

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408331	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/02/2025
NAME OF PROVIDER OR SUPPLIER SENIOR SPIRIT OF JERSEY CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 675 GARFIELD AVENUE JERSEY CITY, NJ 07305		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments Type of Survey: Monitoring Census: 143 Sample Size: 3 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 223	8:43F-3.1(b)(1-7) Administration (b) The administrator shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including participant rights; 2. Planning and administering the managerial, operational, fiscal, and reporting components of the facility; 3. Participating in the quality improvement program for participant care and staff performance; 4. Ensuring that all personnel are assigned	M 223		

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

TITLE

(X6) DATE

New Jersey Department of Health

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M 223	Continued From page 1 duties based upon their education, training, competencies, and job descriptions; 5. Ensuring the provision of staff orientation, staff education, and ongoing staff training in accordance with N.J.A.C. 8:43F-6.3; 6. Establishing and maintaining liaison relationships and communication between facility staff and services providers and with participants and their caregivers; and 7. Verifying that each Medicaid-eligible participant is eligible to receive services available at the adult day health services facility prior to the participant's entry into the program. For the purposes of this section, the administrator shall be entitled to rely on any prior authorization performed by the Department for the participant in accordance with N.J.A.C. 8:86. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow its policy and procedure titled, "Participant Environment" for floor mats, ceiling tiles, vermin, wires, extension cords and fire extinguishers to maintain a sanitary and safe environment for all participants who attend the program. This deficient practice was evidenced by the following:	M 223			

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M 223	Continued From page 2 On 9/2/25, the Department of Health (DOH) conducted a monitoring survey following an 8/20/24 visit of the office of Inspector General (OIG) which revealed that the facility was out of compliance with maintaining a safe and sanitary environment for all participants. The surveyor reviewed picture evidence of unsecured extension cords, wires, floor mats, vermin, and ceiling stains. In addition, the surveyor reviewed a picture of an expired basement fire extinguisher that was initially serviced and inspected in April of 2022, with the expiration date of 2023. At 10:40 a.m., the surveyor toured the participant's Quiet Room with the Director of Marketing (DOM) and observed a circular brownish discoloration stain located on the white ceiling tile. At 10:48 a.m., the surveyor toured the Beauty Parlor and observed that there were two rubber mats placed on the floor at the base of the two salon chairs. At 11:02 a.m., the surveyor toured all entrances to the facility and observed that there was a rubber-based floor mat placed on the floor at both entrances to the facility. During tour with the DOM, she stated that the floor mats were used for safety when it rained, so that the participants would not slip and fall. At 12:35 p.m., the surveyor interviewed the Administrator regarding the ceiling tiles and floor mats. The Administrator stated that she would contact the Landlord to repair the ceiling tile. In	M 223		

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M 223	Continued From page 3 addition, the Administrator stated that the floor mats at the entrances and in the beauty parlor were slip resistant and for resident safety. The Administrator then removed the floor mats. During the OIG visit on 8/20/24, the OIG observed a basement fire extinguisher that was expired and last inspected in April of 2022. While touring with the DOM, the surveyor inspected the fire extinguishers, including the extinguisher located in the basement and observed that all the extinguishers last annual inspection was 4/2025, post OIG inspection on 8/20/24, eight months later. In addition, the surveyor inquired about unsecured extension cords and wires located in the beauty salon, Social Services and Activities office floors observed on 8/20/24 during the OIG inspection. The DOM stated that the wires were removed. At 1:30 p.m., the surveyor interviewed the Administrator regarding vermins and the fire extinguishers. The Administrator stated that the facility was exterminated monthly. The Administrator stated that the fire extinguishers were inspected during the quarterly fire drills. The surveyor reviewed the facility policy and procedure titled, "Participant Environment" which revealed "... The following housekeeping, sanitation, and safety conditions shall be met: ...Throw rugs or scatter rugs shall not be used in the facility; All furnishings shall be clean and in good repair. ... Program shall be maintained to keep ... vermin out of the facility; ..." In addition, the surveyor reviewed the facility "Fire/Disaster Drill Procedure" dated 11/30/23	M 223			

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M 223	Continued From page 4 which revealed a check list that indicated "...Fire Extinguishers [were] updated ... yes ..." However, there was no documentation that indicated which fire extinguisher was updated or serviced.	M 223		
M 689	8:43F-14.17(f)(g) Physical Plant Requirements (f) Drills of emergency plans shall be conducted at least four times a year and documented, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The four drills shall include at least one drill for emergencies due to fire. (g) The facility shall conduct at least one drill per year for emergencies due to another type of disaster, such as storm, flood, other natural disaster, bomb threat, or nuclear accident. All staff shall participate in at least one drill annually, and program participants may take part in drills. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to implement at least one drill annually for emergencies for all employees. This deficient practice was evidenced by the following: On 9/2/25 at 11:50 a.m., the surveyor reviewed the facility Fire/Disaster Drill records provided by the Administrator which revealed that a disaster	M 689		

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M 689	Continued From page 5 drill for bomb threats was held on 8/26/24 and 8/28/25, post the Office of Inspector General on 8/20/24. At 1:30 p.m., the surveyor interviewed the Administrator regarding disaster drills trainings. The Administrator stated that she conducted annual disaster drills. In addition, the Administrator stated that she maintained the drill records in her binder. The surveyor then requested the records for the 2023 annual drills for review. At 1:35 p.m., the surveyor reviewed the annual drill records dated 2023, which revealed that there was no documentation in the records that indicated a disaster drill was conducted in the year 2023. During interview with the Administrator, she stated that she thought the 2023 annual disaster drill was conducted. The surveyor reviewed the facility policy and procedure titled, "Emergency Plans and Procedures" which revealed that the facility will "... Exercise mock disaster scenarios. ... Three fire drills and one drill due to an unforeseen emergency shall be done yearly with participants and staff to make sure it is ready to be executed if needed ..."	M 689			
M 767	8:43F-16.2(a)(1-4) Infection Control, Santation, Housekeeping (a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications, incorporated herein by	M 767			

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M 767	Continued From page 6 reference: 1. Guideline for Hand Hygiene in Health-Care Settings, PB85-923404, as amended or supplemented; 2. OSHA Standards 29 CFR--1910.1030, Bloodborne pathogens, as amended and supplemented; 3. Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly, and contained in MMWR 39(RR-10), as amended or supplemented; and 4. Prevention of Nosocomial Pneumonia, PB95-176970, January 3, 1997, 46(RR-1), as amended or supplemented. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to ensure that its Infection Control Policy and Procedure was consistently reviewed annually. This deficient practice was evidenced by the following: On 9/2/25 at 10:00 a.m., the surveyor requested the facility policy and procedure manual from the Administrator for review. At 11:29 a.m., the surveyor reviewed the policy	M 767			

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M 767	Continued From page 7 and procedure manual and observed a document titled, "Annual Review of Policies and Procedures (ARPP)" which revealed documentation of annual signatures and dates to indicate that the policies in the manual were reviewed. In addition, the ARPP revealed that the annual policy review for the year 2024 was completed on 1/6/24. During review of the ARPP, the surveyor observed that the Administrator documented next to the 1/6/24, that all policies were reviewed. However, the surveyor did not observe the annual review for the infection control policy. At 11:35 a.m., the survey interviewed the Administrator regarding the procedure for annual review of policies and procedures. The Administrator stated that she reviewed the policies annually. The surveyor further reviewed the ARPP which revealed, "The administrator shall conduct an annual review of the policies and procedures contained in this manual and shall verify the review by entering signature and date on this record ..."	M 767			

POC# 2
Rec'd 10/2/25
accepted
10/2/25

Plan of Correction

Date of Survey: 9/2/2025

M223

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

All participants were identified as having the potential to be affected by the deficient practice.

To address the deficiency related to the facility's failure to follow its policy and procedure regarding maintaining a sanitary and safe environment, the following corrective actions have been implemented:

Immediate Remediation:

- All areas identified as unsanitary or unsafe were immediately cleaned, disinfected, and restored to meet environmental safety standards as of 9/3/2025.
- Environmental audits and weekly supervisory reviews have been initiated to ensure continued compliance started on 10/2/2025.
- The facility owner was contacted regarding the findings of the fire extinguisher in the basement not being inspected in 2023. To assure the timely inspection will be completed.

Measures to Prevent Recurrence

To ensure this deficiency does not recur, the facility has implemented the following systemic changes:

- Staff education on sanitation and safety policies completed on 10/2/2025.
- Weekly environmental audits, eventually progressing to monthly audits will continue to monitor compliance and identify any emerging risks
- Employees' refresher training to reinforce standards of safety and sanitation. 10/2/2025

Plan of Correction

M223 (continue)

2. How the facility will identify other participants having the potential to be affected by the same deficient practice and ensure recurrence does not occur.

All participants are considered to have the potential to be affected by the same deficient practice.

Corrective actions include:

- **Comprehensive Environmental Review:** A full inspection of all program areas—licensed and unlicensed—was conducted to assess compliance with sanitation and safety standards. This review included spaces used by all participants, not just those initially identified.

Staff Interviews and Observations: Staff were interviewed and observed to identify any patterns or practices that may have contributed to the deficiency. This helped pinpoint areas of vulnerability and reinforce accountability.

- **Systemic Safeguards:** The facility has instituted cross-checks between environmental services and program operations to ensure that all areas used by participants meet regulatory standards
- **Ongoing Monitoring:** Weekly environmental audits, eventually progressing to monthly audits, will be conducted to continue monitoring compliance and identify any emerging risks.

These measures are designed to build a sustainable system that prevents recurrence and promotes a culture of safety and vigilance.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur:

Measures and Systemic Changes to Prevent Recurrence

To ensure that the deficient practice—failure to follow facility policy and procedure regarding maintaining a sanitary and safe environment—does not recur, the facility has implemented the following systemic changes:

M223 (continue)

Plan of Correction

- **Policy Reinforcement and Staff Education:** All staff have received mandatory re-education on sanitation and safety protocols. Training sessions included a review of the facility's environmental policies.
- **Weekly Environmental Safety Checklist:** Weekly environmental audits, eventually progressing to monthly audits will be conducted to continue to monitor compliance and identify any emerging risks. Audit results will be reviewed by the Administrator with immediate corrective action taken if deficiencies are found.
- **Yearly Refresher Training and as needed:** Ongoing training sessions will be scheduled to reinforce best practices and update staff on any changes to environmental safety standards or procedures.
- **Accountability and Reporting Culture:** Staff are encouraged to report any environmental concerns immediately.
- **Cross-Departmental Oversight:** Coordination between environmental services, program staff, and administration has been strengthened to ensure consistent application of safety protocols across all areas, including unlicensed spaces.
- **Quality Assurance Monitoring:** The Quality Assurance Committee will track compliance trends, review audit data, and recommend improvements to ensure sustained adherence to policies.

M223 (continue)

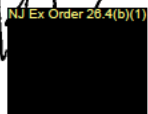
Plan of Correction

4. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur:

To ensure that the corrective actions are effective and that the deficient practice does not recur, the facility has implemented the following monitoring strategies:

- Ongoing Environmental Audits: Weekly audits of all program areas will be conducted by the Administrator or designee. Audit results will be documented and reviewed by the Administrator to ensure continued compliance with sanitation and safety standards.
- Random Spot Checks: The Administrator will perform unannounced spot checks at least monthly to verify that staff is consistently following environmental protocols.
- Quality Assurance Oversight: The Quality Assurance Committee will review audit data during monthly meetings. Trends will be analyzed to identify areas for improvement or retraining.
- Continuous Improvement Loop: All monitoring data will be used to refine policies, improve training, and strengthen accountability systems. Updates will be communicated to staff as needed.

5. Final Completion Date: 10/2/2025

Accepted
10/2/25

NJ Ex Order 26.4(b)(1)

Plan of Correction

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

All participants were identified as having the potential to be affected by the deficient practice of not implementing in 2023 at least one drill annually due to emergencies for all employees. One drill due to an emergency was completed in 2024 and 2025.

1. Corrective Action for potential Affected Individuals

- The facility conducted an emergency drill in 2024 and 2025, and the next emergency drill is scheduled for 2026.

2. Measures to Prevent Recurrence

To ensure this deficiency does not recur, the facility has implemented the following systemic changes:

- Annual Drill Calendar: A recurring annual emergency drill has been added to the facility's compliance calendar, with automated reminders sent to leadership 30 days in advance as of 9/19/2025
- Policy: The facility shall continue to follow its Emergency Plans and Procedures, and an annual drill calendar has been added to the facility compliance calendar.

3. Monitoring of Corrective Action

To ensure the corrective action is sustained and the deficiency does not recur:

- The Administrator or designee will verify completion of the annual drill and staff participation as part of the facility's annual compliance audit.
- The Quality Assurance Committee will review emergency drill documentation as needed to ensure adherence to policy.
- Any missed drills or incomplete participation will trigger immediate corrective action and retraining.

M-689 (continue)

Plan of Correction

2. How the facility will identify other participants having the potential to be affected by the same deficient practice and ensure recurrence does not occur.

All participants are considered to have the potential to be affected by the same deficient practice—failure to conduct an annual emergency drill involving all employees. To address this, the facility has taken the following steps:

- Annual Emergency Drill Calendar: A recurring annual emergency drill has been added to the facility's compliance calendar, with reminders to leadership 30 days in advance.
- Staff-Wide Training and Drill Participation: All employees, regardless of role or shift, will be included in the corrective emergency drill and receive updated training to ensure consistent response protocols across the board.
- Annual Emergency Drill Calendar and Tracking: A centralized tracking system has been implemented to ensure that future drills are scheduled, documented, and verified.

These actions ensure that every individual served by the facility is safeguarded against future lapses in emergency preparedness.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur:

Measures and Systemic Changes to Prevent Recurrence

To ensure that the failure to conduct an annual emergency drill for all employees does not recur, the facility has implemented the following systemic changes:

- Annual Emergency Drill Calendar: A recurring emergency drill has been added to the facility's compliance calendar. Reminders will be sent to the Administrator and department heads 30 days prior to the scheduled drill to ensure timely execution.
- All staff will receive Emergency procedure training yearly. Last completed in 2025.
- Quality Assurance Oversight: The Quality Assurance Committee will monitor drill completion and documentation as part of its quarterly review process. Any missed drills or incomplete participation will trigger immediate corrective action.

Plan of Correction

M 689 (continue)

4. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur:

Monitoring of Corrective Action to Ensure Sustained Compliance

To ensure that the corrective actions are effective and that the failure to conduct an annual emergency drill does not recur, the facility has implemented the following monitoring strategies:

- Compliance Calendar Oversight: The Administrator will oversee the facility's compliance calendar to ensure the annual emergency drill is scheduled and completed on time. Calendar alerts will be reviewed monthly to prevent oversight.
- Drill Documentation Review: All emergency drill records, including date, scenario, staff participation, and outcomes, will continue to be monitored and documented by the administrator on a quarterly basis.

5. Completed: 10/2/2025

accepted
10/2/25
NJ Ex Order 20.4(b)(1)

M767

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

All participants were identified as having the potential to be affected by the deficient practice.

Plan of Correction

Corrective Action Taken: The administrator has conducted an immediate review of the current infection control policies and procedures to identify any outdated or missing elements. Updates have been made on 1/2025 and policy has been reviewed on 10/2/2025.

Systemic Changes:

- A recurring Infection Control Policy and Procedure compliance calendar/Policy Review Tracker has been added to the facility's compliance calendar.
- All revised policies will be distributed to staff and incorporated into ongoing training sessions.

2. How the facility will identify other participants having the potential to be affected by the same deficient practice and ensure recurrence does not occur.

All participants are considered to have the potential to be affected by the same deficient practice.

Preventive Measures to Ensure Recurrence Does Not Occur:

- A recurring Infection Control Policy and Procedure compliance calendar/Policy Review Tracker has been added to the facility's compliance calendar. The Policy Review Tracker will be implemented to monitor and document timely reviews of all infection control policies.

M767 (continue)

- The facility will incorporate infection control policy review into its QA program.

These steps will ensure that the deficient practice is corrected systemically and sustainable.

Plan of Correction

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur:

Systemic Changes to Prevent Recurrence

To ensure the infection control policy and procedure is consistently reviewed and the deficient practice does not recur, the facility will implement the following systemic changes:

- A recurring Infection Control Policy and Procedure compliance calendar/Policy Review Tracker has been added to the facility's compliance calendar. The Policy Review Tracker will be implemented on 9/22/2025 to monitor and document timely reviews of all infection control policies.
- Policy Review Log: A centralized log will be maintained to document each review
- Administrator Oversight: The administrator will schedule automated reminders to verify that scheduled reviews are completed. Failure to comply will trigger immediate corrective action.
- QA Integration: Infection control policy review log will be added as a standing agenda item in the facility's Quality Assurance Book. This ensures ongoing monitoring.

These measures will create a sustainable framework for policy oversight and accountability, ensuring that infection control procedures remain current and effective.

M767 (continue)

4. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur:

Monitoring Corrective Action to Prevent Recurrence

Plan of Correction

To ensure the corrective action is effective and the deficient practice does not recur, the facility will implement the following monitoring strategies:

- A recurring Infection Control Policy and Procedure compliance calendar/Policy Review Tracker has been added to the facility's compliance calendar. The Policy Review Tracker will be implemented to monitor and document timely reviews of all infection control policies.
- Policy Review Log: A centralized log will be maintained to document each review.
- Administrator Oversight: The administrator will schedule automated reminders to verify that scheduled reviews are completed. Failure to comply will trigger immediate corrective action.
- QA Oversight: Infection control policy review status will be a standing agenda item in the facility's Quality Assurance meetings. Audit findings will be discussed, and any deviations will prompt immediate follow-up.

5. Completed: 10/2/2025

Accepted
10/2/25
NJ Ex Order 26.4(b)(1)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 408331	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 9/2/2025
NAME OF FACILITY SENIOR SPIRIT OF JERSEY CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 675 GARFIELD AVENUE JERSEY CITY, NJ 07305	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0223	Correction	ID Prefix M0689	Correction	ID Prefix M0767	Correction
Reg. # 8:43F-3.1(b)(1-7)	Completed	Reg. # 8:43F-14.17(f)(g)	Completed	Reg. # 8:43F-16.2(a)(1-4)	Completed
LSC	10/02/2025	LSC	10/02/2025	LSC	10/02/2025
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	
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 9/2/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			