb Turn Lock in stairwells D and E on both sides of the door and replaced with a Panic Bars. The US FOIA (b)(6) was in-service by the Administrator regarding improper signage on exit door, and creating a life saftey checklist to include confirming stairwells have panic bars. Action taken to identify other residents that may have been affected by the deficient practice: All resident have the potential to be	

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K 222	Continued From page 3 B) Observation on 11/07/2024 at 8:15 AM with US FOIA on the Third Floor Stairway exit discharge door C, revealed the following: 1. The door had a Delayed-Egress Locking System with a sign on egress side that state "PULL UNTIL ALARM SOUND, Door can Be Opened In Fifteen Seconds". This door required a sign reading "PUSH UNTIL ALARM SOUNDS..." 2. The door also had thumb turn lock on the egress side of door. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The US FOIA confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference at 2:35 PM. NJAC 8:39 -31.2 (e)	K 222	affected by this deficiency practice. All doors have been inspected by the Maintenance Director at the time of the survey to ensure no doors contained Thumb Turn Locks that would impede a means of egrees in case of an emergency. The measures the facility will take to ensure the problem will be corrected and will not reoccur: The Maintenance department will monitor all exit doors for proper signage. The Maintenance Director will conduct weekly rounds and added to life Safety checklist. All doors will be inspected to ensure free from obstruction or impediments in case of an emergency. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: The Maintenance Director/designee will submit an monthly audit of its findings to the monthly QAPI committee for review. Date of Completion 11/26/2024	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically	K 223		11/26/24

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K 223	Continued From page 4 closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/06/2024 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that doors with self-closing device were kept in the closed position in accordance with NFPA 101:2012 Edition, Sections 7.2.1.8. and 19.2.2.2.7. This deficient practice had the potential to affect 28 of 124 residents and was evidenced by the following: An observation on 11/06/2024 at 2:00 PM revealed that the fourth floor shared service corridor door was held open with brick-stone. In an interview at that time, the US FOIA confirmed the finding. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/07/2024 at 2:35 PM. N.J.A.C 8:39-31.2(e)	K 223	K 223 Corrective Action taken for those alleged to have been affected by the deficient practice: The Maintenance Director and staff, during the survey immediately removed the 4th floor shared service corridor door that was being prompted open by brick-stone, eliminating the need for a self-closing door. Action taken to identify other residents that may have been affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The Maintenance Director/ designee inspected all doors during the time of the survey to ensure that no doors were prompted open with a door stopper. Maintenance staff was in-serviced by Maintenance Director not to leave any item used to prompt open doors to prevent smoke penetration. The measures the facility will take to	

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K 223	Continued From page 5	K 223	ensure the problem will be corrected and will not reoccur: The Maintenance Director/designee will conduct daily/weekly rounds and include with the Environmental rounds safety checklist to ensure no doors are prompted open with any item. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: The Maintenance Director/designee will submit an audit of the daily/weekly environmental rounds safety checklist to the Monthly QAPI for review. Completion date 11/26/2024	
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, documentation review and interview on 11/06/2024 and 11/07/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to conduct Annual functional testing of emergency lighting system in accordance with NFPA 101: 2012	K 291	K 291 Emergency Lighting SS=F How the corrective action will be accomplished	11/27/24

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K 291	Continued From page 6 Edition, Sections 19.2.9.1 and 7.9.3 This deficient practice had the potential to affect all 124 residents and was evidence by the following: Documentation review on 11/06/2024 revealed no records that annual emergency lighting functional testing was conducted. During an interview on 11/07/2024 at 1:10 PM, the US FOIA confirmed that the facility monthly emergency lighting system testing was conducted, and no annual 1.5 hours functional testing had been performed. No records indicating annual functional testing had been conducted was provided to the surveyor. The US FOIA confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/07/2024. N.J.A.C 8:39-31.1(c), 31.2(e)	K 291	The US FOIA (b)(6) has been in-serviced by Administrator on providing annual documentation on testing of the emergency lighting system. An inspection of the Emergency Lighting System was conducted by Qualus Services, LLC dated 12/13/2023 and 12/4/2024. Action taken to identify other residents that may have been affected by the deficient practice All residents have the potential to be affected by the deficient practice. A review of all required inspections and documentation for the facility was complete at the time of the survey to ensure regulatory compliance. Other areas will be reviewed by the Maintenance Director/designee The measures the facility will take to ensure the problem will be corrected and will not reoccur The Maintenance Director / designee will maintain organized records of all required Life Safety inspections tests including Emergency Lighting Systems. Monthly audits of all required Life Safety inspections will be completed by the Maintenance Director designee. Monthly audits will be conducted for 3 months to ensure regulation compliance than annually. Quality Assurance plan to monitor facility performance to make sure corrections are	

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K 291	Continued From page 7	K 291	achieved The Maintenance Director/ designee will submit results of the monthly audits of the Emergency lighting System to the Monthly QAPI committee for review. Completion date 11/27/2024	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		11/26/24

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K 321	Continued From page 8 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/07/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that hazardous areas were protected with self-closing doors in accordance with NFPA 101: 2012 Edition, Sections 19.3.2,19.3.5.9 and 8.4. This deficient practice had the potential to affect all 124 residents and was evidenced by the following: 1. An observation with the US FOIA [redacted] at 2:19 PM revealed the Fire Pump room door was not closing to its frame. 2. An observation with the US FOIA [redacted] at 2:21 PM revealed the Meter room door had no self-closing device. The US FOIA [redacted] confirmed the findings at the times of observations. The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit at 3:35 PM. NJAC 8:39-31.2(e)	K 321	K 321 Corrective Action taken for those alleged to have been affected by the deficient practice: Based upon the observation of the State Surveyor during his tour the door in the "meter room" did not close / seal to the door frame. To address this concern the maintenance team replaced the hinges on the doors with "spring loaded hinges to ensure that the door remains closed and seals correctly to the door frame. 1/7/25 Photos or corrective measures were submitted to surveyor to his email address. The door leading to the "fire pump" area was not properly alligned to ensure proper closure at the time of the inspection so the maintenance team adjusted the door to ensure proper closure. Action taken to identify other residents that may have been affected by the deficient practice All residents are affected by fire doors that do not close properly. To address this concern the maintenance team replaced	

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K 321	Continued From page 9	K 321	the hinges on the door with "spring loaded hinges to ensure that the door remains closed and seals correctly to the door frame at all times. The door leading to the "fire pump" area that was not properly alligned to ensure proper closure at the time of the inspection was adjusted the door to ensure proper closure. The measures the facility will take to ensure the problem will be corrected and will not reoccur The maintenance team will monitor all facility doors as part of the weekly checks to make sure they are in proper operating order. Reporting with be submitted to the QAPI committee Quality Assurance plan to monitor facility performance to make sure corrections are achieved The issue of proper door operation on all facility doors will be reviewed during the 4th quarter QAPI meeting to assure that all doors are compliant / in proper working order. Completion date 11/26/2024	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101	K 324		11/26/24

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K 324	Continued From page 10 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review of facility documents on 11/06/2024 and 11/07/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that A) The kitchen hood suppression systems was inspected monthly, B) Two of 8 kitchen cooking equipment's Wet Chemical fire suppression systems nozzles were in the proper position to protect against fire, C) Three of 8 spray nozzle caps were in place to protect the	K 324	K 324 Corrective Action taken for those alleged to have been affected by the deficient practice: Based upon the observation of the State Surveyor during his tour the fire supression system on the kitchen hood had not been current with it's annual inspection. Upon investigation is appears	

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K 324	Continued From page 11 nozzles from grease clogs and D) To performed Kitchen hood suppression system Cylinder Hydrostatic tests in accordance with NFPA 101:2012 edition, Section 19.3.2.5.3*(10) and NFPA 17 and 96. This deficient practice had the potential to affect 124 all residents and was evidenced by the following: 1) A documentation review on 11/06/2024 at 1:30 PM revealed no record from 2021, 2022, 2023 or 2024 indicating the kitchen hood suppression system Cylinder Hydrostatic had been conducted, when it was last conducted or when it was due. At that time, the surveyor interviewed the [redacted] who confirmed the finding. 2) An observation on the 11/07/2024, in the kitchen revealed the following: a. At 12:09 PM, the monthly inspection tag was blank and no required monthly inspection of the hood suppression system was logged. At that time, the surveyor interviewed the [redacted] who confirmed that the monthly inspection tag was not completed and left blank. b. At 12:11 PM, 3 of 8 fire suppression system spray nozzle caps were not in place to protect the nozzles from grease clogs. c. At 12:14 PM, 2 of 8 suppression spray nozzles were not positioned to protect the cooking equipment. In an interview, the [redacted] confirmed and	K 324	that service of this device was not part of the origianl contract and no one had identifed this as being a concern. Arrangements were made with the vendor who currently services all other fire supression equipment at PeaceCare St. Joseph's to service this device - copy of report provided to surveyor. All fire suppression equipment will be inspected / servcied going forward on a monthly basis. 12/9/24 As the surveyor observed at the time of the inspection the Dietary staff took a wet soapy rag and washed the nozzle heads in question. At that time the staff also ensured that all nozzle caps were in proper placement. A weekly service plan is in place to ensure that all nozzles on fire supression equipment are cleaned and re-capped weekly after each cleaning. As previously stated the hood in question will continue to be serviced on a monthly basis going forward. Reports are available for the surveyor to review during the next inspection. Action taken to identify other residents that may have been affected by the deficient practice The vendor who services the other fire supression equipment at PeaceCare St. Jospeh's serviced this device and will continue to perform annually inspectionsP (maintneance staff will perfrom monthly	

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K 324	Continued From page 12 acknowledged the findings. The US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference at 2:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 96	K 324	inspections) scheduled service for the reminder of their contractural agreement with PeaceCare St. Joseph's The measures the facility will take to ensure the problem will be corrected and will not reoccur Annual, as well as monthly, scheduled service for this and all other fire supression equipment at PeaceCare St. Joseph's will occur as part of the current service contract by the qualified vendor. The monthly inspections will be conducted by the maintenance team at PeaceCare St. Joseph's Quality Assurance plan to monitor facility performance to make sure corrections are achieved The issue of reviweing the fire supression equipment at PeaceCare St. Joseph's will occur on a monthly basis and finalized in an annual report that will be reported the 4th quarter QAPI meeting to assure compliance. Completion date 11/26/2024	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K 351		2/13/25

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K 351	Continued From page 13 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 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 observation and interview on 11/07/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all 124 residents and was evidenced by the following: Observations on 11/07/2024, at Exit stairwell A&B revealed no fire sprinklers coverage under the First floor, Second floor Third floor or Fourth floor accessible landing. In an interview at the time, the US FOIA [redacted] confirmed the observations. The facility's US FOIA (b)(6) was notified of the	K 351	K-351 Sprinkler System-Installation SS=F Corrective Action taken for those alleged to have been affected by the deficient practice: On 12/5/2024 an assessment was completed by United Fire Protection (UFP) to install (6) New Sprinkler Heads. On 02/13/2025 (UFP) installed (4) sprinkler heads and piping in stairwell B, 4th, 3rd,2nd and 1st floors. (2) Sprinkler Heads and piping were installed in Stairwell A, 4th,3rd, 2nd and 1st floors. The facility is in compliance with NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.2.5.2, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1).	

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	315452	A. BUILDING **01** B. WING _____	**11/07/2024**

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K 351	Continued From page 14 deficient practice at the Life Safety Code survey exit at 3:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	The US FOIA (b)(6) was in-serviced by the Administrator on maintaining compliance with the NFPA regulations. Action taken to identify other residents that may have been affected by the deficient practice All residents have the potential to be affected by this deficient practice. The Maintenance Director/designee conducted an Environmental Safety round of the facility to ensure the facility is in compliance with requirements of NFPPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.3.1. The measures the facility will take to ensure the problem will be corrected and will not reoccur The Maintenance Director/designee will conduct monthly audits of the Sprinkler System to ensure the facility is in compliance with NFPA regulations. Monthly audits will be conducted for 3 months then annually. The measures the facility will take to ensure the problem will be corrected and will not reoccur The Maintenance Director/designee will present their monthly audits findings to the Monthly QAPI committee for review.	

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K 351	Continued From page 15	K 351		
			Date of Completion:02/13/2025	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interviews and record review of facility documents on 11/06/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that fire sprinkler system backflow preventer were inspected and tested annually in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25: 2011 Edition, Section 5.2.1.1.1(2). This deficient practice had the potential to affect all 124 residents and was evidenced by the	K 353	K 353 SS=F Corrective Action taken for those alleged to have been affected by the deficient practice: The United Fire Protection (UFP) conducted the Fire Sprinkler System backflow preventer inspection and tested the system on 12/13/2024 and were found	12/13/24

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K 353	Continued From page 16 following: Documentation review at 11:15 AM revealed the facility sprinkler annual report for 2022, 2023 and 2024 had no indication that annual sprinkler backflow preventer test was being performed. In an interview at that time, the [US FOIA] confirmed the finding. The [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 11/07/2024 at 2:35 PM. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	to be in compliance per requirements of NFPA 101:2012, Section 9.5.5,9.7.7, 9.7.8 and NFPA 25: 2011, Section 5.2.1.1.1(2). The Maintenance Director/designee have been in-serviced by Administrator on completion of all required NFPA regulations. Action taken to identify other residents that may have been affected by the deficient practice All residents have the potential to be affected by the deficient practice. The Maintenance Directed completed a review of all required facility systems inspections and tests. All areas have the potential to be affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur The Maintenance Director/designee will maintain an organized records of all required inspections and tests for the facility including the Fire System Backflow Preventer Inspection and test. A monthly audit of all required facility inspections and test will be completed by the Maintenance Director/designee. Quality Assurance plan to monitor facility performance to make sure annual testing is conducted in a timely manner.	

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K 353	Continued From page 17	K 353	The Maintenance Director/designee will submit a monthly audit inspection and tests including the Fire Sprinkler System backflow preventer to the Monthly QAPI committee for review. Completion date 12/13/2024	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review of facility documents on 11/06/2024 in the presence of the [redacted] it was determined that the facility failed to maintain or replace 8 fire extinguishers that were overdue for service in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12,9.7.4.1 and NFPA 10: 2010 Edition, Sections 7.1.3. This deficient practice had the potential to affect all 124 residents and was evidenced by the following: A documentation review at 10:20 AM revealed that the facility's annual fire extinguisher report, dated March 1, 2024, indicated that 8 fire extinguishers were overdue for service. The surveyor requested records on replacement, but	K 355	K 355-Portable Fire Extinguishers SS=F Corrective Action taken for those alleged to have been affected by the deficient practice: The Maintenance Directed contacted, United Fire Protection (UFP) to inspect the Portable Fire Extinguishers. On March 1, 2024 the (UFP) conducted an inspection of 73 Fire Extinguishers and found 8 Portable Fire Extinguishers needed Due for Services. On March 26, 2024, all Portable Fire Extinguishers were in good standing. The [redacted]	11/25/24

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K 355	Continued From page 18 no further records were provided as evidence for replacement. In an interview at that time, the US FOIA confirmed and acknowledged the findings. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/07/2024 at 2:35 PM. NJAC 8:39 -31.1 (c), 31.2 (e) NFPA 10	K 355	U.S. FOIA (b) (6) has been in-serviced by the Administrator on ensuring all Fire Extinguishers are up to code and replaced or serviced as required. Action taken to identify other residents that may have been affected by the deficient practice: All residents have the potential to be affected by the deficient practice. A review of all required inspections and documentation for the facility was completed. The measures the facility will take to ensure the problem will be corrected and will not reoccur: The Maintenance Director will maintain organized records of all required inspections for the facility, including Fire Extinguishers. The Environmental Safety Rounds conducted by maintenance on a weekly basis will include checking Fire Extinguishers for expiration. The Maintenance Director/designee will ensure proper scheduling/completion of Fire Extinguisher inspections by the (UFP) prevention monthly. Quality Assurance plan to monitor facility performance to make sure corrections are achieved :	

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K 355	Continued From page 19	K 355	The Maintenance Director/designee will submit results of the monthly audit of the required facility inspections including the Fire Extinguisher inspections to the Monthly QAPI committee for review. Completion date 11/25/24	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/07/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that residents room air conditioner (AC) units were maintained in safe operating condition in accordance with the National Fire Protection Association (NFPA) 90 A. This deficient practice was identified for 2 of 75 rooms observed and was evidenced by the following: During the tour on 11/07/2024 between 11:15 AM and 2 :10 PM in the presence of the US FOIA (b) [redacted] the	K 521	K 521 Corrective Action taken for those alleged to have been affected by the deficient practice: Based upon the findings of the State surveyor it was determined that dirty air filters were observed in 2 of the 75 rooms that were inspected as part of this survey. The corrective action taken at the time of the inspection was to replace the 2 (of 75) air filters reported to be clogged / dirty and	11/24/24

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K 521	Continued From page 20 surveyor observed resident room #305 and #306 AC unit filters were clogged and dirty. In an interview at the time, the US FOIA confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference at 2:35 PM. N.J.A.C 8:39-31.2(e)	K 521	to make sure that all filters are replaced on a quarterly basis. Action taken to identify other residents that may have been affected by the deficient practice All residents could be affected by clogged / dirty air filters in their rooms. All resident air filters are changed on a quarterly basis, supporting documentation will be more closely monitored going forward. The measures the facility will take to ensure the problem will be corrected and will not reoccur The maintenance team will more closely monitor the quarterly changing of air filters for compliance / completion. (It appears that the air filters in question are from older units that the maintenance staff member did not have on his cart at the time of the repalcement. Going forward multiple size filters (2 sizes of filters used in house) will kept with them while conducting quartertly filter replacement). Quality Assurance plan to monitor facility performance to make sure corrections are achieved The results of the quarterly air filter replacement will be reviewed during the quarterly QAPI meeting to assure compliance. Completion date	

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K 521	Continued From page 21	K 521	11/24/2024	
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 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: REPEAT DEFICIENCY Based on documentation review and interview on 11/06/2024 and 11/07/2024, in the presence of the US FOIA (b)(6) [redacted] A). It was determined that the facility failed to ensure that there was documented evidence that all existing elevators; having a travel distance of 25 feet or more above or below the level that best served the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service	K 531	K 531 Elevator Inspection Corrective Action taken for those alleged to have been affected by the deficient practice: The Facility received a final annual report from [redacted] Elevator confirming compliance with the Firefighters Service requirements of ASME/ANSI A17.3. 1/30/2025. All	1/30/25

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K 531	Continued From page 22 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.19.5.3, 9.4.2, 9.4.3). and B). It was determined that the facility failed to ensure 5 of 5 elevators were inspected annually. This deficient practice had the potential to affect all 124 residents was evidenced by the following: A). On 11/06/2024 at 11:45 AM, the surveyor reviewed all elevator documentation provided by the US FOIA The monthly testing of the firefighters 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 was not provided. At the time, an interview was conducted with the US FOIA who confirmed there was no current firefighter's monthly service log for 5 of 5 elevator devices. B). At 11:55 AM, the surveyor reviewed all elevator documentation provided by the US FOIA dated 3/3/21. The annual elevator inspection was approved for use until: 3/31/22 and was not inspected in over 31 months. In an interview at the time, the US FOIA indicated that he called the "Elevator Construction Code Division department" and was informed that the city was short one elevator inspector and they were currently behind conducting elevator inspections.	K 531	elevators were inspected and up to code. The US FOIA (b)(6) has been in-serviced by Administrator on proper documentation and the importance of adherence to State and Federal regulations concerning Elevator codes. The Maintenance Director has been in-serviced by Administrator on monthly testing of Phase 1 and 2 Fire Service. Action taken to identify other residents that may have been affected by the deficient practice All residents have the potential to be affected by the deficient practice. The Maintenance Director reviewed all required inspections and documentation for the facility Elevator Codes. The facility is in the process to contracting with another Elevator company to ensure compliance with all Federal and State elevator codes. The measures the facility will take to ensure the problem will be corrected and will not reoccur: The Maintenance Director/designee will schedule/coordinate all required Elevator Inspections quarterly /annual as required. Quality Assurance plan to monitor facility performance to make sure corrections are achieved:	

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K 531	Continued From page 23 The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/07/2024. This deficient practice was cited on the previous Recertification survey dated 08/22/2023 NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	The Maintenance Director/designee will submit a monthly audit on inspections and service records including Firefighters Service requirements and documentation of scheduled elevator inspections to the monthly QAPI committee for review. Completion date 01/30/2025	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on documentation review and interview on 11/06/2024 and 11/07/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the	K 761	K 761 Inspection Testing of Doors Corrective Action taken for those alleged to have been affected by the deficient	11/26/24

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K 761	Continued From page 24 facility failed to ensure that the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 124 residents was evidenced by the following: A documentation review on 11/06/2024 at 08:50 AM revealed that fire door assemblies were not inspected and tested annually in accordance with NFPA 80 Standard for Fire Doors. The [US FOIA] was interviewed at the time of the document review, and he confirmed that fire/smoke door annual inspection report did not meet the minimum standard and could not provide any documentation that met the minimum standard requirement for annual fire/smoke testing. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/07/2024. This deficient practice was cited on the previous Recertification survey, dated 08/22/2023. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	practice: The Maintenance Director contracted with an outside company (REMEDI8) to service and test all Fire related Doors. On 11/26/2024 fire doors were inspected. Annual inspections will be conducted according to NFPA 101 Life Safety Code, Section 7.2.2.15 and NFPA 80 Standard for Fire Doors. The U.S. FOIA (b) (6) has been in-serviced by the Administrator on documentation of the importance of maintaining fire door inspections and ensuring all inspections are completed as scheduled. Action taken to identify other residents that may have been affected by the deficient practice All residents have the potential to be affected by the deficient practice. Annual inspections will be conducted by (REMEDI8). All areas will be monitored. The measures the facility will take to ensure the problem will be corrected and will not reoccur The Maintenance Director/ designee will continue to arrange for our certified door inspector to Survey / inspect each door at PeaceCare St. Joseph□s annually to ensure that they are in proper working. The US FOIA (b)(6) will In-service maintenance team on how to	

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K 761	Continued From page 25	K 761	inspect and report any issues with doors. The Maintenance Director/designee will include in its daily environmental prevention maintenance checklist checking fire doors. Quality Assurance plan to monitor facility performance to make sure all doors are inspected on an annual basis. The annual inspection of facility doors will be reviewed during the 4th quarter QAPI meetings to assure compliance. Completion date 11/26/2024	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or	K 914		11/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING **01** B. WING _____	**11/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE** **JERSEY CITY, NJ 07306**

(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 914	Continued From page 26 equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 11/06/2024 and 11/07/2024 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was identified for 75 resident rooms observed, had the potential to affect all 124 residents and was evidenced by the following: A documentation review on 11/06/2024 at 1:00 PM revealed the annual inspection report provided by the US FOIA was dated August 30, 2022. The annual inspection was overdue for 15 months. No further documentation was provided to the surveyor. In an interview at that time the US FOIA confirmed and acknowledged the findings. Observations on 11/07/2024 at 8:10 AM to 1:45 PM revealed all 75 resident rooms were equipped with non-hospital grade outlets. In an interview at that time, the US FOIA confirmed the findings.	K 914	K 914 Annual Electrical Inspection Corrective Action taken for those alleged to have been affected by the deficient practice: Documentation for the annual inspection of the electrical system has been provided to the State surveyor. Documentaiton provided demonstrated that the last electrical inspection at PeaceCare St. Joseph's was conducted on 12/13/23 which means the 2024 annual inspection PeaceCare St. Joseph's is due 12/24. Please see the 2024 annual electrical inspection was completed on 11 / 26 / 24 provided to the surveyor Action taken to identify other residents that may have been affected by the deficient practice All residents / families / and staff could be affected by faulty electrical system. Please see the 2024 annual inspection conducted on 11/26/24 provided to the State surveyor.	

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	315452	A. BUILDING **01** B. WING _____	**11/07/2024**

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PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE** **JERSEY CITY, NJ 07306**

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K 914	Continued From page 27 The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference at 2:35 PM NJAC 8:39-31.2(e) NFPA 99	K 914	The measures the facility will take to ensure the problem will be corrected and will not reoccur PeaceCare St. Joseph's acknowledges that all residents / families / and staff could be affected by faulty electrical systems and therefore will continue to ensure that an annual electrical inspection is conducted at our facility. Quality Assurance plan to monitor facility performance to make sure corrections are achieved The annual inspection of the electrical system will be reviewed during the 4th quarter QAPI meetings to assure compliance. Completion date 11/26/2024	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		11/26/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE** **JERSEY CITY, NJ 07306**

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K 918	Continued From page 28 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 11/06/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that the emergency and standby power generator diesel fuel quality was tested and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 918	K 918 Essential Electrical System SS=F Corrective Action taken for those alleged to have been affected by the deficient practice: The Maintenance Director failed to provide and communicate effectively the test and inspection of the emergency and	

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	315452	A. BUILDING 01 B. WING _____	11/07/2024

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K 918	Continued From page 29 A review of the facility's generator annual service report year 2024, provided by the [redacted] revealed no record that a diesel fuel sample analysis test had been conducted. No further documentation was provided regarding a diesel fuel sample analysis test. In an interview at 11:20 AM, the confirmed the findings. The [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 11/07/2024 at 2:35 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	standby power generator diesel fuel quality from Cummins Sales and Service dated 5/10/24 through 10/29/24. The [redacted] has been in-serviced by the Administrator on proper documentation and ensuring all inspections are conducted according to schedule. Action taken to identify other residents that may have been affected by the deficient practice All residents have the potential to be affected by the deficient practice. The Maintenance Directed reviewed all required inspections that could affect other areas. The measures the facility will take to ensure the problem will be corrected and will not reoccur Director of Maintenance will maintain organized records of all required inspections for facility, including test and inspection of the emergency and standby power generator diesel fuel quality and complete monthly audit of all required inspections. Director of Maintenances or designee will ensure proper scheduling / completion of test and inspection of the emergency and standby power generator diesel fuel quality annually. The Maintenance Director will maintain current preventative	

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K 918	Continued From page 30	K 918	maintenance logs/documentation of all inspections. Quality Assurance plan to monitor facility performance to make sure corrections are achieved The Director of Maintenance/ designee will submit results of monthly audit to monitor of all required facility inspections, including test and inspection of the emergency and standby power generator diesel fuel quality, and documentation of the scheduling of the annual emergency and standby power generator diesel fuel quality test and inspection to the QAPI Committee for review. Completion date 11/7/2024	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several	K 921		11/26/24

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K 921	Continued From page 31 electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 11/06/2024 and 11/07/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all 124 residents and was evidenced by the following: A documentation review on 11/06/2024 revealed no policy on patient care related electrical equipment.	K 921	K 921 Electrical System Corrective Action taken for those alleged to have been affected by the deficient practice: Based upon the findings of the State surveyor PeaceCare St. Joseph's did not conduct an annual inspection of the electrical systems and properly inspected / tag all electrical equipment logging any repairs necessary or faulty equipment. Maintneance staff reviewed / updated the policy on electrical equipment safety and made sure all electrical equipment was properly inspected / taged for electrical	

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K 921	Continued From page 32 In an interview at the time, the US FOIA (b)(6) confirmed the findings. Observations on 11/07/2024 from 8:15 AM to 1:45 PM revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility. In an interview at that time, the US FOIA (b)(6) confirmed the findings and acknowledged that there was no policy. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference at 2:35 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	safety. The maintenance team with perfrom the daily, monthly, and annual inspections (utilizing the TELS system) as required as per the facility policy noting any repairsrequired / made during that reporting period. Action taken to identify other residents that may have been affected by the deficient practice All residents / families / and staff could be affected by faulty electrical equipment /systems. PeaceCare St. Joseph's reviewed the policy on electrical safety and proceeded to inspect / tag all electrical equipment (documenting the findings in the TELS system)to ensure all equipment is in proper working order The measures the facility will take to ensure the problem will be corrected and will not reoccur PeaceCare St. Joseph's acknowledges that all residents / families / and staff could be affected by faulty electrical equipment / systems and therefore will continue to ensure that an annual electrical inspection which consists of inspecting / tagging of all electrical equipment is conducted at our facility on a daily, weekly, monthly basis.	

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K 921	Continued From page 33	K 921	Quality Assurance plan to monitor facility performance to make sure corrections are achieved The annual inspection of the electrical system / equipment will be reviewed during the 4th quarter QAPI meetings to assure compliance. Completion date 11/26/2024	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315452 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/23/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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 K0321	11/26/2024	LSC K0324	11/26/2024	LSC K0521	11/24/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0914	11/26/2024	LSC K0921	11/26/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/7/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{E 000}	Initial Comments	{E 000}		
{K 000}	INITIAL COMMENTS A desk review of Peace Care St Joseph's Plan of Correction was conducted on 1/23/2025, and 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 Occupancies. Peace Care St Joseph's is a four-story building consisting of multi-phase construction that was built in 1899, 1915 & 2001. It is composed of Type I & II construction. The facility is divided into 20 smoke zones.	{K 000}		
{K 222} SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.	{K 222}		2/4/25

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

Electronically Signed | 02/04/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 222}	Continued From page 1 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire	{K 222}		

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{K 222}	Continued From page 2 detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: The facility was cited during the 11/7/2024 Recertification survey for failure to maintain designated exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies. Stairwells D and E had thumb turn locks on the egress side of both doors. The thumb turn lock and fastening device on each door could restrict emergency use of the exit. A desktop review of the facility's Plan of Correction (POC) was conducted on 1/23/2025, and the POC was found to be unacceptable. Compliance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 could not be verified.	{K 222}	K222 Egress Doors SS=F How the corrective action will be accomplished: The PeaceCare St. Joseph's maintenance staff removed the "thumb turn lock" in stairwell D & E and replaced with panic bar. How the facility will identify other areas having the potential to be affected by the same deficient practice: A tour / inspection of all passage doors by facility maintenance staff at time of survey was completed to assure that no doors contained "thumb turn locks" that could impede a means of egress in a case of emergency. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur: Director of Maintenance or designee will conduct monthly inspections of the entire campus to ensure that all egress doors do not contain "thumb turn locks" and are free of restriction in case of emergency for six (6) months.	

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{K 222}	Continued From page 3	{K 222}	How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not occur: The Director of Maintenance will submit results of the monthly inspections to the QAPI Committee. Date of Completion: 2/4/25	
{K 223} SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: The facility was cited during the 11/7/2024 Recertification survey for failure to ensure that that the fourth floor shared service corridor door was kept in the closed position. The door was held open with a brick-stone.	{K 223}	K223 Doors with self- closers SS=F How the corrective action will be accomplished:	2/4/25

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{K 223}	Continued From page 4 A desktop review of the facility's Plan of Correction (POC) was conducted on 1/23/2025, and the POC was found to be unacceptable. Compliance with the requirements of NFPA 101:2012 Edition, Sections 7.2.1.8. and 19.2.2.2.7. could not be verified.	{K 223}	The PeaceCare St. Joseph's maintenance staff, at the time of survey, removed the door on the 4th floor service corridor that was being propped open with a brick eliminating the need for a self-closing door. The door was not part of a fire compartment and therefore deemed non-essential. How the facility will identify other areas having the potential to be affected by the same deficient practice: A tour / inspection of all doors was conducted by maintenance staff at time of survey to assure that no doors were propped open and eliminated items that could be used as a door stop. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur: Director of Maintenance or designee will conduct weekly inspections of the entire campus to ensure that all doors are not propped open and remove any items that could be used as a door stop for six (6) consecutive months. Staff were in-serviced by the Director of Maintenance on not propping doors open and all staff will be in serviced annually. How the facility will monitor its corrective action to ensure that the deficient practice	

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{K 223}	Continued From page 5	{K 223}	is being corrected and will not occur: Director of Maintenance will submit report of weekly inspection results and in-services to the QAPI Committee. Date of Completion: 2/4/25	
{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: The facility was cited during the 11/7/2024 Recertification survey for failure to conduct a 1.5 hour Annual functional testing of the emergency lighting system. No records indicating annual functional testing had been conducted was provided to the surveyor. A desktop review of the facility's Plan of Correction (POC) was conducted on 1/23/2025, and the POC was found to be unacceptable. Compliance with the requirements of NFPA 101: 2012 Edition, Sections 19.2.9.1 and 7.9.3 could not be verified.	{K 291}	K291 Emergency Lighting SS=F How the corrective action will be accomplished The PeaceCare Maintenance director failed to provide and communicate effectively the annual functional testing of the emergency lighting system inspection to surveyor that was conducted by Qualus dated 12/13/23 that indicated that Peace Care St. Joseph's had no issues with the emergency lighting system. Additional functional testing of the emergency lighting system inspection completed by Qualus on 11/26/24 indicating that there were no issues with Peace Care St. Joseph's emergency lighting system.	2/4/25

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{K 291}	Continued From page 6	{K 291}	How the facility will identify other areas having the potential to be affected by the same deficient Practice A review of all required inspections and documentation for the facility was completed at the time of survey to ensure adherence to regulatory compliance. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur Director of Maintenance will maintain organized records of all required inspections for facility, including functional testing of the emergency lighting system and complete monthly audit of all required inspections. Director of Maintenances or designee will ensure proper scheduling / completion of functional testing of the emergency lighting system inspection by Qualus annually. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not occur The Director of Maintenance will submit results of monthly audit of required facility inspections including annual functional testing of the emergency lighting system to the QAPI Committee for review. Date of Completion: 2/4/25	
{K 351} SS=F	Sprinkler System - Installation	{K 351}		2/13/25

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{K 351}	Continued From page 7 CFR(s): NFPA 101 Spinkler 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 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: The facility was cited during the 11/7/2024 Recertification survey for failure to provide automatic fire sprinkler protection to all areas of the facility, specifically exit stairwell A and B under the first, second, third and fourth floor accessible landings to meet compliance requirements of NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1. A desktop review of the facility's Plan of Correction (POC) was conducted on 1/23/2025, and the facility did not install sprinkler protection by their 12/6/2024 completion date.	{K 351}	K-351 Sprinkler System-Installation SS=F Corrective Action taken for those alleged to have been affected by the deficient practice: On 12/5/2024 an assessment was completed by United Fire Protection (UFP) to install (6) New Sprinkler Heads. On 02/13/2025 (UFP) installed (4) sprinkler heads and piping in stairwell B, 4th, 3rd,2nd and 1st floors. (2) Sprinkler Heads and piping were installed in Stairwell A, 4th,3rd, 2nd and 1st floors.	

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{K 351}	Continued From page 8	{K 351}	The facility is in compliance with NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.2.5.2, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1). The Maintenance Director was in-serviced by the Administrator on maintaining compliance with the NFPA regulations. Project completed 02/13/2025. Action taken to identify other residents that may have been affected by the deficient practice All residents have the potential to be affected by this deficient practice. The Maintenance Director/designee conducted an Environmental Safety round of the facility to ensure the facility is in compliance with requirements of NFPPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.3.1. The measures the facility will take to ensure the problem will be corrected and will not reoccur The Maintenance Director/designee will conduct monthly audits of the Sprinkler System to ensure the facility is in compliance with NFPA regulations. Monthly audits will be conducted for 3 months then annually. The measures the facility will take to ensure the problem will be corrected and will not reoccur	

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{K 351}	Continued From page 9	{K 351}	The Maintenance Director/designee will present their monthly audits findings to the Monthly QAPI committee for review. Date of Completion:02/13/2025	
{K 353} SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: The facility was cited during the 11/7/2024 Recertification survey for failure to ensure that fire sprinkler system backflow preventer was inspected and tested annually per requirements of NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25: 2011 Edition, Section	{K 353}	K 353 Maintenance and Testing SS=F How the corrective action will be accomplished:	2/4/25

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{K 353}	Continued From page 10 5.2.1.1.1(2). A desktop review of the facility's Plan of Correction (POC) was conducted on 1/23/2025, and the facility did not inspect and test the fire sprinkler system backflow preventer by their 12/6/2024 completion date.	{K 353}	Contactor, United Fire Protection, conducted fire sprinkler system backflow preventer inspection and tested the system at PeaceCare St. Joseph□s on 12/13/24 and were found to be compliant. How the facility will identify other areas having the potential to be affected by the same deficient practice: Director of Maintenance completed a review of all required facility system inspections and tests at time of survey to ensure adherence to regulatory compliance. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur: Director of Maintenance or designee will maintain organized records of all required inspections and tests for the facility including the fire system backflow preventer inspection and test. A monthly audit of all required facility inspections and tests will be completed. Director of Maintenance or designee will ensure proper scheduling / completion of fire system sprinkler backflow preventer inspection and testing annually. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not occur:	

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{K 353}	Continued From page 11	{K 353}	The Director of Maintenance will submit results of monthly audit of required inspections and tests including annual fire sprinkler system backflow preventer to the QAPI Committee. Date of Completion: 2/4/25	
{K 355} SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: The facility was cited during the 11/7/2024 Recertification survey for failure to provide documentation that 8 fire extinguishers were replaced. A desktop review of the facility's Plan of Correction (POC) was conducted on 1/23/2025, and the POC was found to be unacceptable. Compliance with the requirements of NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition, Sections 7.1 could not be verified.	{K 355}	K 355 Portable Fire Extinguishers SS=F How the corrective action will be accomplished: The Peace Care Maintenance Director failed to provide and communicate effectively the service report from United Fire Protection dated 3/26/24 that stated fire extinguishers cited were replaced. How the facility will identify other areas having the potential to be affected by the same deficient practice: A review of all required inspections and	2/4/25

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{K 355}	Continued From page 12	{K 355}	documentation for the facility was completed at the time of survey to ensure adherence to regulations. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur: Director of Maintenance will maintain organized records of all required inspections for facility, including fire extinguisher inspections and complete monthly audit of all required facility inspections. Director of Maintenances or designee will ensure proper scheduling / completion of fire extinguisher inspections by United Fire Prevention monthly. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not occur: The Director of Maintenance will submit results of monthly audit of required facility inspections including the fire extinguisher inspections to the QAPI Committee for review. Date of Completion: 2/4/25	
{K 531} SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING	{K 531}		2/4/25

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{K 531}	Continued From page 13 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 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: The facility was cited during the 11/7/2024 Recertification survey for failure to: A) ensure that there was documented evidence that all existing elevators having a travel distance of 25 feet or more above or below the level that best served the needs of emergency personnel for firefighting purposes conformed 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.19.5.3, 9.4.2, 9.4.3) and; B) ensure that 5 of 5 elevators were inspected annually A desktop review of the facility's Plan of Correction (POC) was conducted on 1/23/2025. The facility failed to submit a POC.	{K 531}	K 531 Elevator Inspection SS=F How the corrective action will be accomplished: Obtain final annual elevator inspection from [redacted] elevator on 1/30/25 confirming compliance with Firefighters Service Requirements. How the facility will identify other areas having the potential to be affected by the same deficient practice: A review of all required inspections and documentation for the facility was completed at the time of survey to ensure	

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{K 531}	Continued From page 14	{K 531}	adherence to regulations. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur: Director of Maintenance or designee will schedule / coordinate all required quarterly / annual inspections for elevator service. Director of Maintenance or designee will complete monthly audit of required elevator inspections and service records including Firefighters Service Requirements. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not occur: The Director of Maintenance will submit audit report on monthly elevator inspections and service records including Firefighters Service Requirements and documentation of scheduled elevator inspections to the QAPI Committee. Date of Completion: 2/4/25	
{K 761} SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested	{K 761}		2/4/25

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{K 761}	Continued From page 15 annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: The facility was cited during the 11/7/2024 Recertification survey for failure to ensure that the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15 and NFPA 80 Standard for Fire Doors. A desktop review of the facility's Plan of Correction (POC) was conducted on 1/23/2025, and the facility did not conduct a fire door inspection by their 11/14/2024 completion date.	{K 761}	K 761 Inspection of Fire Doors SS=F How the corrective action will be accomplished: Contracted a certified door technician on 11/26/24 to complete annual inspection of all fire doors and maintenance staff completed all recommendations. How the facility will identify other areas having the potential to be affected by the same deficient practice: A review of all required inspections and documentation for the facility was completed at the time of survey to ensure adherence to regulations. What measures will be put in place or systemic changes made to ensure that the deficient practice will	

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{K 761}	Continued From page 16	{K 761}	not occur: Director of Maintenance or designee will schedule / coordinate all required annual inspections for facility fire doors. Director of Maintenance or designee will complete quarterly audit of required fire door inspections. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not occur: The Director of Maintenance will submit quarterly audit report on fire door inspections and documentation of scheduled fire door inspections to the QAPI Committee. Date of Completion: 2/4/25	
{K 918} SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	{K 918}		2/4/25

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	315452	A. BUILDING **01** B. WING _____	R **01/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	**537 PAVONIA AVENUE** **JERSEY CITY, NJ 07306**

(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 17 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility was cited during the 11/7/2024 Recertification survey for failure to ensure that the emergency and standby power generator diesel fuel quality was tested and maintained. A desktop review of the facility's Plan of Correction (POC) was conducted on 1/23/2025, and the POC was found to be unacceptable. Compliance with the requirements NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8 could not be verified.	{K 918}	K 918 Essential Electrical System SS=F How the corrective action will be accomplished: The Peace Care Maintenance Director failed to provide and communicate effectively the test and inspection of the emergency and standby power generator diesel fuel quality from [redacted] Sales and Service dated 5/10/24 through 10/29/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING **01** B. WING _____	R **01/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{K 918}	Continued From page 18	{K 918}	How the facility will identify other areas having the potential to be affected by the same deficient practice: A review of all required inspections and documentation for the facility was completed at the time of survey to ensure adherence to regulatory compliance. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur: Director of Maintenance will maintain organized records of all required test and inspections for facility, including test and inspection of the emergency and standby power generator diesel fuel quality and complete monthly audit of all required inspections. Director of Maintenances or designee will ensure proper scheduling / completion of test and inspection of the emergency and standby power generator diesel fuel quality annually. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not occur: The Director of Maintenance will submit results of monthly audit of all required facility inspections, including test and inspection of the emergency and standby power generator diesel fuel quality, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. BUILDING **01** B. WING _____	R **01/23/2025**

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{K 918}	Continued From page 19	{K 918}	documentation of the scheduling of the annual emergency and standby power generator diesel fuel quality test and inspection to the QAPI Committee for review. Date of Completion: 2/4/25	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315452 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/12/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE CARE ST JOSEPH'S	537 PAVONIA AVENUE JERSEY CITY, NJ 07306

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 K0222	02/04/2025	LSC K0223	02/04/2025	LSC K0291	02/04/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	02/13/2025	LSC K0353	02/04/2025	LSC K0355	02/04/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	02/04/2025	LSC K0761	02/04/2025	LSC K0918	02/04/2025
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	
11/7/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO