STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING _____ B. WING _____	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

(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 168544, 178887 STANDARD SURVEY: 12/12-12/19/24 CENSUS: 101 SAMPLE SIZE: 21+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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the proper administration of [NJ Ex Order 26.4(b)(1) redacted]) in accordance with manufacturer's specifications and professional standards of practice during the medication pass observation on 12/13/24. The deficient practice was identified for 1 of 4 nurses who administered medications to 1 of 4 residents (Resident #11) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title	F 658	Criteria 1: "Resident #11: Primary Physician was notified that [NJ Ex Order 26.4(b)(1) redacted]) was not administered according to manufacturer□s specifications. Primary Physician had no further orders. Criteria 2: "All residents have the potential to be	1/31/25

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

Electronically Signed — 01/17/2025

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

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F 658	Continued From page 1 45, Chapter 11. Nursing Board. The nurse practice act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 casefinding; 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." A review of the manufacturer's specification for NJ Ex Order 26.4(b)(1) under instructions for use included the following: NJ Ex Order 26.4(b)(1) [redacted] ... On 12/13/24 at 9:04 AM, the surveyor observed the U.S. FOIA (b) (6) [redacted] prepare medications for Resident #11. The medications	F 658	affected by the deficient practice of failing to ensure that Fluticasone (Flonase) must be administered according to manufacturer□s specification. Criteria 3: "The Assistant Director of Nursing (ADON) reviewed the manufacturer□s specifications of administering Fluticasone (Flonase) with the LPN who administered it to resident #11. "The LPN that administered Fluticasone (Flonase) to resident #11 completed a med pass observation/competency conducted by the Pharmacy consultant on 1/7/2025. "The Assistant Director of Nursing, (ADON) started a mandatory inservice for all Nurses on administering Fluticasone (Flonase) according to manufacturer□s specifications. "Facility Medication Pass Competency form will be revised to include administration of nasal sprays in accordance with manufacturer□s specifications. Criteria 4: "Assistant Director of Nursing /Staff Educator or designee will include Nasal Spray administration as part of the medication pass competency for new nurse hires done on orientation and annually thereafter.	

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F 658	Continued From page 2 included a physician's order for NJ Ex Order 26.4(b)(1) [redacted] one time a day for [redacted] with an order start date of [redacted] At 9:06 AM, the surveyor observed the U.S. FOIA pull one piece of [redacted] and folded it into her hand. At 9:07 AM, the U.S. FOIA confirmed with the surveyor that she was ready to administer Resident #11's medication and walked into the resident's room with the medication and one [redacted] At 9:08 AM, the surveyor observed the U.S. FOIA explain to the resident that she would be administering their NJ Ex Order 26.4(b)(1). The U.S. FOIA NJ Ex Order 26.4(b) [redacted] into each of the resident's [redacted] and handed [redacted] to the resident. The resident used the NJ Ex Order 26.4(b)(1) at the NJ Ex Order 26.4(b) from the [redacted] At 9:10 AM, outside the resident's room, in front of the medication cart, the surveyor and the U.S. FOIA reviewed the medication package for the NJ Ex Order 26.4(b)(1) that was stored in the U.S. FOIA (b) medication cart. The manufacturer's specification for the NJ Ex Order 26.4(b)(1) was not in the box. The surveyor and the U.S. FOIA reviewed the electronic Medication Administration Record for Resident #11's NJ Ex Order 26.4(b)(1) The medication instructions did not include ancillary instruction as per manufacturer's specification for the resident to NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) prior to administration. At that time, the U.S. FOIA stated that she could always look up the information on her phone if there was information that she did not know. The U.S. FOIA also stated that she would look for the proper administration of NJ Ex Order 26.4(b)(1) at the nurse's station.	F 658	"Assistant Director of Nursing/Staff Educator or designee will include Nasal spray administration as part of the mandatory Medication Management inservice for all nurses done on orientation and annually. "Nurse Unit Managers will conduct weekly spot checks on the administration of Fluticasone (Flonase) and findings will include any corrective actions implemented and will be reported monthly, to the Director of Nursing for 3 months. Results will be reported to the administrator. "Pharmacy Consultant will include administration of nasal sprays when conducting medication pass observation/competency on nurses done monthly and reports will be submitted to the Director of Nursing and Administrator. "All reports will be discussed at the Quality Assurance and performance Improvement meeting held quarterly.	

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F 658	Continued From page 3 On 12/16/24 at 11:40 AM, during an interview with the surveyor, U.S. FOIA (b) (6) for NJ Exec Order 26.4b NJ Exec Order 26.4b1 and NJ Exec Order 26.4b stated that the manufacturer's package insert for the NJ Ex Order 26.4(b)(1) should have been with the medication package. At that time the NJ Ex Order 26.4(b) also stated that the US FOIA (b) who administered the medication to Resident #11 should have instructed Resident #11 to NJ Ex Order 26.4(b)(1) prior to administration of the NJ Ex Order 26.4(b)(1) to ensure full effectiveness of the medication. The U.S. FOIA (b) (6) stated that she would educate the staff on proper administration of NJ Ex Order 26.4(b)(1) and ensure that the manufacturer's package insert would be left in the medication package for reference. The U.S. FOIA (b) (6) informed the surveyor that she would communicate the concern with the U.S. FOIA (b) (6)) and believed that upper management was aware of the concern. On 12/16/24 at 1:37 PM, during a meeting with the survey team, the U.S. FOIA (b) the U.S. FOIA (b) (6) , the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), the surveyor discussed the concern regarding the improper administration of the NJ Ex Order 26.4(b)(1) to Resident #11, that was not in accordance with manufacturer's specifications and professional standards of practice. On 12/18/24 at 11:11 AM, the U.S. FOIA (b) acknowledged the medication pass concern. The U.S. FOIA (b) (6) provided in-services that was started with the nursing staff. A review of the provided facility policy, Medication Management dated October 2024, included the	F 658		

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F 658	Continued From page 4 following: It is the policy to maintain safe and competent medication management system that is based on best practice and care process of the resident ...	F 658		
F 686 SS=D	NJAC 8:39-11.2(b), 29.2(d) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to maintain infection control standards and procedures during NJ Ex Order 26. care treatment for 1 of 2 residents (Resident #89), reviewed for care and services for NJ Ex Order 26.4(b)(1). This deficient practice was evidenced by the following:	F 686	Criteria 1: "Resident # 89: the Primary Physician was notified of the treatment pass observations. No new orders were received. Criteria 2: "All residents have the potential to be	1/31/25

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F 686	Continued From page 5 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 12/12/24 at 12:20 PM, the surveyor observed Resident #89 in bed on a [redacted] mattress. The surveyor reviewed the medical record for Resident # 89. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses that included but were not limited to [redacted], [redacted], [redacted]	F 686	affected by the deficient practice of placing all treatment supplies on an unclean surface; not removing soiled gloves and washing hands after disinfecting overbed table then touching the garbage can; not cleaning scissors before and after each use. Criteria 3: "The Infection Preventionist RN reviewed Infection Control standards and procedures when providing wound care treatment on residents with the LPN who performed the treatment. "A wound treatment competency/observation on LPN was conducted by the Infection Preventionist RN. "The Assistant Director of Nursing started a mandatory inservice for ALL nurses on Infection Control Standards and procedures when providing wound care that includes but not limited to, Wound care supplies must be set only on clean surfaces; Changing gloves and performing hand hygiene after disinfection of surfaces; changing gloves after handling the trash can and disinfecting treatment scissors before and after use. "A wound treatment observation/competency which includes infection control standards and procedures will be conducted by ADON/ Designee as part of orientation and annually thereafter on all nurses.	

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F 686	Continued From page 6 NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b)(1) A review of the Admission Minimum Data Set assessment tool (MDS) dated NJ Ex Order 26.4(b)(indicated the resident had a NJ Ex Order 26.4(b)(1) as referenced by a score of NJ E on the Brief Interview for Mental Status (BIMS) in Section NJ E Section NJ E indicated the resident was admitted with NJ Ex Order 26.4(b)(1) . The NJ Ex Order 26.4(Weekly NJ Ex Order 26.4 Assessment Report included documentation regarding the NJ Ex Order 26.4(which was currently unchanged. A review of the Physician Order (PO) dated NJ Ex Order 26.4(b)(included NJ Ex Order 26.4(b)(1) with NJ E) for 15 minutes, remove the NJ Ex Order 26.4(b)(1) after 15 minutes, pat dry, apply NJ Ex Order 26.4(b)(1) , NJ Ex Orde with NJ Ex Order 26.4(b)(1) and cover with NJ Ex Order 26.4(b On 12/17/24 at 11:05 AM, the surveyor observed the NJ Ex Order 26.4(b)(1) treatment. The U.S. FOIA (b) (6) , assisted by the U.S. FOIA (b) (6) performed the treatment. After reviewing the physician's treatment order, the U.S. FOIA gathered all of the supplies and placed them on top of the treatment cart. The U.S. FOIA and U.S. FO then donned (put on) surgical masks, disposable gowns and gloves, and entered Resident #89's room. The U.S. FOIA placed the supplies on top of the uncleaned dresser,	F 686	Criteria 4: "The Assistant Director of Nursing or designee will conduct a mandatory inservice for ALL nurses on Infection Control Standards and procedures when providing wound care upon hire and annually. "Wound treatment competency including Infection control standards and procedures on all nurses will be conducted by the Assistant Director of Nursing or designee upon hire and mandated annually. "Nurse unit Managers will conduct one wound treatment competency randomly weekly for 3 months. Findings and corrective actions will be reported monthly to the Director of Nursing and Administrator. "Director of Nursing will report all findings and corrective actions during the Quality Assurance and Performance Improvement meetings held quarterly.	

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F 686	Continued From page 7	F 686		

disinfected the resident's overbed table, picked up the trash can and moved it next to the bed. The [U.S. FOIA (b] with the same gloves (now considered soiled), applied a clean barrier to the overbed table and put the supplies on top of the clean barrier.

The [U.S. FOIA] removed her gloves and performed hand hygiene. The [U.S. FOIA] removed the [NJ Ex Order 2] and [NJ Ex Order 26.4(b] from the resident's [NJ Ex Order 26], removed her gloves, and proceeded to the bathroom to perform hand washing.

On 12/17/24 at 11:20 AM, the [U.S. FOIA] applied clean gloves and NJ Ex Order 26.4(b)(1) with [NJ Ex Order 26.4(b]. The [U.S. FOIA] and [U.S. FO] NJ Ex Order 26.4(b)(1) the resident, doffed (took off) their Personal Protective Equipment (PPE) washed their hands and left the room, allowing the [NJ Ex Order 26.] for 15 minutes according to the physician's order.

On 12/17/24 at 11:35 AM, the [U.S. FOIA] gathered the needed supplies and placed them on top of the treatment cart. The supplies included a [NJ Ex Orde] of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), scissors, sterile Q-Tips, a [NJ Ex Order 26.4(b)(1)] and a marker. The [U.S. FOIA] put a small amount of [NJ Ex Order 26] into a plastic cup and put the [NJ Ex Orde] back into the treatment cart. The [U.S. FOIA] and [U.S. FO] donned PPE and entered Resident #89's room. The [U.S. FOIA] set the supplies onto the dresser, disinfected the overbed table and with the same gloves (now considered soiled) applied the [NJ Ex Order 26.4(b)(1)], and then placed all the supplies on the [NJ Ex Order 26.4(b)(1)].

The [U.S. FOIA] performed hand hygiene, donned gloves, and removed the [NJ Ex Order 26.4(b] from the [NJ Ex Order 2]. The [U.S. FOIA] removed her gloves, performed

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F 686	Continued From page 8	F 686		

hand hygiene, and applied the [NJ Ex Order 26] to the [NJ Ex Order 26] with a sterile Q-Tip. The [U.S. FOIA] without cleaning the scissors, cut the NJ Ex Order 26.4(b)(1) package, [NJ Ex Order 26.4(] the [NJ Ex Order 26] with the [NJ Ex Order 26.4(b)] [redacted], and applied the dated initialed [NJ Ex Order] [redacted]

The surveyor interviewed the [U.S. FOIA] and [U.S. FO] after the [U.S. FOIA] had completed the treatment. The [U.S. FOIA] confirmed that she should not have placed all of the treatment supplies on an unclean surface. The [U.S. FOIA] acknowledged that she should have removed her soiled gloves and washed her hands after she disinfected the overbed table and touched the garbage can. The [U.S. FOIA] stated that the facility policy was to clean the scissors before and after each use.

On 12/17/24 at 12:29 PM, the surveyor discussed the treatment observation with the [U.S. FOIA (b) (6)] [redacted] and the U.S. FOIA (b) (6) [redacted]).

On 12/19/24 at 12:45 PM, the surveyor interviewed the [U.S. FOIA (b] who confirmed the [U.S. FOIA] should not have put the supplies on an unclean surface, should have changed her gloves after disinfecting the overbed table and handling the trash can, and should have disinfected the scissors before and after each use.

A review of the facility's undated [NJ Ex Order 26.4(] Care Competency included performing hand hygiene before setting up a clean field.

No further information was provided by the facility.

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F 686	Continued From page 9 NJAC 8:39 19.4 (a)	F 686		

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
315072 Y1	A. Building B. Wing Y2	2/20/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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 F0658	Correction	ID Prefix F0686	Correction	ID Prefix	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. #	Completed
LSC	01/31/2025	LSC	01/31/2025	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?
12/23/2024	☐ YES ☐ NO

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	315072	A. BUILDING **01** B. WING _____	**12/23/2024**

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E 000	Initial Comments Heath Village was in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/19/2024, 12/20/2024 and 12/23/2024. Heath Village 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. Heath Village is a single story, Type II Protected building that was built in January 2021. The facility is divided into 9 smoke zones. The facility has a 375 KW emergency generator that runs on Diesel or Natural Gas.	K 000		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/20/24	K 281	CRITERIA 1:	2/15/25

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

Electronically Signed | 01/17/2025

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
	315072	A. BUILDING 01 B. WING _____	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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K 281	Continued From page 1 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101: 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 2 of 8 exit access areas observed and was evidenced by the following: 1. An observation at 11:20 AM revealed the Juniper exit access path to exit discharge was not provided with emergency lighting. 2. An observation at 11:55 AM revealed the Willow exit access path to exit discharge was not provided with emergency lighting. In an interview at that time, the U.S. FOI confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 12/23/2024 at 2:25 PM. NJAC 8:39-31.2(e)	K 281	" Heath Village contacted NJ Ex Order 26.4(b)(1) on 1/6/25 of missing access path to exit emergency lighting located in Juniper and Willow and installation date is scheduled to be completed by 2/15/25. CRITERIA 2: " All residents have the potential to be affected by the deficient practice of failing to ensure access path to exit emergency lighting to Willow and Juniper. CRITERIA 3: " Maintenance staff will monitor Emergency lighting located in the access path to exit Juniper and Willow. " Maintenance staff will ensure that emergency lighting in all access paths to exits will be monitored and checked in all households on an annual basis and findings will be reported to the maintenance director and assistant. " Findings will be documented and will be included in the Life Safety book. CRITERIA 4: " Director of Maintenance or designee will monitor the corrective action when completed by 2/15/25. " Maintenance Foreman or designee will monitor the annual inspection conducted by the maintenance staff.	

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K 281	Continued From page 2	K 281	" A report will be submitted to the Administrator and will be discussed at the Quality Assurance and Performance Improvement meeting.	
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 documentation review and interview on 12/23/2024 in the presence of the Director of Maintenance (DM), it was determined that the facility failed to conduct functional testing of emergency lighting system in accordance with NFPA 101: 2012 Edition, Section 19.2.9.1 and 7.9.3. This deficient practice had the potential to affect all 101 residents and was evidenced by the following: A documentation review at approximately 11:17 AM, revealed no documents for functional testing of battery back-up emergency lighting system, monthly for not less than thirty seconds and annually for one and half hours. In an interview at 1:02 PM, the U.S. FOI stated functional testing of emergency lighting system was conducted but could not provide documentation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code survey exit at approximately 2:25 PM.	K 291	CRITERIA 1: " Documentation of functional testing of emergency lighting system is attached. Completed on 12/24/24. (see exhibit A) CRITERIA 2: " All residents have the potential to be affected by this deficient practice of failure to provide documentation of emergency light testing for 30 seconds monthly and 90 minutes annually. CRITERIA 3: " The Maintenance staff will document the inspections of the emergency light testing for 30 seconds monthly and 90 minutes annually and will be logged in the Life safety book. " The maintenance team leader and staff were educated on emergency light testing	2/15/25

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K 291	Continued From page 3 NJAC 8:39-31.2(e)	K 291	for 30 seconds monthly and 90 minutes annually. CRITERIA 4: " The Maintenance Director or designee will do a monthly audit of the documentation of inspections done monthly and annually, and that documentation is entered in the life safety book. " Findings will be reported to the administrator monthly and during the Quality Assurance Performance Improvement meetings held quarterly.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/19/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to provide exit signs showing the direction of travel, in every location where the direction of travel to reach the nearest exit in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, and 7.10.2.1. The	K 293	CRITERIA 1: " A directional sign was installed by the physical therapy room exit access path on 1/9/2025.(see exhibit B.1) " A directional sign was installed at the main kitchen exit access on 1/9/2025.	2/15/25

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K 293	Continued From page 4 deficient practice was identified for 2 of 18 exit access observed and was evidenced by the following: Observations at 12:55 PM revealed the exit access by physical therapy to the nearest exit discharge was not provided with an exit or directional sign. Observations at 2:25 PM revealed main kitchen exit access was not provided with an exit or directional sign. The U.S. FOI confirmed the finding at the time of observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 12/23/2024 at 2:25 PM. NJAC 8:39 -31.2 (e)	K 293	(see exhibit B.2) " CRITERIA 2: " All residents have the potential to be affected by this deficient practice of failure to provide directional signs by the physical therapy access paths and main kitchen exit access. CRITERIA 3: " Maintenance staff will conduct monthly inspections to ascertain that directional signs for all exit pathways are present. " Documentation of inspection will be logged in the life safety book. CRITERIA 4: " The maintenance Director or designee will audit monthly inspections of directional signs for exit pathways conducted by the maintenance staff monthly, for 3 months then quarterly thereafter. " All findings will be reported to the Administrator monthly, and at the QAPI meetings held quarterly.	
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	K 321		2/15/25

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K 321	Continued From page 5 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) 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 observation and interview on 12/19/2024 in the presence [U.S. FOIA (b) (6) redacted], it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2, 19.3.2.1.3, 8.4 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all 101 residents and was evidenced by the following: Observations with the [U.S. FOI redacted] from 8:45 AM to 3:41	K 321	CRITERIA 1: " Therapy room # 1 was emptied of all combustibles and relocated to designated proper storage area. " A set of astragals were installed on the Sprinkler/hot water room to eliminate gap on completed by 12/19/2024 by maintenance staff. (see exhibit C.1)	

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K 321	Continued From page 6 PM, revealed the following: 1. Therapy Room # 1 measured over 50-square feet and was being used to store combustibles and had no self-closing device installed on the door. 2. The Sprinkler/Hot water room set of doors had a gap between the meeting edges when it was tested. 3. The Housekeeping storage room set of doors had a gap between the meeting edges when it was tested. 4. The Main Central Supply storage room set of doors had a gap between the meeting edges when it was tested. 5. The Maintenance shop set of doors had a gap between the meeting edge when it was tested. In an interview at the time, the U.S. FOI confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 12/23/2024 at 2:25 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 321	" A set of astragals were installed on the housekeeping storage room doors to eliminate gaps on 12/24/2024. (see exhibit C.2) " A set of astragals were installed on the main central supply storage room on 1/15/2025. (see exhibit C.3) " A set of astragals were installed on maintenance shop doors on 1/14/2025. (see exhibit C.4) CRITERIA 2: " All residents have the potential to be affected by this deficient practice of failure to ensure that the hazardous areas were protected in accordance with NFPA 101:2012 edition and NFPA 80 2010 edition. CRITERIA 3: " Rehab staff were educated on storing combustible items only in the designated storage area on 12/19/24. " Maintenance staff will inspect all storage rooms monthly for 3 months, then quarterly thereafter to ensure that combustibles are only stored in designated storage areas in accordance with NFPA 101: 2012 edition and NFPA 80 2010 edition. Documentation of findings will be logged in the life safety book. " Maintenance staff will inspect all fire and	

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K 321	Continued From page 7	K 321	smoke- rated doors to ensure that hazardous areas are protected. This will include, but not limited to, doors to the corridors for gaps and rooms with no self-closing devices to ensure that areas are not being used for storage monthly. Documentation of inspections will be logged in the Life safety book. CRITERIA 4: " Maintenance Director or designee will review all inspection results and corrective actions if any, monthly, reports will be submitted to the administrator, and findings will be reported at the Quality Assurance and Performance Improvement meetings held quarterly.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 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	K 324		2/15/25

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K 324	Continued From page 8 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 and interview on 12/19/2024 in the presence U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that A) 2 of 6 kitchen cooking equipment's wet chemical fire suppression systems nozzles were in the proper position to protect against fire and B) 2 of 2 kitchen hood suppression systems were inspected monthly in accordance with NFPA 101: 2012 Edition, Section 19.3.2.5.1 and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 2:46 PM in the main kitchen revealed the following: 1) The wet chemical fire suppression system (over the cooking equipment) had two suppression spray nozzles that were not positioned to protect the cooking equipment. 2) The monthly inspection tag to the fire suppression system lacked documentation of monthly visual inspections. Observations at 1:01 PM in ADL kitchen revealed the monthly inspection tag to the fire suppression system lacked documentation of monthly visual	K 324	CRITERIA 1: " The 2-kitchen cooking equipment's wet chemical fire suppression system nozzles were adjusted to be in the proper position to protect against fire on 12/20/2024. "The 2-kitchen hood suppression system was visually inspected on 1/13/25 and documented.(see exhibit D) CRITERIA 2: " All residents have the potential to be affected by the deficient practice of improper position of the 2-kitchen cooking equipment's wet chemical fire suppression system nozzles and the failure to document visual inspections of the 2-kitchen hood suppression system monthly. CRITERIA 3: " The maintenance staff will inspect the cooking equipment wet chemical fire suppression nozzles for proper positioning and will document on inspection tags	

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K 324	Continued From page 9 inspections. In an interview at that time, the [U.S. FOIA] confirmed the observations. The facility's [U.S. FOIA (b) (6)] was notified of the deficient practice at the Life Safety Code survey exit conference on 12/23/2024 at 2:25 PM. NJAC 8:39-31.2(e) NFPA 10, 17, 96	K 324	monthly. " The Maintenance foreman or designee will do spot checks on both kitchen hood suppression systems inspection tags monthly for 3 months then quarterly thereafter. CRITERIA 4: " The Maintenance Director or designee will review all documentation of inspections monthly and findings will be discussed at the Quality Assurance and Performance Improvement meetings held quarterly.	
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	K 353		2/15/25

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K 353	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 12/23/24 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to conduct 3 years air leakage test in accordance with NFPA 101: 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7 and NFPA 25: 2011 Edition, Section 13.4.4.29. This deficient practice had the potential to affect all 101 residents and was evidenced by the following: A documentation review at approximately 11:30 AM revealed the facility's sprinkler system inspection reports did not indicate any 3 year air leakage was conducted as required by NFPA 25. In an interview at that time, the U.S. FOI[redacted] confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference at 2:25 PM. NJAC 8:39-31.2(e) NFPA 25	K 353	CRITERIA 1: " A 3-year air leakage test for the sprinkler system will be conducted by NJ Ex Order 25.4(b)(1) [redacted] is scheduled 2/03/2025. CRITERIA 2: " All residents have the potential to be affected by the deficient practice of failure to conduct a 3-year air leakage test for the sprinkler system. CRITERIA 3: " A 3-year air leakage testing for the fire suppression system is scheduled accordingly (every 3 years) to comply with NFPA 101 2012 LSC EDITION, SECTION 19,3.5.1, SECTION 4,6,12, SECTION 9.7 AND NFPA 25: 2011 EDITION SECTION 13.4.4.29. CRITERIA 4: " The Maintenance Director or designee will monitor scheduled maintenance and findings will be reported to the Administrator and discussed at the Quality Assurance and Performance Improvement meetings held quarterly.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101	K 363		2/15/25

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K 363	Continued From page 11 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 363		

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K 363	Continued From page 12 Based observations and interview on 12/19/2024 and 12/20/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that corridor doors were maintained to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Section 19.3.6.3. This deficient practice had the potential to affect all 101 residents and was evidenced by to following: Observations on 12/19/24 from 8:30 AM to 3:15 PM revealed all resident rooms door on Laurel Place, Juniper Way and Chestnut Lane had a gap at the meeting edge when tested. In an interview at that time, the U.S. FOI confirmed the observations. Observations on 12/20/24 from 9:17 AM to 2:47 PM, revealed all resident rooms door on Balsam Court, Hickory Lodge and Willow Terrace had a gap at the meeting edge when tested. In an interview at that time, the U.S. FOI confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 12/23/2024 at 2:25 PM. N.J.A.C 8:39-31.2(e)	K 363	CRITERIA 1: " Door astragals will be installed on the corridor doors located in Laurel Place, Juniper Way, Chestnut Lane, Balsam Court, Hickory Lodge and Willow Terrace households by 2/15/25. CRITERIA 2: " All residents have the potential to be affected by the deficient practice of failure to ensure that corridor doors were maintained to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Section 19.3.6.3. CRITERIA 3: " The maintenance staff will conduct inspections of all Corridor doors in all of the households to ensure that door astragals are in place and maintained to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Section 19.3.6.3., quarterly for 6 months then annually thereafter. " Inspections will be documented and logged in the Life Safety book. CRITERIA 4: " The Maintenance Director or designee will review all inspection reports quarterly and findings will be reported to the Administrator and will be discussed at the Quality Assurance and Performance Improvement meetings held quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING **01** B. WING _____	**12/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	**451 SCHOOLEY'S MOUNTAIN RD** **HACKETTSTOWN, NJ 07840**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 12/20/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to conduct fire drills with varying activation types in accordance with NFPA 101: 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 12 of 13 fire drills, had the potential to affect all 101 residents and was evidenced by the following: A review of the facility's fire drill reports at 2:20 PM revealed that records provided for 12 of 13 months had no indication the fire drills were conducted with an activation or the type of alarm transmission signal: Pull, Smoke or Page. In an interview, the findings were verified by the U.S. FOI [redacted] at the time of record review. The U.S. FOI [redacted] confirmed that the fire drills were not descriptive as to the type of device used to activate the fire alarm system, (pull, page, and smoke). The facility's U.S. FOIA (b) (6) was notified of the	K 712	CRITERIA 1: " On 1/3/2025 The Maintenance Foreman who filled out the fire drill forms was in-service on proper procedure for completion of The Fire Drill form to include the type of device being activated and alarm transmission in accordance with NFPA 101 2012 edition Section 19.7.1.4 through 19.7.1.7. CRITERIA 2: " All residents have the potential to be affected by the deficient practice of failure to ensure type of device activated and alarm transmission during a fire drill are not indicated on Fire Drill forms. CRITERIA 3: " The Assistant Maintenance Director or designee will review all completed Fire	2/15/25

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	315072	A. BUILDING **01** B. WING _____	**12/23/2024**

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K 712	Continued From page 14 deficient practice at Life Safety Code survey exit conference on 12/23/2024 at 2:25 PM. NJAC 8:39-31.2(e)	K 712	Drill forms to ensure that the type of device activated, and alarm transmission is recorded after each scheduled fire drill. CRITERIA 4: " Findings will be reported to the Maintenance Director and Administrator monthly and will be discussed at the Quality Assurance and Performance Improvement meetings held quarterly.	
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: Based on observations, documentation review and interview on 12/19/2024 and 12/23/24 in the presence of U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the fire doors assemblies were inspected, tested and documented annually by an individual who could demonstrate knowledge and understanding	K 761	CRITERIA 1: " The policy and procedure for inspection of fire door assemblies is attached. (see exhibit E.1) " Documentation of Inspection of fire door assemblies is attached. (see exhibit E.2)	2/15/25

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	315072	A. BUILDING **01** B. WING _____	**12/23/2024**

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K 761	Continued From page 15 of the operating components in accordance with NFPA 101:2012 Edition, Section 19.7.6, 8.3.3.1 and NFPA 80: 2010 Edition, Section 5.2,5.2.3. This deficient practice had the potential to affect all 101 residents and was evidenced by the following: Observations with U.S. FOI during the tour on 12/19/24 from 9:15 AM to 3:45 PM, revealed smoke and fire rated doors at various locations including, horizontal exit, hazardous enclosures and exits. A documentation review on 12/23/2024 at 10:25 AM revealed that facility did not provide policy and procedures for fire door assemblies and no documentation to indicate fire door assemblies were inspected and tested annually. In an interview at the time, the U.S. FOI confirmed the observation and documentation review. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code survey exit conference at 2:25 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	CRITERIA 2: " All residents have the potential to be affected by the deficient practice of failure to ensure that a policy and procedure is in place for inspection of fire door assemblies and that documentation of inspection and testing is completed annually. CRITERIA 3: " Maintenance Foreman/ designee will ensure that policy and procedure for inspection of fire door assemblies annually is adhered to and that inspection results are documented and logged in the Life Safety book. CRITERIA 4: " Maintenance Director or designee will monitor schedules of inspections of fire door assemblies to ensure timely completion and inspection sheets will be on file in the life safety book and finding will be discussed at the Quality Assurance and Performance Improvement meeting held quarterly.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the	K 911		2/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. BUILDING **01** B. WING _____	**12/23/2024**

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K 911	Continued From page 16 applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/19/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 99:1012, Section 6.3.2.1 and NFPA 70, Section 210.8. This deficient practice was observed for 1 of 21 electrical outlets located next to a water source and was evidenced by the following: Observations at 11:10 AM in the Physical Therapy room revealed that a Hydrocollator was plugged into a non-GFCI protected outlet. The Hydrocollator was filled with water, had a heating element and was required to be protected by a GFCI (ground-fault circuit interrupter) to prevent a shock. In an interview at the time, the U.S. FOI[redacted] confirmed the finding. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 12/23/2024 at 2:25 PM NJAC 8:39 -31.2 (e) NFPA 70, 99	K 911	CRITERIA 1: " The outlet where hydrocollator was plugged in the therapy room is replaced with a GFCI (Ground-fault circuit interrupter) protected outlet on 1/9/2025. (see exhibit F) CRITERIA 2: " All residents have the potential to be affected by the deficient practice of failure to ensure that hydrocollator was plugged into a GFCI(Ground-fault circuit interrupter) protected outlet. CRITERIA 3: " Maintenance staff will conduct monthly inspections to include checking areas where equipment that contains water is plugged into a GFCI(Ground-fault circuit interrupter) protected outlet. " Findings and corrections will be reported to the Director of Maintenance monthly for 3 months then quarterly thereafter. CRITERIA 4: " Director of Maintenance or designee will review all monthly inspections and corrective actions and a report will be submitted to the Administrator.	

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K 911	Continued From page 17	K 911	" All reports will be discussed at the Quality Assurance and Performance Improvement meetings held quarterly.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test 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	K 918		2/15/25

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	315072	A. BUILDING 01 B. WING	12/23/2024

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HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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K 918	Continued From page 18 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 12/23/2024 in the presence of the U.S. 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 101 residents and was evidenced by the following: A review of the facility's generator annual service report dated 11/07/ 2024, provided by the U.S. FOIA 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 or results. In an interview at 11:22 AM, the U.S. FOI [redacted] stated the diesel fuel sample analysis test was conducted by vendor but could not provide any documentation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code survey exit at approximately 2:25 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	CRITERIA 1: " A copy of the annual Diesel fuel sample analysis test conducted by NJ Ex Order 26.4(b)(1) [redacted] was completed on 1/6/2025 and results will be provided on or before January 31,2025 and will be filed in the Life safety book CRITERIA 2: " All residents have the potential to be affected by the deficient practice of failure 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. CRITERIA 3: " Director of maintenance or designee will ensure that Diesel fuel sample analysis testing is scheduled annually and conducted by a licensed vendor. " A copy of the annual Diesel Fuel analysis report will be obtained and retained in the life safety book. CRITERIA 4: " Results of the Diesel Fuel analysis	

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K 918	Continued From page 19	K 918	testing will be reported to the administrator. " Results of testing will be discussed at the Quality Assurance and Performance Improvement meeting held quarterly.	
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 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	K 921		2/15/25

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K 921	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 12/19/24 and 12/20/24 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to provide safety electrical labels or tags for all the patient care related electrical equipment (PCREE), conduct inspection for 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 101 residents and was evidenced by the following: Observations from 9:15 AM to 3:45 PM on 12/19/2024, 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 U.S. FOI confirmed the observations. A review of the facility's policy for (PCREE) provided by U.S. FOI on 12/20/2024 at 2:30 PM revealed, "The maintenance person will date, and initial safety tag attached to the equipment being inspected." The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 12/23/2024 at 2:25 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	CRITERIA 1: " Inspection stickers will be applied to all fixed and portable patient -care related equipment and will be completed by 2/15/2025. CRITERIA 2: " All residents have the potential to be affected by the deficient practice of failure to ensure that safety electrical labels or tags were attached to all patient care related electrical equipment. CRITERIA 3: " Annual inspection of all (PCREE) patient care related electrical equipment that is plugged into an outlet will now be tagged with an inspection sticker and will continue to be logged in the inspection sheet and filed in the life safety book. " Random spot checks will be conducted by the Maintenance Director or designee on all (PCREE) patient care related electrical equipment) to ensure that inspection stickers are attached monthly for 3 months then quarterly thereafter. CRITERIA 4: " Maintenance Director or designee will submit reports to the Administrator monthly for 3 months and findings will be discussed at the Quality Assurance and	

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K 921	Continued From page 21	K 921	Performance Improvement meeting held quarterly.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315072 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/20/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH VILLAGE	451 SCHOOLEY'S MOUNTAIN RD HACKETTSTOWN, NJ 07840

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 K0281	02/15/2025	LSC K0291	02/15/2025	LSC K0293	02/15/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	02/15/2025	LSC K0324	02/15/2025	LSC K0353	02/15/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	02/15/2025	LSC K0712	02/15/2025	LSC K0761	02/15/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0911	02/15/2025	LSC K0918	02/15/2025	LSC K0921	02/15/2025
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	
12/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO