STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING _____ B. WING _____	10/11/2022

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ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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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 Survey Date: 10/11/22 Census: 87 Sample: 18 + 2 closed records =20 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accommodate a resident's need and provide a functioning air conditioner. This deficient practice was identified for Resident # 75, 1 of 18 residents reviewed for the accommodation of needs, and was evidenced by the following:	F 558	F558 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #75 was provided with a new air-conditioning unit.	11/18/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/28/2022

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F 558	Continued From page 1 On 9/28/22 at 12:29 PM, during an initial tour of the facility, the surveyor met with resident #75, who was in the bed. During the interview, the resident told the surveyor that he/she had no air conditioning "throughout the summer." Resident #75 said that the Certified Nursing Assistants (CNAs) and the nurses were also complaining about the heat in the room. On that same date and time, the surveyor asked the resident if anyone was notified such as maintenance and Resident #75 said "yes" and was told that a new air conditioner was ordered but it never arrived. The resident showed the surveyor a fan that he/she had to have family bring in to "help tolerate the heat." The surveyor reviewed Resident #75's medical record. The Admission Record (admission summary or Face sheet) revealed that Resident #75 was admitted to the facility with medical diagnoses that included, but were not limited to [redacted] The quarterly Minimum Data Set (MDS), an assessment tool for the management of care, dated 9/12/22 indicated that the resident's Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], meaning the resident was cognitively [redacted]. On 9/28/22 at 12:35 PM, the surveyor met with the Regional Director of Plant Operations (RDPO) regarding the resident's air conditioner. The	F 558	How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. All air-conditioning units in all resident rooms were tested and all were found to be properly functioning. Nurses and Maintenance Staff were in-serviced on the use of the TELS electronic reporting system which the facility uses to record maintenance requests and repairs carried out. The TELS system has replaced the system of recording maintenance requests and repairs carried out in binders at nurses' stations. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will perform a random weekly audit of 3 resident room air-conditioning units 3 times a week for 3 weeks and 3 times a month for 3 months thereafter and forward results to the administrator for review. The Maintenance Director or designee will perform a random weekly survey of 3 residents and 3 nurses for 3 weeks and 3 times a month for 3 months thereafter to determine if all maintenance requests have been documented in the TELS system and that repairs were carried out and documented in the TELS system and	

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F 558	Continued From page 2	F 558		

RDPO stated that the Maintenance Director (MD) of the facility was out of work sick and that he would look into it. The surveyor asked the RDPO to provide any documentation regarding Resident #75 air conditioner repairs or order invoices since the resident was told an order for a new unit was placed.

At that same time, the RDPO was not able to provide documentation about the air conditioner to the surveyor.

On 9/29/22 at 11:30 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) regarding the process for notifying maintenance if a resident needed repair of something in their room. The UM/LPN stated that the operator was called and would transfer the call to the maintenance department.

On that same date and time, during the interview with the UM/LPN, the Licensed Practical Nurse (LPN) told the surveyor there was a "maintenance logbook", and proceeded to show the surveyor a blue binder labeled maintenance. The surveyor reviewed the sheets in the binder which showed that on 8/24/22 it was logged that the air conditioner in Resident #75 room was "not working correctly". The column on the sheet showing the issue was addressed was blank.

On 9/29/22 at 12:14 PM, the surveyor interviewed the LPN regarding the air conditioner. The LPN told the surveyor that she was on sick leave, returned to work in July and the air conditioning was not working, "but maintenance said one had to be ordered".

On 10/04/22 at 01:15 PM, the survey team met

forward results to the administrator for review.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:
The results of the air conditioning unit audits and maintenance request surveys will be reviewed by the facility's Quality Assurance Committee at each Quarterly Meeting for 6 months to ascertain if any trends are present and determine if any further action is needed.

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F 558	Continued From page 3	F 558		

with the Vice President of Operations (VPoO), Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Risk Management Regional Nurse (RMRN), and Regional Registered Nurse (RRN) and discussed the above concern.

On 10/06/22 at 01:24 PM, the surveyor interviewed the MD regarding the air conditioner in Resident #75's room. The MD told the surveyor that the air conditioning was not working in July and "I fixed the button so maintenance can adjust the thermostat". The surveyor asked if the staff could adjust the temperature and he said, "no, they can turn it on high and low, or cool and warm".

At that same time, the surveyor showed the MD the maintenance log binder from the unit in the presence of the RDPO. The surveyor asked why the items on the log were not marked as repaired. The RDPO told the surveyor that the facility had not used the binders/logs for one year, and an electronic system was in place. The surveyor informed the MD that the staff in the North Unit were not aware there was an electronic system. The MD had no comment.

Furthermore, the surveyor asked how the staff were trained for the new electronic maintenance system and the RDPO told the surveyor "They should receive training with orientation". The surveyor asked the RDPO if he could provide documentation on the training of new staff and the current staff, and none was provided to the surveyor.

On 10/07/22 at 12:13 PM, the survey team met with the LNHA, DON, and RRN. The RRN stated

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F 558	Continued From page 4 that there was no additional information. NJAC 8:39-31.2 (b), (e)	F 558		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		11/18/22

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F 656	Continued From page 5 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to develop a comprehensive person-centered care plan to include resident preferences for 1 of 3 residents, Resident #4, reviewed for the resident council meeting and was evidenced by the following: On 9/29/22 at 10:30 AM, the surveyor conducted a Resident Council Meeting at the facility. Three residents attended the meeting that included Resident #4. On 9/29/22 at 11:21 AM, following a resident council meeting, Resident #4 stated that there was an incident a month and a half ago that happened between the resident and the nurse. The resident stated that he/she did not like the nurse. The resident further stated that the incident was reported to the previous Licensed Nursing Home Administrator (LNHA) and the Social Worker (SW). The resident indicated it was investigated. On that same date and time, the resident informed the surveyor that the involved nurse still works in the facility, but no longer was taking care of the resident since the incident. Then, the resident told the surveyor that the nurse was still working "in my hallway."	F 656	F656 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The care plan for Resident #4 was updated to reflect the resident's preference. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected Facility Grievance Log was audited and all current residents' preferences are care planned in residents' clinical record. Residents will be asked if they have any preferences they wish addressed at their careplan meetings and careplans will be updated to address any preferences expressed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur:	

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F 656	Continued From page 6 The surveyor reviewed Resident #4's medical records. The Admission Record (admission summary or Face Sheet) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to: [redacted]. According to the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 6/28/22 revealed a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which means that the resident's cognition was [redacted] The Grievance/Complaint Report dated 7/27/22 showed that the resident "does not like" the Licensed Practical Nurse (LPN) and would like a different nurse caring for him/her. The personalized care plan did not include the 7/27/22 Grievance/Complaint Report and did not show the interventions about not having the LPN caring for the resident as per the resident's preference. On 9/29/22 at 01:15 PM, the survey team met with the LNHA, Director of Nursing, and Regional Registered Nurse (RRN) and were made aware of the above concerns. On 10/04/22 at 01:14 PM The surveyor asked the administrative team if the resident's preference not to have that nurse should have been included	F 656	Licensed Nursing Staff and Social Services Staff were re-educated on the facility grievance and care plan policy related to resident preferences by the Administrator. Facility Grievance Log will be audited weekly for 3 months and monthly for 3 months thereafter by the Social Service Director or designee and presented to Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the audits will be reviewed by the facility's Quality Assurance Committee Quarterly meeting for 6 months to ascertain if any trends are present and determine if any further action is needed.	

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F 656	Continued From page 7 in the resident care plan. The LNHA, Director of Nursing (DON), and Regional Registered Nurse (RRN) acknowledged to the survey team that resident care plans should be "person-centered". On that same date and time, the RRN stated that the resident's preference not to receive care from that nurse should have been in the resident's care plan. The RRN acknowledged that there was no care plan initiated that speaks of the resident's preference not to have a certain nurse. A review of the undated facility's Care Plan policy included the policy statement indicating that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. NJAC 8:39-11.2 (f), 27.1 (a)	F 656		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		11/18/22

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F 761	Continued From page 8 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 1 of 4 medication carts inspected. This deficient practice was evidenced by the following: On 10/03/22 at 11:33 AM, the surveyor inspected the South Middle med cart in the presence of a Registered Nurse (RN). The surveyor observed two opened boxes o [redacted] that belong to two residents, Residents#72 and #183 that were discharged from the facility. The surveyor interviewed the RN who stated that both residents were discharged from the facility and were not able to tell the surveyor when they will be returning to the facility. The RN also stated that all medications belonging to residents who were discharged from the facility should be removed from active medication stock. On 10/03/22 at 1:45 PM, the surveyor met with	F 761	F761 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The two opened boxes of Ipratropium bromide/Albuterol Solution 0.5-2.5,3 ml vials (Medication for breathing) that belonging to Residents #72 and #183 were removed from the medication cart and destroyed. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. All medication carts in the facility were audited and there were no medications belonging to discharged residents present. The Director of Nursing re-educated licensed nursing staff on the policy related	

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F 761	Continued From page 9 the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Regional RN no further information was provided by the facility. A review of the facility's policy for the Storage of Medications that was undated and was provided by the Regional RN indicated the following: "4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." NJAC: 8:39-29.4 (d)(h)	F 761	to medication labeling, storage and disposal. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility instituted that upon endorsing medication cart to incoming nurse, the outgoing nurse will confirm which if any patients were discharged from the facility during the previous shift and medications will be removed and destroyed per policy by both nurses. All licensed nursing staff were in-serviced on this policy. The Director of Nursing or designee will perform a random weekly audit of 2 medication carts, 3 times a week for 3 weeks and 3 times a month for 3 months thereafter and forward results to the administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the audits will be reviewed by the facility's Quality Assurance Committee at its quarterly meeting for 6 months to ascertain if any trends are present and determine if any further action is needed.	
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality	F 868		11/18/22

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F 868	Continued From page 10 assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to assure the Licensed Nursing Home Administrator (LNHA) attended the quarterly Quality Assurance (QA) meetings. This was identified for 2 of the 3 QA meetings reviewed. This deficient practice was evidenced by the following: On 10/07/22 at 10:27 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with the sign-in sheets for the last three QA meetings and showed the following: 1/27/22 (1st Quarterly QA Meeting)=attendees included an Infection Preventionist Nurse (IPN), Medical Director (MD), and the Director of Nursing (DON). 4/6/22 (2nd Quarterly QA Meeting)=attendees included IPN, LNHA, and the DON. 7/7/22 (3rd Quarterly QA Meeting)=attendees	F 868	F868 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Facility's Quality Assurance Committee has met with the Administrator, Director of Nursing and Medical Director in attendance, in addition to all Facility Department Managers and other members of the Committee. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that	

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F 868	Continued From page 11 included IPN and DON. According to the above three quarters QA meetings sign-in sheets, the LNHA did not attend the 1st and 3rd quarters QA meetings. In addition, the above sign-in sheets revealed that the MD did not attend the 2nd and 3rd quarters QA meetings. On 10/07/22 at 9:57 AM, the surveyor interviewed the LNHA regarding concerns with the QA meeting sign-in sheets. The LNHA stated that the LNHA, DON, and MD should always be present at the QA meeting. The LNHA further stated that he was not sure why the LNHA and MD were not present at the previous QA meetings. On 10/07/22 at 12:13 PM, the surveyor met with the LNHA, DON, and the Regional Registered Nurse. The LNHA provided a letter from the MD dated 10/07/22 indicating that the MD confirmed that he was present at all QA meetings. On that same date and time, the LNHA indicated that he started to work at the facility two weeks ago. The LNHA had no answer why the previous LNHA did not attend the 1st and 3rd quarters QA meetings. Later on that same date, the facility did not provide additional information. A review of the facility's policy for the Quality Assurance Performance Improvement Plan that was dated 3/21/22 and was provided by the LNHA indicated the following: "The QAPI plan provides guidance for our overall quality improvement program. Decision making is guided by the principles of quality assurance performance improvement. Focus has been	F 868	the deficient practice will not recur: The new facility Administrator re-educated the quality assurance team on the participants who are required to be in attendance. The QA committee will appoint a secretary who will maintain a calendar and a folder with copies of each meeting's sign-in sheet and will inspect each sign-in sheet at the commencement and conclusion of each meeting to ensure that the sign-in sheet are signed by all attendees and forwarded to the Administrator for review. If either of the Administrator, Director of Nursing or Medical Director are not present, the Secretary will reconvene the meeting on the next business day. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The QA committee secretary / designee will audit quality assurance meeting attendees with each quality assurance meeting quarterly for the next 6 months. Additional audit frequency will be determined based on audit findings. Audit results will be submitted monthly to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING _____ B. WING _____	10/11/2022

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F 868	Continued From page 12 placed to promote quality of care, quality of life, resident choice, person centered care, and resident transitions. Focus areas include systems that affect resident and family satisfaction, quality of care services provided, and all areas that affect the quality of life for persons living and working in our facility." "QAPI principles and staff responsibilities related to QAPI, and ongoing quality improvement will be included in orientation for all new employees. All staff will participate in ongoing annual QAPI training which will include how to identify areas for improvement, updates on current performance improvement projects." "All department managers, the administrator, the director of nursing, infection control and prevention officer, a nursing assistant, medical director, consulting pharmacist, resident and/or family representatives (if appropriate), and additional general staff will provide QAPI leadership by being on the QAA committee. General staff members will be chosen from staff that have direct care and/or service responsibilities, including nursing assistants, nurses, housekeeping aides, maintenance workers, and dietary aides. The facility may opt to have general staff serve a one-year commitment or rotate the positions amongst staff to ensure as many persons as possible could serve on the committee. Participating residents and/or family members will receive confidentiality training prior to participating in any QAPI activity." NJAC: 8:39-33.1 (b)	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		11/4/22

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F 880	Continued From page 13 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 14 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documentation, it was determined that the facility failed to ensure a.) that staff handle clean linens and towels appropriately to prevent contamination and b.) all staff entering the building were screened for Covid-19 signs and symptoms in accordance with the facility policy "Covid-19 Employee Screening" and Centers for Disease Control and Prevention (CDC) guidelines. This deficient practice was evidenced by the following:	F 880	F880 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The linens and towels which were handled by the Hospice Aide were relaundered. The Hospice Aide was provided with in-service education on Infection Control	

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F 880	Continued From page 15 Reference: Centers for Disease Control and Prevention (CDC) COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 9/23/22, reflected "1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic... Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria...2) symptoms of COVID-19..." 1. On 10/04/22 at 12:40 PM, in the presence of a second surveyor it was observed that a hospice aide (HA) was holding clean linens and towels directly against her uniform in the presence of the Director of Nursing. Upon interview, the HA acknowledged that the linens should not have been held against her uniform because of "contamination." On 10/04/22 at 01:14 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Registered Nurse (RRN), Vice President of Operations (VPoO), and Risk Management Nurse (RMN) and were made aware of the above concern. On that same date and time, the DON stated that HA "should have not done it," and that the HA was educated about the proper handling of linens and towels to prevent contamination. The RMN acknowledged that the HA had direct contact with Resident #46 and should not hold the linens and towels against her uniform due to infection	F 880	Management with a focus on Linen Handling. The CNA was provided in-service education on completing the COVID-19 Screening prior to reporting to resident areas to start working. How the facility will identify other residents having the potential to be affected by the same deficient practice: All Direct Care Staff were provided with in-service education on Infection Control Management with a focus on Linen Handling. Infection Control practices related to Linen management to prevent cross contamination during transport were posted at linen storage areas. All Direct Care staff were provided re-education on completing the COVID-19 Screening prior to reporting to resident areas to start working. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Facility audits of staff while handling linen will be completed on three employees per day for two weeks and then weekly for 6 weeks. The facility will complete 3 audits per week of the kiosk entries and staff scheduled for two weeks, then 1 audit per week for 2 weeks. How the facility will monitor its corrective actions to ensure that the deficient	

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F 880	Continued From page 16 control. 2. A review of the Certified Nursing Aide's (CNA's) "Time Cards" from 8/01/22 through 9/29/22 reflected that she worked in the facility on the following dates: 8/22/22 8/23/22 8/25/22 8/26/22 9/01/22 9/02/22 9/03/22 9/05/22 9/08/22 9/09/22 9/12/22 9/13/22 9/15/22 9/16/22 9/17/22 9/19/22 9/20/22 9/23/22 9/24/22 9/26/22 9/28/22 9/29/22 On 9/28/22 at 12:43 PM, Surveyor#1 interviewed the CNA who was assigned to the Covid positive unit. The CNA informed the surveyor that she did not perform the routine Covid-19 screening process using the kiosk upon entry to the facility not until today when she observed another staff who came in at the same time as the CNA at the employee entrance.	F 880	practice is being corrected and will not recur: Results will be submitted to the QAPI Committee for further review and recommendations as needed. Further audit frequency will be determined based on the audit findings. ROUTE CAUSE ANALYSIS WILL BE SENT TO THE EMAIL ADDRESSES STIPULATED IN THE DPOC. DPOC: Per the DPOC facility has taken the following steps: 1. Nursing Home Infection Preventionist Training Course Module 1 Infection Prevention & Control Program https://www.train.org/main/course/1081350/ - Training provided to: The Director of Nursing, Assistant Director of Nursing, Medical Director, and Infection Preventionist. 2. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw - Training provided to: Direct care staff nurses and nursing assistants and contracted direct care providers. 3. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Module IID Linen Management https://www.train.org/cdctrain/course/1081818/	

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F 880	Continued From page 17 On 9/29/22 at 1:15 PM, the DON, LNHA, and RRN met with the survey team. The surveyor discussed the above concerns. On that same date and time, during the interview with the surveyor, the DON stated that the staff was supposed to do the Covid-19 screening process by answering the questionnaires using the kiosk and temperature checks before going to work. The RRN further stated that "all" staff were required to do the Covid-19 screening process using the kiosk when they enter the facility. Furthermore, the DON and RRN acknowledged that the CNA did not perform the Covid-19 screening process on "all" the days she worked in the facility since August 2022. The administrative team could not provide documented evidence that the CNA did the Covid-19 screening process for the days that she worked in the facility from August 2022 to the present day. On 10/04/22 at 1:14 PM, the DON, LNHA, RRN, VPoO, and RMN met with the survey team. The surveyor asked the administrative team if they have documentation to provide regarding the CNA not performing the Covid-19 screening process. The DON and the RRN stated "no." The facility procedure "COVID-19 Employee Screening" revised in April 2020 included the following: "Procedure: 1. Upon entrance to the facility, employees will clock in and complete the COVID-19 Employee Screening Tool. 2. The facility may utilize a kiosk for Employee Screening. 3. Employees screened to identify:	F 880	- Training provided to: Direct care staff nurses and nursing assistants and contracted direct care providers. 4. Nursing Home Infection Preventionist Training Course Module 4 Infection Surveillance https://www.train.org/cdctrain/course/1081802/ - Training provided to: The Director of Nursing, Assistant Director of Nursing, Medical Director, and Infection Preventionist. 5. Nursing Home Infection Preventionist Training Course Module 5 Outbreaks https://www.train.org/cdctrain/course/1081803/ - Training provided to: The Director of Nursing, Assistant Director of Nursing, Medical Director, and Infection Preventionist. 6. Further optional training will be provided to staff as needed based on facility audit outcomes. Training modules are available at the Nursing Home Infection Preventionist Training Course located at https://www.train.org/cdctrain/training_p1an/3814	

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F 880	Continued From page 18 a. symptoms consistent with COVID-19; b. exposure to COVID-19 without use of appropriate Personal Protective Equipment; and c. whether they have a temperature 100.0° or greater." The facility policy "Coronovirus Disease (COVID-19)- Infection Prevention and Control Measures reflected that "Anyone entering the facility (including staff) is screened and triaged for signs and symptoms of and exposure to others with SARS-CoV-2 infection, including:" fever that was measured temperature greater than 100 degrees Fahrenheit or subjective fever, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and/or diarrhea. The "Screening of Staff, Visitors & Residents- NJ" dated 8/5/21 reflected that Healthcare Personnel (HCP) "screening will be conducted at the beginning of each shift." It included "Whether in the last 14 days, the HCP has had an identified exposure *to someone with a confirmed diagnosis of COVID-19, someone under investigation for COVID-19, or someone experiencing respiratory illness;" and "Whether the HCP has been diagnosed with COVID-19 and has not yet met criteria to return to work." On 10/07/22 at 12:14 PM, the LNHA, DON, and RRN met with the survey team. No additional information was provided by the facility management.	F 880		
F 921 SS=D	N.J.A.C.8:39-19.4 (a)(b) Safe/Functional/Sanitary/Comfortable Environ	F 921		11/18/22

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F 921	Continued From page 19 CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a safe and sanitary environment in the folding and laundry rooms in accordance with the facility's policy. This deficient practice was evidenced by the following: On 10/06/22 at 9:10 AM, two surveyors interviewed Laundry Aide #1 (LA#1) who was in the room with folded and stacked linens. She informed the surveyors that the room was the folding area, where they folded the clean linens. The surveyors observed a table in the room. LA#1 stated that they utilized the table for folding the clean linens. On that same date and time, during the interview of the surveyors, LA#2 entered the room. LA#1 and #2 stated that the folding room was a "clean room." Furthermore, the surveyors observed the folding room with folded and stacked linens on the folding table, metal wall-mounted shelves, and 4-tier metal shelves cart. There was a capped half-full bottle of water on the folding table, touching the clean folded and stacked linens. LA#1 and #2 stated that the bottle did not belong to them, and both were unsure of whom it	F 921	F921 v2 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The bottle of water, knife, fork and plastic cup lid were all removed and discarded. The book was removed from the laundry room. All clean linen was removed from the table and the wall-mounted shelves and relaundered. The area behind Washer #1 was cleaned and dried. Washer #1 was repaired and is free of leakage. The door of Washer #1 was cleaned of all soap residue. The tops of Washer #2 and Dryer #2 and the pipes connected to them were all cleaned. The stained ceiling tiles were replaced with new ceiling tiles. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. A cleaning schedule and log of cleaning assignments performed was instituted for	

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F 921	Continued From page 20	F 921		

belonged to and where it came from. Both LA#1 and #2 stated that the water bottle should have not been left on the table touching the clean linens. The surveyors observed LA#1 removed and threw out the water bottle in the garbage afterward.

During the surveyors' tour in the folding room in the presence of LA#1 and #2, the surveyors observed a metal fork on the metal wall-mounted shelves, touching the folded and stacked linens. The surveyors also observed a metal knife and a bible book partially tucked in between the folded and stacked linens on the 4-tier metal shelves cart. LA#2 stated that he found the bible in the garbage, cleaned it, and kept it in the folding room "a long time ago." He also stated that he used the knife to fix " if something gets stuck" in the 4-tier metal shelves.

Additionally, the surveyors observed a clear plastic cup lid on the bottom shelf of the 4-tier metal shelves that had drops of brownish fluid on it. LA#1 and #2 stated that they did not know why it was there and how long it had been there. LA#1 removed and threw out the metal fork and knife, and the plastic cup lid in the garbage afterward.

On the same day at 9:20 AM, the surveyors toured the laundry room that was located across the folding room, in the presence of LA#1 and #2. The surveyors observed dryer machine #1 (dryer#1) on the left side of the laundry room. LA#2 stated that the washing machines (washers) and dryers were cleaned by the Housekeeping (HK) staff, and the Laundry staff did the lint cleaning in the dryers.

During the Laundry room tour, the surveyors

the laundry department.
All Laundry Aides were given in-service education on the requirements and correct procedures for:
- Keeping all clean linen areas free from any potential contaminants.
- Keeping the Laundry Room, Folding Room, Washers, Dryers and pipes clean and free of dust.
- Maintaining a cleaning schedule and log of cleaning assignments performed.
- Reporting and recording reports of any repairs needed via TELS electronic maintenance system.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur:
The Maintenance Director or designee will perform a random inspection and audit of the Laundry Room and Folding Room 3 times a week for 3 weeks and 3 times a month for 3 months thereafter to verify that:
- All clean linen areas are free of potential contaminants.
- All machinery and pipes are clean and free of dust.
- Cleaning schedules are posted and current and Logs of cleaning assignments performed are up to date and accurate.
- Any machinery or equipment in need of repair has been reported and recorded via the TELS maintenance reporting system.

These inspections and audits will be forwarded to the Administrator for review.
How the facility will monitor its corrective actions to ensure that the deficient

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F 921	Continued From page 21 observed a pool of clear water behind washer#1. LA#2 acknowledged that the pool of water came from washer#1. He stated that the "machine sometimes" blew steam which created a pool of water behind washer#1. He also stated that it "sometimes happens" and it had happened before. Furthermore, he informed the surveyors that he verbally notified the Maintenance Department when it happened, but they had no accountability record that the issue was reported to the Maintenance Department. However, LA#2 stated that he had not reported to the Maintenance Department about the current pool of water behind washer#1. On the same day at 9:30 AM, the surveyors interviewed the HK Director. The surveyors informed him about the pool of water behind washer#1. The HK Director acknowledged that he was not aware of it and stated that the staff "must have missed to dry up this morning." He stated, "sometimes water is hot" and caused the pool of water. He stated to the surveyors that he did not know it had happened before until it was pointed out by the surveyors. The HK Director acknowledged that they did not have the accountability to log the reported concerns in the laundry room to the Maintenance Department and stated that they only had a "verbal discussion" with the Maintenance staff. The surveyor showed the HK Director the pink-crusted material on the outside of washer#1's glass door. He informed the surveyor that it was the accumulation of the "caking" of the soap and stated, "it didn't happen just today, it seems like it's been there for a couple of days." He stated that it should have been cleaned by the Laundry staff. The HK Director stated that they	F 921	practice is being corrected and will not recur: The results of the inspections and audits will be reviewed by the facility's Quality Assurance Committee Quarterly meeting for 6 months to ascertain if any trends are present and if any further action is needed.	

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F 921	Continued From page 22	F 921		

did not have accountability for the cleaning log in the laundry room.

During the laundry room tour with the HK Director, the surveyor pointed out a high accumulation of grayish, fuzzy, and powdery material on top of washer#2 and on the metal pipes that were connected behind it, and on the top of dryer#2. The surveyors observed the HK Director touched the top of washer#2 and its metal pipes. The surveyors observed a collection of grayish, fuzzy, and powdery material in the HK Director's fingers, and he acknowledged that it was "dust." He stated that "it's not an excuse not to clean, it should have been done." He also stated that there was no documented evidence of accountability for the dust cleaning in the laundry room.

Furthermore, the surveyors observed several brown circular discoloration marks on the ceiling tiles. The HK Director stated that "at one point there was a leak, but not anymore."

During the interview, the surveyors informed the HK Director about the surveyors' findings and concerns in the folding room with LA#1 and #2. He acknowledged to the surveyors that the mentioned items should have not been in the folding room touching the clean linens "because that's contamination."

On 10/06/22 at 01:57 PM, the Director of Nursing (DON), Risk Management Nurse (RMN), and Licensed Nursing Home Administrator (LNHA) met with the survey team. The surveyor discussed the findings and concerns that were found in the folding and laundry room.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING _____ B. WING _____	10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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F 921	Continued From page 23	F 921		

During the follow-up interview with the HK Director on 10/07/22 at 9:22 AM, the HK Director acknowledged that it was the LA's responsibility to clean the laundry room's washers, dryers, and the "dusting." He also stated that the pool of water should have been reported to him, so he could have notified the Maintenance Department. He acknowledged to the surveyor that he was not notified about the pool of water behind the washing machine in the laundry room until the surveyor's inquiry.

Additionally, the HK Director acknowledged that they did not have documented evidence of accountability for cleaning, dusting, and disinfecting the laundry room and the equipment.

A review of the facility policy "Laundry and Bedding, Soiled reflected that "5. Clean linens are protected from dust and soiling during transport and storage to ensure cleanliness."

A review of facility procedure "Departmental (Environmental Services)- Laundry and Linen" reflected that "7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, ..."

On 10/06/22 at 12:14 PM, the LNHA, DON, and Regional Registered Nurse met with the survey team. No additional information was provided by the facility management.

NJAC 8:39-31.4 (a)(b)(f)

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060201	A. BUILDING: _____ B. WING _____	10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CI	85 HARRETON ROAD ALLENDALE, NJ 07401

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.	S 560	S560 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Staffing Coordinator will review staffing schedules for one week in advance daily	11/18/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060201	A. BUILDING: _____ B. WING _____	10/11/2022

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S 560	Continued From page 1 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the	S 560	to identify any potential shortfall in scheduled certified nursing assistants and call certified nurse aides and licensed nurses in staffing pool to fill vacant shifts. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Facility will take the following measures: • Advertise open positions. • Offer sign-on bonuses for newly hired certified nurse aides. • Offer bonuses for existing staff who refer newly hired certified nurse aides. • Sponsor qualified candidates to complete an approved Nurse Aide in Long Term Care Facilities Training and Competency Evaluation Program. • Offer free transportation for day and evening shifts to select locations. • The facility Director of Nursing and Scheduler will meet daily during the week to review recruitment efforts and current and following weeks staffing schedule. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Administrator / Designee will complete an audit of staffing and resident care needs / preferences 5 times per week for 2 weeks, then 3 times per week for 2 weeks. Additional audit frequency will be determined based on audit findings. Audit results will be submitted monthly to the Quality Assurance Performance Improvement Committee for further review	

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S 560	Continued From page 2 midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 9/11/22 and ending 9/24/22 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs on 11 of 14 day shifts as follows: 09/11/22 had 7 CNAs for 91 residents on the day shift, required 11 CNAs. 09/12/22 had 8 CNAs for 90 residents on the day shift, required 11 CNAs. 09/13/22 had 10 CNAs for 89 residents on the day shift, required 11 CNAs. 09/17/22 had 7 CNAs for 86 residents on the day shift, required 11 CNAs. 09/18/22 had 7 CNAs for 86 residents on the day shift, required 11 CNAs. 09/19/22 had 9 CNAs for 86 residents on the day shift, required 11 CNAs. 09/20/22 had 10 CNAs for 86 residents on the day shift, required 11 CNAs. 09/21/22 had 7 CNAs for 86 residents on the day shift, required 11 CNAs. 09/22/22 had 7 CNAs for 86 residents on the day shift, required 11 CNAs. 09/23/22 had 10 CNAs for 88 residents on	S 560	and recommendations as needed.	

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S 560	Continued From page 3 the day shift, required 11 CNAs. 09/24/22 had 10 CNAs for 87 residents on the day shift, required 11 CNAs. On 10/07/22 at 12:42 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing, and Regional Registered Nurse and were made aware of the above concerns. The facility team did not provide additional information.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315497 Y1	A. Building B. Wing Y2	12/12/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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 F0558	Correction	ID Prefix F0656	Correction	ID Prefix F0761	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.21(b)(1)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	11/18/2022	LSC	11/18/2022	LSC	11/18/2022
ID Prefix F0868	Correction	ID Prefix F0880	Correction	ID Prefix F0921	Correction
Reg. # 483.75(g)(1)(i)-(iii)(2)(i)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)	Completed
LSC	11/18/2022	LSC	11/04/2022	LSC	11/18/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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?
10/11/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060201		12/12/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/18/2022	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	ID Prefix Reg. # LSC	Correction Completed
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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	
10/11/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING **01** B. WING _____	**10/11/2022**

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ALLENDALE REHABILITATION AND HEALTHCARE CENTER	**85 HARRETON ROAD** **ALLENDALE, NJ 07401**

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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 10/11/22 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 This building is a 1-story LTC facility that was opened in 2006, It is composed of Type I fire resistant construction. The facility is divided into 9- smoke zones. The generator does approximately 60 % of the facility. No elevators are involved in the long term care side of the building. The assisted living section of the building has 2-stories and 1-elevator. The fire sprinkler system is supplied by city pressure.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at	K 222		11/4/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/28/2022

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

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K 222	Continued From page 2 door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of Maintenance Director (MD) and Regional Plant Operations Director (RPOD) on 10/11/22, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 for 2 of 2 sets of exterior exit/egress doors observed. This deficient practice was identified for 3 of 3 sets of doors and was evidenced as follows: 1. At 9:30 AM, the Surveyor, MD and RPOD observed two sets of glass sliding doors located at the front entrance of the facility, the interior set of sliding glass doors indicated with a red strip sign approximately 3" x 20" that "IN AN EMERGENCY PUSH TO OPEN". The doors were observed to not have the ability to push to open in the event of an emergency due to the inside of both sets of doors having a keyed latch that if locked, would prevent the door from opening in the event of an emergency. The current evacuation plan indicated that the front doors were designated an exit/egress route. 2. At 12:18 PM, the Surveyor, MD and RPOD observed outside the Long Term Care unit, a set of exit/egress doors were designated as an	K 222	K222 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The keyed latches were removed from both doors at Exit #8. How the facility will identify other residents having the potential to be affected by the same deficient practice: All exit/egress doors in the facility were inspected and all are free of keyed latches and all are able to be pushed open in the event of an emergency. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct an inspection monthly for 3 months to verify that all exit/egress doors in the facility are free of keyed latches and are able to be pushed open in the event of an emergency. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility□s Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are	

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K 222	Continued From page 3 exit/egress route on the facility evacuation plan. The exit/egress door marked #8 was equipped with a red door latch located on the upper left door. The red door latch was in the locked position and required a red string to be pulled down to open the door in the event of an emergency. The MD and RPOD both confirmed the findings during the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 10/11/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	present and determine if any further action is needed to maintain compliance.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/11/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 1 of 1 transfer switches and was evidenced by the following:	K 291	K291 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: A battery back-up emergency light above the ATS-1 emergency generator transfer switch was installed in boiler room. How the facility will identify other residents having the potential to be affected by the same deficient practice:	11/4/22

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ALLENDALE REHABILITATION AND HEALTHCARE CENTER	**85 HARRETON ROAD** **ALLENDALE, NJ 07401**

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K 291	Continued From page 4 At 01:07 PM, the surveyor observed in the boiler room where the generator transfer was located, that the ATS-1 transfer switch was not equipped with battery back-up emergency lighting. The Maintenance Director and Regional Plant Operations Director, both confirmed the findings at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit on 10/11/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	All areas in the facility requiring a battery back-up emergency light were inspected to ensure that there is a battery back-up emergency light installed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility instituted a monthly test of the battery back-up emergency light above the ATS-1 emergency generator transfer switch to ensure it is working. The test will be performed by the Maintenance Director or designee. The Maintenance Director or designee will conduct an inspection monthly for 3 months to verify all areas in the facility requiring a battery back-up emergency light have one installed and it is working. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility's Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to	K 341		11/4/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING **01** B. WING _____	**10/11/2022**

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K 341	Continued From page 5 provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/11/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: At 12:38 PM, the surveyor, MD and RPOD observed in the enclosed courtyard, that no evidence of a fire alarm notification (horn/strobe) was located. An interview was conducted during the observation and the surveyor asked the MD and RPOD, if there was a horn/strobe, tied into the fire alarm system within the above enclosed courtyard. The MD and RPOD both confirmed	K 341	K341 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: A fire alarm notification (horn/strobe) was installed in the enclosed courtyard and is connected to the facility fire alarm system. How the facility will identify other residents having the potential to be affected by the same deficient practice: A facility inspection was conducted to ensure that all areas requiring a fire alarm notification (horn/strobe) have one installed and that they are connected to the facility fire alarm system. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct an inspection monthly for 3 months to verify that all that all areas in	

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K 341	Continued From page 6 that currently there are no horn/strobe devices tied into the fire alarm system in the enclosed courtyard observed. The Administrator was notified of the findings at the Life Safety Code exit conference on 10/11/2022. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	the facility requiring a fire alarm notification (horn/strobe) have one installed and that they are connected to the facility fire alarm system. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility□s Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5,	K 351		11/25/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 7 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/11/22 in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the facility failed to a.) provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment and b.) to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in these areas. At 01:25 PM, the surveyor, MD, and RPOD observed in the occupied sun room (approximately 7' x 20'), that no fire sprinkler heads were observed. The glass and metal sunroom was observed to covered in combustible wood framing and fabric covered over the ceiling glass panels. The sunroom contained combustible furniture. An interview was conducted with the MD and RPOD at the time of the observation, both confirmed the facility's sun room did not have any fire sprinkler coverage. The Administrator was informed of the findings at the Life Safety Code exit conference on 10/11/22. NJAC 8:39-31.2(e)	K 351	K351 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Two sprinkler heads were installed in the sunroom and were connected to the facility□s sprinkler system. How the facility will identify other residents having the potential to be affected by the same deficient practice: A facility inspection was conducted to ensure that all areas requiring sprinkler coverage have sprinklers installed and that they are connected to the facility sprinkler system. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct an inspection monthly for 3 months to verify that all that all areas in the facility requiring sprinkler coverage have sprinklers installed and that they are connected to the facility sprinkler system. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility□s Quality	

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K 351	Continued From page 8	K 351	Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
K 363 SS=E	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 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.	K 363		11/4/22

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K 363	Continued From page 9 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 10/11/22 in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was further identified in 5 of 25 residents' room doors observed and was evidenced by the following: During the building tour from 9:15 AM to 3:00 PM, the surveyor, MD and RPOD toured the facility and observed: Resident Room # [redacted] the door hits the door frame. Resident Room # [redacted] the door gets caught on the floor Resident Room # [redacted] the door hits the door frame. Resident Room # [redacted] the door rubbed on the door frame not closing properly. Resident Room # [redacted] the door would not latch into its frame.	K 363	K363 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Doors in rooms numbered [redacted] and [redacted] were all repaired and all close completely to properly confine fire and smoke products and to properly defend occupants in place. How the facility will identify other residents having the potential to be affected by the same deficient practice: All doors in the facility were inspected to ensure that they all close completely. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct an inspection of all doors in the facility monthly for 3 months to verify that all doors close completely. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be	

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K 363	Continued From page 10 At the time of observations, the surveyor interviewed the MD and RPOD, who both confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 10/11/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	reviewed by the facility□s Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/11/22, in the presence of the facility Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to ensure resident bathroom ventilation system's for 11 of 30 resident rooms, were adequately maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following:	K 521	K521 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Motor that powers the exhaust fans in the bathrooms of Resident Room numbers [redacted], and [redacted] was replaced. Ventilation is now present via the exhaust fans in all of these bathrooms. How the facility will identify other residents	11/4/22

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K 521	Continued From page 11 Starting from 11:00 AM to 3:00 PM, the surveyor observed that the ventilation in the following resident room bathrooms did not function: [redacted]. The surveyor requested that the Maintenance Director, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Maintenance Director and Regional Plant Operations Director, who both stated and confirmed the ventilation in the resident room bathrooms was not working at the time of the observations. The Maintenance Director indicated a roof top motor seems to be malfunctioning. The Administrator was informed of the findings at the Life safety code exit conference on 10/11/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	having the potential to be affected by the same deficient practice: All bathrooms in all resident rooms were inspected to ensure that ventilation systems are functioning properly in all of them. All motors powering exhaust fans in the facility were inspected to ensure they are functioning properly. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will conduct a random inspection of 3 resident rooms weekly for 3 weeks and monthly for 3 months thereafter to verify that the bathroom ventilation systems are fully functioning. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the inspections will be reviewed by the facility□s Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	
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	K 918		11/18/22

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K 918	Continued From page 12 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 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility documents on 10/11/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to a.) certify the time needed by their generator to transfer power	K 918	K918 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: A load test was performed and power was	

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K 918	Continued From page 13 to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems and b.) ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 1-generator log provided by the RPOD by the following: a). At 09:30 AM, a review of the generator records for the previous twelve months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the monthly load test document provided by the RPOD indicated that on the following dates no transfer time was being logged: 9/9/22, 8/5/22, 7/7/22, 6/6/22, 5/30/22, 4/28/22, 3/25/22, 2/12/22, 1/11/22, 12/10/22, 11/12/22, and 10/2/22. The RPOD then provided documentation from the facility Direct Supply TELS system. The dates on the provided documents indicated on 8/26/22 and 9/02/22 that the diesel generator tested under load were 15-seconds for transfer time to emergency power. It was also noted that the load test date's from the TELS system were different from the first generator load test log provided by the RPOD. An interview was conducted with the RPOD at the time of record review, who confirmed no transfer times were currently on the facility log's provided. He then confirmed that the TELS load test	K 918	verified to transfer to the building in less than 10 seconds. A remote manual stop station to prevent inadvertent or unintentional operation was installed remote of the enclosure housing the prime mover of the generator. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Maintenance Director or designee will perform a quarterly audit for one year of monthly generator load tests, to ensure that power is transferred to the building in less than 10 seconds. The Maintenance Director or designee will perform a monthly inspection of the generator for one year to verify that remote manual stop station is correctly installed. The results will be forwarded to the Administrator for review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The results of the audits and inspections will be reviewed by the facility's Quality Assurance Committee at its Quarterly Meeting to ascertain if any trends are present and determine if any further action is needed to maintain compliance.	

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K 918	Continued From page 14 documents indicated 15- seconds to transfer time to emergency power. b). At 12:40 PM, the surveyor, MD, and RPOD, observed that the facility's generator did have a remote shutoff. An interview was conducted during the observation with the MD and RPOD, who stated that they were aware that the generator did not have a remote manual stop station to prevent inadvertent or unintentional operation located (remote) of the enclosure housing the prime mover. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 10/11/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		

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
315497 Y1	A. Building 01 - ALLENDALE NURSING HOME B. Wing Y2	12/12/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	11/04/2022	LSC K0291	11/04/2022	LSC K0341	11/04/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	11/25/2022	LSC K0363	11/04/2022	LSC K0521	11/04/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	11/18/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
10/11/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO