STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey 2/13/2023 Census 128 Sample Size 25 + 3 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		2/14/23

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

Electronically Signed | 03/02/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 1 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 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop and implement a comprehensive, person-centered care plan (CP) for a resident in the facility. This deficient practice was identified for 1 of 1 resident reviewed for comprehensive care plans (Resident #99) who had a diagnosis of Ex Order 26. 4B1 . This deficient practice was evidenced by the following: On 2/01/23 at 11:15 AM, the surveyor observed Resident # 99 in bed. The resident stated he/she was a Ex Order 26. 4B1 and was on Ex Order 26. 4B1 . A review of Resident #99's medical record revealed the following:	F 656	Criteria #1: Care Plan for Resident 99 with diagnosis of Ex Order was completed immediately after the state surveyor identified the deficiency. Care Plan included a patient centered plan of care on Ex Order 26. 4B1 management and Ex Order 26. 4B1 administration. An In-service was conducted to RN-UM and RN / LPN staff regarding facility's policy on creating / initiating person centered care plan 24hrs upon admission; and revisions can be made 48hrs after admission. Criteria #2: All residents / patients that includes new admissions with diagnosis of Ex Order will be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 2 The Face Sheet (an admission summary) revealed that Resident #99 was admitted to the facility with diagnoses that included but not limited to Ex Order 26. 4B1 [redacted]. The admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date of Ex.Order 26.4(b)(1) revealed a Brief Interview for Mental Status score of Ex Ord out of 15, which indicated that the resident was Ex Order 26. 4B1 [redacted]. The admission MDS further revealed that the resident had an active diagnosis of Ex Order and was on Ex Order 26. 4B1. A review of Resident #99's CP did not include that the resident was a Ex Order 26. 4B1 and was on Ex Order 26. 4B1 [redacted]. A review of the facility policy titled, "Diabetes - Clinical Protocol" revealed under Monitoring and Follow-Up, "4. The Physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into the Medication Administration record and care plan." A review of the facility policy titled "Care Plans, Comprehensive Person-Centered" under Policy Interpretation and Implementation, "8. The comprehensive, person-centered care will: g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; o. Reflect the recognized standards of practice for problem areas and conditions. 9.	F 656	Residents / patients with a DM diagnosis will have their comprehensive person centered care plan. The care plan will include desired parameters and information, reporting related to blood sugar management and insulin administration. Review of parameters and diabetic management by PMD and revisions will be made by UM ad needed. Criteria #3: Review and re-education of Policy and Procedure of facility's Diabetic management and completion of care plan will be given to RN / LPN staff by the DON or designee. Facility wide identification and review of patient's / residents with dx of DM by DON and Unit Manager and revised as needed. Criteria #4: Review of all admitted patients to facility with diagnosis of DM will be conducted on a weekly basis identifying the following: Name of patient with dx of DM Admission date Primary MD Diabetes Management ordered Presence of DM care plan This tool will be used to ensure appropriate care plan is in place. Criteria #5: Weekly on Thursdays x 4 weeks the quarterly leading to 12/31/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 3 Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan." A review of the facility policy titled "Comprehensive Assessment and Care Delivery Process" revealed under Policy Interpretation and Implementation, "3 Information analysis, b. Define conditions and problems that are causing, or could cause, other problems. (1) Identify potential causes or contributing factors of problems and symptoms, including: (a) Medical. C. Define current treatment and services; link with problems/diagnoses." On 2/07/23 at 11:38 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) assigned to the First Floor-[Ex Order 26. 4] Unit. The RN/UM stated that the admission CP are completed by the admitting nurse within 48 hours and that the unit manager will review and add any additional CP if needed. The RN/UM further revealed that residents who had a diagnosis of [Ex Order] should have a CP. The RN/UM could not explain why Resident #99 did not have a CP addressing his/her diagnosis of [Ex Order] and [Ex Order 26. 4B1] [redacted]. On 2/09/23 at 11:06 AM, the team met with the Licensed Nursing Home Administrator (LNHA), Assistant LNHA, Director of Nursing (DON), and Infection Preventionist. The surveyor discussed the above concern. The surveyor asked if a resident who had a diagnosis of [Ex Order] should have a care plan. The DON stated, "Yes, there should be a care plan. Sometimes [Ex Order 26. 4B1] and [Ex Order 26. 4] [redacted] may be under the *Ex Order 26. 4B1* but it should be care planned."	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 4 On 2/13/23 at 11:00 AM, the team met with the LHNA, Assistant LNHA, and DON. No additional information was provided.	F 656		
F 695 SS=D	NJAC 8:39-11.2 (e)(2) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure that the Ex Order 26. 4B1 was dated properly and b.) develop a comprehensive, person-centered care plan for a resident who was receiving continuous Ex Order 26. 4B1. This deficient practice was observed for 1 of 4 residents (Resident #71) reviewed for Ex Order 26. 4B1. This deficient practice was evidenced by the following: On 2/1/23 at 11:59 AM, during the initial tour, the surveyor observed Resident #71 in bed with Ex Orde in use via a Ex.Order 26.4(b)(1) set at Ex Order 26. 4B1 attached to a humidified Ex Order 26. 4B1. The Ex Order 26. 4B1 was dated Ex.Order 26.4(b)(1).	F 695	Criteria #1: LPN/Unit Manager (UM) immediately reviewed the physician's order and completed a person-centered care plan. LPN/UM immediately replaced and dated the Ex Order 26. 4B1 according to facility policy. Criteria #2: All residents/patients requiring oxygen use will be reviewed and will initiate appropriate care plan as needed. All residents/patients using oxygen will be identified, ensuring all tubing and other respiratory equipment are dated if opened.	2/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 5 On 2/7/23 at 12:04 PM, the surveyor observed Resident #71 in bed with [redacted] in use via [redacted] set at [redacted] attached to a humidified [redacted]. There was no date indicated on the [redacted] when it was last changed. On 2/8/23 at 12:30 PM, the surveyor observed Resident #71 in bed with [redacted] in use via a [redacted] set at [redacted] attached to a humidified [redacted]. There was no date indicated on the [redacted] when it was last changed. A review of Resident 71's medical record revealed the following: The Face Sheet (an admission summary) revealed that Resident #71 was admitted to the facility with diagnoses that included but not limited to [redacted]. The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date of [redacted], reflected that Resident #71's [redacted] was not completed due to [redacted]. A further review of qMDS under Section [redacted]. Treatment and Procedures, indicated that the resident received [redacted] treatments in the facility. The February 2023 Physician's Order Form revealed that there was an order dated [redacted] for	F 695	Criteria #3: Director of Nursing (DON)/Designee will review and in service the policy in completing person centered care plan with the licensed nurses and LPN/UM by the date of compliance. DON/Designee will review and in-service the policy in properly dating respiratory with licensed nurses and LPN/UM by the date of compliance. Schedule of Oxygen Tubing changes will be reflected in the Treatment Administration Record (TAR) to ensure compliance and accountability. The policy on respiratory therapy - prevention of infection will indicate a regular schedule day and shift (Thursday 11-7shift) of oxygen tubing changes in the TAR. In-service staff on the updated oxygenation policy of facility to ensure deficiency will not recur. Criteria #4: DON/Designee will schedule audits for 3 patients/ resident using oxygen monthly x 3 months. Audit Tool has been initiated that includes Resident/Patient Name, Diagnosis and Date Tubing changed. Findings within 3 months will be submitted to Quality Assurance Committee for review and further actions as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 6 [redacted] at [redacted] via Ex.Order 26.4(b)(1) continuous; clean [redacted] and change [redacted] weekly on Thursdays on 11:00 PM to 7:00 AM shift. The surveyor reviewed the resident's comprehensive care plans which did not reflect a care plan for Resident #71's continuous [redacted] use. On 2/8/23 at 12:33 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) was brought inside Resident #71's room. During the interview, the LPN/UM stated that Resident #71 was on continuous [redacted] and that the [redacted] "are changed weekly every Thursdays by the night shift nurse." The LPN/UM acknowledged that the [redacted] was not dated. She stated, "it should be dated to ensure that it was changed." At around the same date and time, the LPN/UM stated that she was responsible for initiating and revising the residents' care plans in her assigned unit. The surveyor and the LPN/UM reviewed the resident's care plans. She acknowledged that there should have been a care plan for Resident #71 who was on continuous [redacted]. A review of the facility policy titled "Departmental (Respiratory Therapy)- Prevention of Infection" with a review date of 1/2023 under "General Guidelines: 3. Change respiratory tubing and date, humidification bottle, nebulizer kits on a weekly basis when opened." A review of the facility policy titled, "Care Plans, Comprehensive Person-Centered" with a review date of 1/2023 under Policy Statement, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 7 meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. It further indicated under Policy Interpretation and Implementation, "8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; k. Reflect treatment goals, timetables, and objectives in measurable outcomes; 12. The comprehensive, person-centered care plan is developed within (7) days of the completion of the required comprehensive assessments (MDS)." On 2/9/23 at 11:08 AM, the team met with the Licensed Nursing Home Administrator (LNHA), Assistant LNHA, Director of Nursing (DON), and Infection Preventionist (IP). The surveyor discussed the above concern. On 2/13/23 at 11:38 AM, the team met with the LNHA, Assistant LNHA, IP, DON, and ADON. No additional information was provided. NJAC 8:39-11.2(b)(e); 27.1(a)	F 695		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060202	A. BUILDING: _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (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 observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	Criteria #1: All the residents/patients are at risk for a deficient staffing schedule. Facility staffs based on state nursing requirements on a daily basis. Criteria #2: The facility will have resources to staffing agencies/recruitment. Website application such as "Indeed.com". The facility will conduct job fairs and visit nursing schools	2/14/23

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

Electronically Signed | 03/02/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060202	A. BUILDING: _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth 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.	S 560	to ensure current and future staffing needs are met. Facility will create monetary incentives for recruitment by other staff members of their family, friends, colleagues to work at this facility. Criteria #3: Direct Care Staff will be offered weekend bonuses and monetary incentives for perfect attendance and working extra shifts to ensure weekdays and weekends are staffed appropriately. For the next 3 months the Administrator/Director of Nursing/Designee will review the staffing hours to ensure staffing needs meet the state requirements. Criteria #4: For the next 3months the administrator or designee will review current staffing needs and projected staffing hours needed to ensure compliance with state regulations. Criteria #5: Findings of Administrator/Director of Nursing will report to the Quality Assurance Committee that meets quarterly to further establish measures as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060202	A. BUILDING: _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 1/15/23 to 1/21/23 and ending 1/22/23 to 1/28/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 12 of 14 day shifts as follows: The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -01/15/23 had 12 CNAs for 132 residents on the day shift, required 16 CNAs. -01/17/23 had 13 CNAs for 131 residents on the day shift, required 16 CNAs. -01/18/23 had 13 CNAs for 131 residents on the day shift, required 16 CNAs. -01/19/23 had 13 CNAs for 129 residents on the day shift, required 16 CNAs. -01/20/23 had 12 CNAs for 126 residents on the day shift, required 16 CNAs. -01/21/23 had 14 CNAs for 126 residents on the day shift, required 16 CNAs. -01/22/23 had 14 CNAs for 126 residents on the day shift, required 16 CNAs. -01/23/23 had 12 CNAs for 126 residents on the day shift, required 16 CNAs. -01/24/23 had 13 CNAs for 129 residents	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060202	A. BUILDING: _____ B. WING _____	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 on the day shift, required 16 CNAs. -01/25/23 had 14 CNAs for 129 residents on the day shift, required 16 CNAs. -01/27/23 had 13 CNAs for 130 residents on the day shift, required 16 CNAs. -01/28/23 had 13 CNAs for 128 residents on the day shift, required 16 CNAs. The facility Director of Nursing, Licensed Nursing Home Administrator (LNHA), Assistant LNHA, and the Director of Human Resources was informed of their deficient practice on 2/9/23 at 11:00 AM.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315360	A. Building B. Wing	4/4/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

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 F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 02/14/2023	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 02/14/2023	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060202 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

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 02/14/2023	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 02/03/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/03/23 and was found not to be in compliance with 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. Emerson Health Care Center is a two-story building with a partial basement walkout constructed in 1972. All residents are on the first and second floors. The facility has concrete flooring, steel frame roofing and bearing walls and brick façade exterior. Emerson Health Care Center is noted to be a type II (III) noncombustible construction with complete sprinkler system and complete fire alarm system with smoke detection in all bedrooms and at smoke barrier walls in the corridor. The facility has a 100 KW (kilowatt) natural generator that operates at 30% of load when tested. The facility has 131 occupied beds. The facility has six smoke zones. .	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/02/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstruction or impediments to full instant use in the case of fire or other emergency for one of one exterior ramps at an exit discharge in accordance with NFPA 101 Life Safety Code (2012 edition) Section 7.1.10.1. This deficient practice had the potential to affect 25 residents who utilized the west end of the building to exit. Findings include: An observation of a wooden exterior ramp at the exit discharge near bedroom 128 on the first floor on 02/03/23 at 11:10 AM revealed the ramp had not been continuously maintained for full use in an emergency. The ramp had swollen and cracked, had uneven wooden floor planks, and had mildew and slippery sections which were green in color. In addition, a guard rail 10 feet in length and one handrail at the end of the ramp three feet in length were both separated from the deck due to deterioration. The ramp had moved off its foundation as evidenced by the ramp leaning in a different direction than intended.	K 211	POC Criteria#1: The Building Surveyor identified needed repairs for the wooden ramp at the exit discharge near bedroom 128. This identified ramp is old and in need of repairs at this time. This issue affects the residents in room 128 and all other residents residing on the North Unit. The old ramp is being repaired with completion by 03/24/23. In the event of emergency, resident in room 128 will be assisted by staff to any of the three exits within close proximity: Room 128-North Patio Exit Door = 58 feet and on the unit affected Room 128-Rehab Exit Door = 75 feet Room 128-Media Day Room = 95 feet POC Criteria#2: The residents residing in rooms 128 and on the North Unit will be assessed for the physical ability to safely evacuate utilizing the available egress paths in the building near these residents. This evaluation was	3/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 When accessing the ramp, the surveyor noted the ramp was so deteriorated it would creak noticeably with each step the entire length of the ramp. The exit was designated as an exit by the floor plan on the wall and had an exit sign above the door. The ramp was 25 feet long and eight feet wide. An interview with the Maintenance Director at the time of the observation verified the condition of the deck and stated he had not done any work to the deck since starting work such as maintaining or replacing broken sections. He also did not know how long the ramp had been at this location. NJAC 8:39-31.1(c), 31.2(e) .	K 211	performed on 2/14/2023 and all residents who are unable to get to the adjoining egress exits will be accompanied by staff in the case of an emergency. Residents who were identified as affected on this unit will have three(3) egress units: Room 128-North Patio Exit Door = 58 feet and on the unit affected Room 128-Rehab Exit Door = 75 feet Room 128-Media Day Room = 95 feet These egress paths will be used for safe evacuation from the facility in case of an emergency until the repairs to the old ramp are completed on 03/24/23. These egress exits are marked and are all within close proximity of the affected room (room 128) identified as well as the entire North Unit. The old ramp is being repaired with completion date 03/24/23. POC Criteria#3: At this time, there are three(3) immediate paths to egress from room 128 and the North Unit that will be used until the ramp repair is completed. These three(3) paths of egress include the following distances from room identified during survey. Room 128-North Patio Exit Door = 58 feet and on the unit affected Room 128-Rehab Exit Door = 75 feet Room 128-Media Day Room = 95 feet The Facility Maintenance Director as well	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 3	K 211	as the his Assistant will make daily rounds throughout the facility to ensure repairs are handled, prioritized and reported to the Administrator/Administration. Additionally, Facility Administrator and Maintenance Director will make additional weekly environmental rounds to ensure compliance of maintenance to all facets of the building are identified and corrected. The old ramp is being repaired with completion on 03/24/23. POC Criteria#4: The Facility Maintenance Director as well as his Assistant will make daily maintenance rounds of the building for 2 weeks to ensure repairs are identified, handled, prioritized and reported to the Administrator/Administration. This surveillance will be daily for 2 weeks then continue monthly x 3 months and then quarterly thereafter, audited as well as performing documentation of any maintenance repairs performed to the building. The Facility Maintenance Director will report to the Quality Assurance Committee that meets quarterly, compliance with this standard and adherence with this plan of correction (POC). The old ramp is being repaired with completion by 03/24/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 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 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	K 222		2/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 5 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire 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 observations, review of the facility floor plan-exit plan, review of the facility fire safety documents and interview, the facility failed to ensure that 14 of 14 locked exit doors released with the activation of the fire alarm system, smoke detection system and sprinkler system accordance with NFPA 101 (2012 edition) Life Safety Code, section 19.2.2.2.5.2. This deficient practice had the potential to affect all 131 residents. Findings include: An observation of the second-floor exit door near bedroom 201 on 02/03/23 at 10:20 AM revealed the door was locked without egress as tested by	K 222	POC Criteria#1: The Building Surveyor identified that all 14 exit locks located in the facility do not release upon activation of the fire alarm, smoke detection and sprinkler system in accordance with N.F.P.A. 101 (2012 edition). This will affect all residents of the facility. The Fire Alarm System is automated and will release upon activation. In the event of an emergency all residents would be evacuated near all 14 exits would be assisted by staff upon activation of fire alarm system. Maintenance Director tested System on 2/14/23 and weekly thereafter with documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 6 the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. Interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near bedroom 201 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the second floor exit door near bedroom 210 on 02/03/23 at 10:25 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. Interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near bedroom 210 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the second-floor exit door in the main dining room on 02/03/23 at 10:35 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. Interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door in the main dining room releases with the	K 222	Contracted Fire Alarm Company tested and documented all exit doors and Fire Alarm Systems on 03/02/23. Report indicated automated system released doors upon activation of fire alarm system. POC Criteria#2: The identified deficiency involving all 14 exit locks located in the facility do not release upon activation of the fire alarm, smoke detection and sprinkler system in accordance with N.F.P.A. 101 (2021 edition) affects every resident residing in the facility. The Fire Alarm System is automated and will release upon activation. In the event of an emergency all residents would be evacuated near all 14 exits would be assisted by staff upon activation of fire alarm system. Maintenance Director tested System on 2/14/23 and weekly thereafter with documentation.WHen tested on 02/14/24, all exit doors released upon activation of fire alarm system. Contracted Fire Alarm Company tested and documented all exit doors and Fire Alarm Systems on 03/02/23. Report indicated automated system released upon activation of fire alarm system. POC Criteria#3:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 7 fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the second floor exit door near bedroom 217 on 02/03/23 at 10:32 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. Interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near bedroom 217 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the second floor exit door near bedroom 230 on 02/03/23 at 10:34 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. Interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near bedroom 230 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the second-floor exit door near	K 222	Systemic practices were put into place to ensure compliance of all 14 exits releasing upon activation of the fire alarm, smoke detection and sprinkler system in accordance with N.F.P.A. 101 (2012 edition). The Facility Maintenance Director as well as his Assistant will perform weekly testing of fire alarm activation system including documentation of testing for 6 months and quarterly thereafter for release of egress doors at all exits upon activation of Fire Protection Systems. The Contracted Fire Safety Company will perform quarterly and bi annual inspections for the release of all fire exits upon activation of the fire alarm, smoke detection and sprinkler system, submitting written reports as to findings and/or compliance with applicable N.F.P.A. regulations to the facility. POC Criteria#4: The Facility Maintenance Director as well as his Assistant will perform weekly testing of fire alarm activation system including documentation of testing for 6 months and quarterly thereafter for release of egress doors at all exit doors upon activation for Fire Protection Systems. The Maintenance Director/Assistant will report to the Administrator results of weekly testing for the next 6 months and quarterly thereafter for release of egress doors at all exit doors upon activation of Fire Protection Systems.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 8 bedroom 238 on 02/03/23 at 10:35 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. An interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near bedroom 238 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the first floor exit door near bedroom 102 on 02/03/23 at 10:45 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. An interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near bedroom 102 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the first-floor exit door near bedroom 109 on 02/03/23 at 10:50 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. An interview with the Maintenance Director at the time of the observation indicated there is no	K 222	The Maintenance Director/Assistant will report to the Administrator results of the weekly testing for the next 6 months and quarterly thereafter as well to the Quality Assurance Committee quarterly compliance whcih will include the quarterly and bi annual fire inspection reports.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 9 documentation of testing to determine if the exit door near bedroom 109 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the first floor exit door at the main entrance on 02/03/23 at 10:50 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. An interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door at the main entrance releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the first floor exit door near the laundry on 02/03/23 at 10:55 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. An interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near the laundry releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above.	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 10 An observation of the first floor exit door patio on 02/03/23 at 11:05 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. An interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door patio releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the first-floor exit door near bedroom 122 on 02/03/23 at 11:07 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. An interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near bedroom 122 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the first floor exit door near bedroom 128 on 02/03/23 at 11:10 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door.	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**02/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	**100 KINDERKAMACK ROAD** **EMERSON, NJ 07630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 11 An interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near bedroom 128 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. An observation of the first floor exit door near bedroom 105 on 02/03/23 at 11:20 AM revealed the door was locked without egress as tested by the surveyor. The floor plan on the wall and a copy of the floor plan lists the door as an exit. An illuminating exit sign is directly above the door. An interview with the Maintenance Director at the time of the observation indicated there is no documentation of testing to determine if the exit door near bedroom 105 releases with the fire alarm, sprinkler or smoke detection system. In addition, the most recent fire alarm reports dated 01/10/23 and 07/06/22 revealed each report is silent to review or comment on the status of the exit door release noted above. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 222		

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
315360 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0211	Correction Completed 03/24/2023	ID Prefix Reg. # NFPA 101 LSC K0222	Correction Completed 02/14/2023	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO