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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. BUILDING ______ B. WING ______	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	**132 EVERGREEN RD EDISON, NJ 08818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #s NJ 157909, 158478, 158807, 159837, 168443 STANDARD SURVEY: 7/8/24-7/16/24 CENSUS: 159 SAMPLE SIZE: 32+2 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. No deficiences were cited during this survey.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/23/2024

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

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K 000	INITIAL COMMENTS	K 000		

A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 7/12/24, 7/15/24 and 7/16/24, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy

The facility is a 2-story building that was built in 90's, It is composed of Type II unprotected. The facility is divided into 13 smoke zones. The building currently has an interior 850 KW diesel generator that does approximately 50% of the building as per the facility engineer.

The facility is divided into the following wings:

Floor #2:

Liberty wing: RR 400-454
Eagle wing: RR 500-554
Independence wing: RR 300-354
Freedom wing: RR 200-254

Floor #1:

Old Glory wing: RR 600-654 (secured unit)
Stars & Stripes: RR 701-753 (currently not occupied)
PUI rooms: 701-739
Covid rooms: 741-753

The current census is 159, the facility is licensed for 328 certified beds

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
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(X6) DATE: 07/30/2024

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K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of	K 161		8/19/24

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K 161	Continued From page 2 approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview on 7/15/24, in the presence of the U.S. FOIA (b)(6), It was determined that the facility failed to provide acceptable construction standards in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through 19.1.6.7, 19.3.1 and 8.6. This deficient practice could affect all residents residing in the facility, was evidenced for 2 of 10 sections observed in the facility by the following: 1). At 11:22 AM, the surveyor and U.S. FOIA, observed in the floor one # 823 resident storage room, that the vertical steel I-beam from approximately 5' down to the facility floor was missing its fire rated coating. The U.S. FO stated and agreed that the fire rated coating was not applied to the lower section of the steel colunm observed. 2). At 11:40 AM, the surveyor and U.S. FOIA observed in the floor one # 823 resident storage room, that the horizontal I-beam was missing its fire rated coating approximately 12" x 6". The U.S. FOIA stated and agreed that the horizontal I-beam was missing an approximately 12" x 6" section of its fire rated coating. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 7/16/24. NJAC 8:39-31.2(e)	K 161	Corrective Actions related to deficiency The fire rated coating on the 1st floor room #823, resident storage room, vertical steel I-beam was repaired with fire-proof furnace cement on 7/25/2024 The fire rated coating on the 1st floor room #823, resident storage room, horizontal I-beam was repaired with fire-proof furnace cement on 7/25/2024. Identification of At-risk Residents Current residents have the potential to be affected. Systemic Changes The Facility Engineer inspected Resident storage rooms in the Center for fire-coating on vertical steel I-beams. The Facility Engineer inspected Resident storage areas in the Center for fire coating on horizontal steel I-beams. The Facility Engineer will add inspection of vertical and horizontal steel beams in the Center, including storage areas, to the Monthly Preventative Maintenance Schedule. Maintenance staff will be in serviced on visual inspection of steel I-beams. Maintenance staff completing the monthly inspections will document their findings and report any missing fire rated coating to the Facility Engineer for expedited repair. QAPI	

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K 161	Continued From page 3	K 161	The Facility Engineer will review the I-beam inspection records. Results of the I-beam inspection records will be reported by the Facility Engineer or designee to the monthly QAPI Committee x 3 months then quarterly x 2 for review and/or recommendations	
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on documentation review, observation, and interview on 07/15/2024 and 07/16/2024, in presence of U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that fire doors were inspected annually, and doors in smoke barrier were equipped with self-closing device in accordance with NFPA 80, Standard for Fire Doors and other opening protectives and NFPA 101 Life Safety Code (2012 Edition), Section 19.2.2.2.7, 19.2.2.2.8, 7.2.1.8.2, and 7.2.1.15. These	K 223	Corrective Actions related to deficiency The doors were inspected by an outside vendor; NJ Exec Order 26.4b1 [redacted] Self-closures without a locking device were installed on doors #7 and #52 on 7/26/24. The yearly door inspection by an outside vendor had been completed 2/2024. The report was obtained and the 2025 inspection was scheduled.	8/19/24

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K 223	Continued From page 4 deficient practices had the potential to affect all 159 residents and were evidenced by the following: 1. A review of documentation provided by the U.S. FO on 07/15/2024 at 9:00 AM, revealed the fire door inspection record was dated 4/8/2023, more than 15 months ago. 2. The record indicated Opening #52 has a hold-open arm. "If a fire door has a hold open function it must be a fusible link, or a magnet connected to the fire alarm to close in emergency." 3. The record indicated Opening #7 has a hold -open arm. "If a fire door has a hold open function it must be a fusible link, or a magnet connected to the fire alarm to close in emergency." In an interview at the time, the U.S. FOIA (b)(6) confirmed the finding. 4. During the tour between 9:10 AM and 3:00 PM the surveyor, in the presence of the U.S. FOIA (b)(6) observed opening #7 and opening #52 doors were not equipped with self -closing device. In an interview at the time, the U.S. FOIA (b)(6) confirmed the findings. The U.S. FOIA (b)(6) was informed on 07/16/2024 during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e) NFPA 80	K 223	Identification of At-risk Residents Current residents have the potential to be affected. Systemic Changes The Facility Engineer inspected the Center for doors with a hold open arm; there are no others in the Center. The Facility Engineer will add inspection of doors to the Monthly Preventative Schedule to ensure there are no doors with self-closing devices (hold open arms). The Facility Engineer will add yearly door inspection by an outside contractor to NJ Exec Order 26.4b1, a building management system, to ensure scheduling. Maintenance staff will be in serviced on NFPA requirements for doors in exit passageways, stairway enclosures, horizontal exit, smoke barrier, or hazardous area enclosure. Maintenance staff completing the monthly inspections will document their findings and report any doors with locking self-closing devices (hold open arm) to the Facility Engineer for expedited repair. The ACEO will check the NJ Exec Order 26.4b1 schedule of inspections by outside vendors, monthly, to ensure work is scheduled timely. QAPI The Facility Engineer will review the monthly door inspection records. Results will be reported by the Facility Engineer or designee to the monthly QAPI Committee x 3 months then quarterly x 2 for review	

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K 223	Continued From page 5	K 223	and/or recommendations The ACEO will report on the timeliness of scheduling outside vendors to the QAPI Committee the monthly x 3 months then quarterly x 2 for review and/or recommendations	
K 293 SS=F	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 07/15/2024 in presence of U.S. FOIA (b)(6) , it was determined that the facility failed to inspect and maintain exit signs to ensure exit and directional exit signs were provided in accordance with NFPA 101:2012 Edition, Section 19.2.10.1 and 7.10 . This deficient practice had the potential to affect all residents and was evidenced by the following: During the tour at 10:25 AM in the presence of the U.S. FOIA (b)(6), the surveyor observed 1 of 2 exit signs in the closed courtyard was not illuminated. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The facility's U.S. FOIA (b)(6) was notified of the	K 293	Corrective Actions related to deficiency The luminescent exit sign (#2) in the closed courtyard will be hard wired in to the system so that it is continuously illuminated. It will be completed by 7/31/24. Identification of At-risk Residents Current residents have the potential to be affected. Systemic Changes All exit signs in the closed courtyards were inspected for continuous lumination. The Facility Engineer will add inspection of exit signs in closed courtyards to the Monthly Preventative Maintenance Schedule to ensure they are continuously	8/19/24

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K 293	Continued From page 6 deficient practice at Life Safety Code survey exit conference on 07/16/2024. N.J.A.C 8:39-31.2(e).	K 293	illuminated. Maintenance staff will be in serviced on the lighting requirements for Exit signs. Maintenance staff completing the monthly inspections will document their findings and report any Exit signs not continuously illuminated to the Facility Engineer for expedited repair. QAPI The Facility Engineer will review the Exit signs in closed courtyard inspection records for continuously illuminated exit signs. Results of the inspections of Exit signs with continuous illumination in courtyards will be reported by the Facility Engineer or designee to the monthly QAPI Committee x 3 months then quarterly x 2 for review and/or recommendations	
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 ______	K 353		8/19/24

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K 353	Continued From page 7 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 07/12/2024 in the presence of NJ Exec Order 26.4b1 [redacted], it was determined that the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all 159 residents and was evidenced by the following: 1. During the tour at 12:05 PM, the surveyor, NJ Exec [redacted] observed the spare sprinkler heads storage box did not contain a wrench for emergency sprinkler head replacement. In an interview at the time, the NJ Exec Order 26.4b1 confirmed the observation. 2. During the tour at 12:20 PM, the surveyor, U.S. FOIA [redacted] observed in oxygen room # 335, approximately two-foot by one-foot section of ceiling tile was not in place. This condition would allow hot gasses and smoke past the sprinkler head into the space above, delaying the activation of the system. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 07/16/2024.	K 353	Corrective Actions related to deficiency A wrench was placed in the spare sprinkler head storage box 7/17/24 for emergency sprinkler head replacement. The ceiling tile located in oxygen room #335 was put in correct position (place). Identification of At-risk Residents Current residents have the potential to be affected. Systemic Changes The Center maintains only 1 spare sprinkler head storage box. All oxygen storage rooms located in the Center were inspected for ceiling tiles not in place. The Facility Engineer will add inspection of the spare sprinkler head storage box to the Monthly Preventative Maintenance Schedule to ensure a wrench is present. If the wrench is found to be missing, it will be replaced immediately and reported to the Facility Engineer. The Facility Engineer will add inspection of oxygen storage rooms for ceiling tile placement to daily rounds. If any ceiling tiles are out of place, they will immediately be put in to place and the Facility Engineer will be notified. Maintenance staff will be in serviced on why the wrench is necessary to be in the spare sprinkler head storage box.	

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K 353	Continued From page 8 N.J.A.C 8:39-31.2(e) NFPA 25	K 353	Maintenance staff will be in serviced on why ceiling tiles in oxygen storage rooms must be placed correctly. Maintenance staff completing the monthly preventative inspections (spare sprinkler head storage box) will document their findings. Maintenance staff completing daily rounds of the oxygen room ceiling tiles will document the findings of their rounds. QAPI The Facility Engineer will review the spare sprinkler storage box box inspection records. Results of the spare sprinkler head storage box inspections will be reported by the Facility Engineer or designee to the monthly QAPI Committee x 3 months then quarterly x 2 for review and/or recommendations. The Facility Engineer will review the daily rounds (ceiling tile placement) documentation. Results of the daily rounds will be reported by the Facility Engineer or designee to the monthly QAPI Committee x 3 months then quarterly x 2 for review and/or recommendations	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 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	K 363		8/19/24

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K 363	Continued From page 9 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: Based on observation and interview on 07/15/2024 in the presence of U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirement of	K 363	Corrective Actions related to deficiency Resident room doors #327, #337, and #445 were adjusted 7/23/24 so that they latch into the frames. Identification of At-risk Residents	

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K 363	Continued From page 10 NFPA 101, Life Safety Code 2012 Edition, Section 19.3.6, 19.3.6.3,19.3.6.3.1, and 19.3.6.5. This deficient practice was observed in 3 of 150 resident room doors and was evidenced by the following: During a tour of the facility between 09:10 AM and 3:00 PM, the surveyor observed that the resident room doors 327, 337, and 445 did not latch into the frames. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 07/16/2024. N.J.A.C 8:39-31.2(e)	K 363	Current residents have the potential to be affected. Systemic Changes All Resident room doors were inspected that they latched into the door frame. The Facility Engineer will add inspection of Resident room doors to the Monthly Preventative Maintenance Schedule to ensure they are latching into the frames. Pertinent staff, including Maintenance, Housekeeping and Nursing will be in serviced on reporting improperly latching doors and proper reporting in work order system. Maintenance staff completing the monthly inspections will document their findings and adjust any door found not latching into the frame. QAPI The Facility Engineer will review the inspection documentation and report the results of the inspections of doors not latching onto frames to the monthly QAPI Committee x3 months then quarterly x2 for review and/or recommendations	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3,	K 531		8/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. BUILDING 01 B. WING ______	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	132 EVERGREEN RD EDISON, NJ 08818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 11 Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/12/2024 in the presence of U.S. FOIA (b)(6) , it was determined that the facility failed to maintain elevator emergency communication for 1 of 2 elevators tested in accordance with ASME/ANSI A 17.3 and NFPA 101:2012 Edition, Section 19.5.3, 9.3.2, and 9.4.3. This deficient practice had the potential to affect all residents and was evidenced by the following: At 1:35 PM, the U.S. FO conducted a test of the emergency communication telephone system in the facility passenger elevator #2. The emergency telephone did not function when the button was activated. In an interview at the time, the NJ Exec Order 26.4b1 confirmed the observation. The U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 07/16/2024. N.J.A.C 8:39-31.2(e)	K 531	Corrective Actions Related to the Deficiency: The emergency communication telephone system in passenger elevator #2 was diagnosed by NJ Exec Order 26.4 on 7/29/24 and diagnosed as a dialer problem. NJ Exec Order 26.4 made the repair the same day, 7/29/24. The NJ Exec Order 26.4b1 confirmed the repair 7/30/24. Identification of At-Risk Residents: Current Residents have the potential to be affected. Systemic Changes: NJ Exec Order 26. checked all emergency communication telephone systems in the passenger elevators, #1, #2, #3, #4. Each telephone was working. The confirmed that telephones in elevators #1, #2, #3, #4 were working. The Facility Engineer will add inspection of emergency communication telephone system in passenger elevators to the Monthly Preventative Schedule to ensure	

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	315459	A. BUILDING 01 B. WING ______	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	132 EVERGREEN RD EDISON, NJ 08818

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K 531	Continued From page 12 ASME/ANSI A 17.3.	K 531	they function when operated. Maintenance Staff will be in serviced on the emergency communication requirements for passenger elevators. Maintenance staff completing the monthly inspections will document their findings and report any emergency communication telephones not working to the Facility Engineer for expedited repair. QAPI The Facility Engineer will review the documentation for the emergency communication telephone system in passenger elevators and report the results of the inspections to the monthly QAPI Committee x3 months, then quarterly x2 for review and/or recommendations.	
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	K 918		8/19/24

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K 918	Continued From page 13 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 7/12/24, in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was evidenced for 1 of 1 generators, had the potential to affect all 159 residents, and was evidenced by the following: At 9:44 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds for 12 of 12 times on the provided generator log. Currently, the US FOIA [redacted] was performing monthly generator load testing, but did not indicate the required transfer times on the	K 918	Corrective Actions related to deficiency The Emergency Generator Run Log had a line for the transfer time added to it. Identification of At-risk Residents Current residents have the potential to be affected. Systemic Changes The Center has 1 emergency generator. The Facility Engineer will review the Emergency Generator Run Log after the run to ensure the transfer time was documented. Boiler Room, Engineer and Assistant Engineer will be re-in-serviced on the Emergency Generator Run Log form which includes the line for transfer time. Staff performing the monthly load test will document transfer time and report any	

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	315459	A. BUILDING **01** B. WING ______	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	**132 EVERGREEN RD** **EDISON, NJ 08818**

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K 918	Continued From page 14 provided log dates: 7/19/23, 8/21/23, 9/22/23, 10/27/23, 11/22/23, 12/21/23, 1/23/24, 2/28/24, 3/26/24, 4/23/24, 5/28/24, and 6/25/24. An interview was conducted with the U.S. FOIA during document review, where he stated that currently he was not putting the transfer time on the provided generator monthly load test log. The NJ Exec Order 26.4b1 was informed of the deficient practice at the Life Safety Code exit conference on 7/16/24. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	transfer times greater than 10 seconds to the Facility Engineer for expedited repair. QAPI The Facility Engineer will review the documentation for emergency generator load test and report the results to the monthly QAPI Committee x3 months then quarterly x2 for review and/or recommendations	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		8/19/24

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. BUILDING 01 B. WING	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	132 EVERGREEN RD EDISON, NJ 08818

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K 923	Continued From page 15 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/15/2024 in the presence of NJ Exec Order 26.4b1 , it was determined that the facility failed to prohibit combustible storage within 5-feet of quantities of oxygen exceeding 300 cubic feet in accordance with NFPA 99:2012, Section 11.3.2.1 and 11.3.2.3. This deficient practice was identified for 47 of 47 portable oxygen cylinders and was evidenced by the following: At 10:15 AM the surveyor, NJ Exec Order 26.4b1 observed in NJ Exec Order 26.4b1 oxygen storage closet, that 47-portable oxygen cylinders were stored within 1-foot of combustible cardboard boxes, plastic bags, and bins exceeding 300 cu. Ft. to 3000 cu. Ft. In an interview at the time, the NJ Exec Order 26.4b1 confirmed the observation.	K 923	Corrective Actions related to deficiency All combustibles were removed from the NJ Exec Order 26.4b1 oxygen storage area 7/23/24. Identification of At-risk Residents Current residents have the potential to be affected. Systemic Changes All oxygen areas were inspected to ensure there were no combustibles stored within 5 feet. The Facility Engineer will add inspection of oxygen storage areas to weekly Maintenance rounding. Maintenance and Nursing staff will be in serviced on oxygen storage. Maintenance staff completing the weekly inspections will document their findings and remove any combustibles found in the area.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. BUILDING 01 B. WING ______	07/16/2024

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K 923	Continued From page 16 The U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 07/16/2024. N.J.A.C 8:39-31.2(e) NFPA 99	K 923	QAPI The Facility Engineer will review the weekly rounding documentation with results of the inspections reported by the Facility Engineer or designee to the monthly QAPI Committee x3 months then quarterly x2 for review and/or recommendations	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315459	A. Building 01 - MAIN BUILDING 01 B. Wing	9/4/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	132 EVERGREEN RD EDISON, NJ 08818

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 Reg. # NFPA 101 LSC K0161	Correction Completed 08/19/2024	ID Prefix Reg. # NFPA 101 LSC K0223	Correction Completed 08/19/2024	ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 08/19/2024
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 08/19/2024	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 08/19/2024	ID Prefix Reg. # NFPA 101 LSC K0531	Correction Completed 08/19/2024
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 08/19/2024	ID Prefix Reg. # NFPA 101 LSC K0923	Correction Completed 08/19/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 7/16/2024

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