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 _____	C 03/05/2025

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 Complaint#s: NJ00172473, NJ00171941, NJ00170976 STANDARD SURVEY: 03/05/25 CENSUS: 130 SAMPLE: 26 + 3 closed records. The facility is in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities	F 000		

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

Electronically Signed | 05/20/2025

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

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 _____	C 03/05/2025

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 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 43 E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on the 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	S 560	Criteria #1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?: Every resident is vulnerable to inadequate staffing levels. The facility adheres to state nursing regulations and determines staffing needs on a daily basis. Criteria #2: How you will identify other residents having the potential to be affected by the same deficient practice and what	3/7/25

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

Electronically Signed | 05/20/25

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 _____	C 03/05/2025

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 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	S 560	corrective action will be taken? a.Every resident is vulnerable to inadequate staffing levels. The facility adheres to state nursing regulations and determines staffing needs on a daily basis. b.The Facility will refrain from accepting new residents if it cannot meet the state-mandated minimum ratio of direct care staff to residents. Criteria #3: What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?: The Nursing and Admissions Departments will collaborate to assess the anticipated number of admissions and proper staffing levels. The number of direct care staff scheduled for the weekend will be determined based on the facility's capacity to accommodate new admissions. Nursing Administration will evaluate staffing needs and census requirements as outlined by the State of New Jerssey. The Director of Nursing (DON) or an appointed representative will assess the census and the necessary staffing levels mandated by the State of New Jersey for the upcoming three months. Criteria #4: How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place?	

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 _____	C 03/05/2025

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 the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (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 the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week staffing prior to the survey beginning 2/9/2025 and ending 2/22/2025 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 1 of 14-day shifts as follows: - 2/9/2025 had 16.5 CNAs for 133 residents on the day shift, which required at least 17 CNAs. A review of the facility policy titled "Subject: Emergency/Call out Staffing Strategies and During Emergencies" with an effective date of May 1, 2020 revealed under "Procedure-Call Outs/Emergency Staffing Strategies 3. In the event that a call out is accepted, Nursing Supervisor/Designee will then retrieve the Contract List for all Nursing Employees (CNAs, LPNs, RNs) to begin covering the call out."	S 560	a.The findings from the Director of Nursing/Designee will be submitted to the Quality Assurance Committee at quarterly meetings. b.The Nursing and Admissions Departments will collaborate to assess the anticipated number of admissions and proper staffing levels. The number of direct care staff scheduled for the weekend will be determined basded ont he facility's capacity to accommodate new admissions. Nursing Administration will evaluate staffing needs and census requirements as outlined by the State of New Jersey. c. The Director of Nursing (DON) or an appointed representative will assess the census and the necessary staffing levels mandated by the State of New Jersey for the upcoming three months. Criteria #5: Date by which corrective action will be completed?: March 7, 2025.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
060202	A. Building B. Wing	5/20/2025

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 03/07/2025	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	
3/5/2025	☐ 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 _____	**03/05/2025**

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 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		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 02/26/2025 to 02/28/2025. Emerson Health Care Center was found to be in NONCOMPLIANCE with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.. Emerson Health Care Center is a two-story building with 2 separate partial basements. The facility was 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 facade 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 gas generator that operates at 30% of load when tested. The facility has six smoke zones. .	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101	K 222		3/31/25

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

Electronically Signed | 03/14/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING **01** B. WING _____	**03/05/2025**

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 1 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 ordinary hazard contents in buildings protected	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 _____	**03/05/2025**

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 2 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 observation and interview on 02/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that access-controlled egress door assemblies were provided with a manual release device 40-inches to 48-inches vertically above the floor in accordance with NFPA 101:2012 Edition, Sections 7.2.1.6.2 and 19.2.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:15 AM revealed that the keypad for the access-controlled egress door near the rehab gym was installed at 60 inches above the floor. In an interview at the time, the U.S. FOI confirmed the	K 222	Criteria #1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. In accordance with NFPA 101:2012 Edition 7.2.1.6.2 and 19.2.2.2.4, this deficient practice had the potential to affect all residents. b. The Maintenance Director has contracted with Contractor to lower all keypad stations to a regulatory standard of 40 inches vertically above the floor. This work will be completed by March 31,2025.	

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 _____	**03/05/2025**

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 3 observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K 222	Criteria #2: How did you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. In accordance with NFPA 101:2012 Edition 7.2.1.6.2 and 19.2.2.2.4, this deficient practice had the potential to affect all residents. b. The Maintenance Director has contracted with Contractor to lower all keypad stations to a regulatory standard of 40 inches vertically above floor. This work will be done by March 31, 2025. Criteria #3: What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does ot recur? THe following measures and systemic changes will be put in place to ensure the deficient practice does not recur: a. All keypad stations will be measured by the Maintenance Director and Contractor will lower all keypad stations to regulatory standard of 40 inches vertically above the floor. b. Contractor began work on March 12, 2025 with a completion date of March 31, 2025. c. The Maintenance Director and Administrator will ensure that all keypad	

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 _____	**03/05/2025**

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 4	K 222	stations are lowered to regulatory standards by NFPA requirements of 40 inches vertically above the floor by Contractor. d. The Maintenance Director will report compliance with NFPA requirement to the Quality Assurance Committee at the next quarterly meeting due in April 2025 for the first quarter of 2025. e. The Administrator will report compliance with this NFPA requirement to the residents at the Resident Council at the monthly meeting next due for April 2025. f. All Staff will be updated to the NFPA regulatory compliance at the next in-service scheduled for March 2025. Criteria #4: How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place? a. The Maintenance Director and Administrator will ensure that all keypad stations are lowered to regulatory standards per NFPA requirements of 40 inches vertically above the floor by Contractor. b. The Maintenance Director will report compliance with this NFPA requirement to the Quality Assurance Committee at the next quarterly QAPI meeting due in April 2025 for the first quarter of 2025.	

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 _____	**03/05/2025**

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	K 222	c. The Administrator will report compliance with this NFPA requirement to the residents at the Resident Council at the monthly meeting due for April 2025. d. All Staff will be updated to the NFPA regulatory compliance at the next in-service scheduled for March 2025. Criteria #5: Date by which corrective action will be completed: March 31, 2025.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		5/15/25

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	03/05/2025

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 321	Continued From page 6 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 02/28/2025 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) it was determined that the facility failed to ensure that hazardous areas were separated from other spaces by smoke resisting partitions and doors in accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations between 12:34 PM and 12:45 PM revealed that the elevator machine room doors in both basement areas contained 22-inch by 22-inch open louvers that provided no protection to the exit corridor. In an interview at the time, the U.S. FOI and the U.S. FO confirmed the observation. The U.S. FO stated that the facility was informed to install the louvers 10 to 15 years ago for make-up air to the room. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K 321	Criteria #1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. In accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9, this deficient practice has the potential to affect all residents. b. A Contractor has been contracted to replace fire rated doors in accordance to NFPA requirements. The Maintenance Director and Administrator met with a Contractor in the facility on March 12, 2025 for inspection and replacement with NFPA required doors in accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9.Contractor met again with Maintenance Director on May 5, 2025. Doors will be replaced by May 15, 2025 with 90 minute fire rated doors with functional cyclindrical locks and door closers. Criteria #2: How you will identify other residents	

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 _____	**03/05/2025**

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 321	Continued From page 7	K 321	having the potential to be affected by the same deficient practice and what corrective action will be taken? a. In accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9, this deficient practice has the potential to affect all residents. b. The Contractor has been contracted to replace fire rated doors in accordance to NFPA requirements. The Maintenance Director and Administrator met with Contractor in the facility on March 12, 2025, for inspection and replacement with NFPA required doors in accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9. and on May 5th, 2025. Doors will be replaced by May 15, 2025. Criteria #3: What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a. A Contractor has been contracted to inspect all doors in affected area to ensure compliance in accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9 on March 12, 2025. 90 minute Fire-rated doors will be installed as required by NFPA regulatory requirements . b. The Contractor will install 90 minute fire-rated doors in accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9. by May 20, 2025.	

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 _____	**03/05/2025**

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 321	Continued From page 8	K 321	c. Contractor will also conduct annual inspections of all doors to ensure compliance with the NFPA regulatory standards. Next annual inspection will be a year from the installation of the doors by Contractor. d. Doors will be inspected by Maintenance Director/Designee on monthly basis and PRN (as necessary) and compliance will be reported to the Administrator. e. The Maintenace Director/Designee will report on compliance with the Quality Assurance Committee at scheduled quarterly meetings with this standard and update on new doors installation as well as annual inspections and findings. Crtieria #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur? a. The Maintenance Director/Designee will report compliance to the Quality Assurance Committee on a quarterly basis and as needed as required in accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9. b. The Maintenance Director/Designee will ensure that annual inspections are conducted and report compliance to the Quality Assurance Committee conducted quarterly. c. The Maintenance Director/Designee will	

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 _____	**03/05/2025**

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 321	Continued From page 9	K 321	maintain a log of monthly inspections and report compliance to the Administrator. Criteria #5: Date by which corrective action will be completed: May 15,2025.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced	K 324		3/31/25

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 _____	03/05/2025

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 324	Continued From page 10 by: Based on observation and interview on 02/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that cooking facilities were protected and complied with the requirements of NFPA 101:2012 Edition, Sections 19.3.2.5.4 and 19.3.2.5.3(1) through (10) and (13). This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:25 PM revealed that the rehabilitation gym contained a functioning 4 burner cooking range that was used by staff and residents. Protective devices such as a timer, keyed switch, locked switch, or a switch in a restricted location that deactivates the cook-top or range independent of staff action were not provided. In an interview at the time, the U.S. FOI confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K 324	Criteria #1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? a.In accordance to NFPA 101:2012 Edition, Sections 19.3.2.5.4 and 19.3.2.5.3(1) through (10 and (13) all residents have the potential to be affected by this deficient practice. a. Contractors were contracted for inspection and installation of "turn on/shut off" switch for the stove and oven used in the Rehabilitation Room. An inspection was done on Monday, March 10, 2025 by the electrician. c. Contractor spoke with Maintenance Director and Administrator on Monday, March 10, 2025 after inspection. Appropriate parts of installation have been ordered with the date of completion on or before March 31, 2025. The electric range in the Rehabilitation Room will have a lockable over-ride switch wih will disable power to the unit when not in use. THe device will be installed on or before March 31, 2025. Criteria #2: How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. In accordance to NFPA 101:2012	

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 _____	**03/05/2025**

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 324	Continued From page 11	K 324	Edition, Sections 19.3.2.5.4 and 19.3.2.5.3(1) through (10 and (13), all residents have the potential to be affected by this deficient practice. b.Contractor spoke with Maintenance Director and Administrator on Monday, March 10, 2025 after inspection. Appropriate parts of installation have been ordered with the date of completion on or before March 31, 2025. The electric range in the Rehabilitation Room will have a lockable over-ride switch wih will disable power to the unit when not in use. THe device will be installed on or before March 31, 2025. c. All residents will be supervised by Rehab Team/Designee during any cooking rehabilitative services. d. Rehab room will continue to be locked when no rehabilitative services are conducted. All Supervisors will be updated and alerted to ensure this monitoring is maintained and room is not accessible to residents during rehab off-hours. Criteria #3: What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? a. Contractor spoke with Maintenance Director and Administrator on Monday, March 10, 2025 after inspection. Appropriate parts of installation have been ordered with the date of completion on or	

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 _____	**03/05/2025**

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 324	Continued From page 12	K 324	before March 31, 2025. The electric range in the Rehabilitation Room will have a lockable over-ride switch wih will disable power to the unit when not in use. THe device will be installed on or before March 31, 2025. b. The Maintenance Director will report compliance to the Quality Assurance Committee at quarterly meetings or sooner as necessary with this NFPA requirement. c. The Maintenance Director/Designee will, as part of their daily rounds will ensure compliance with this requirement and any issues will be addressed with the Administrator/Designee immediately. Criteria #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? a. The Maintenance Director/Designee will report compliance to the Quality Assurance Committee at quarterly meetings or sooner as needed complianc with this standard and findings. b. The Maintenance Director/Designee will, as part of their daily rounds ensure compliance in accordance to NFPA 101:2012 Edition, Sections 19.3.2.5.4 and 19.3.2.5.3(1) through (10 and (13). c. Any issues identified by the Maintenance Director/Designee will be	

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 _____	**03/05/2025**

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 324	Continued From page 13	K 324	addressed with the Administrator/Designee immediately. Criteria #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance progra will be put in place? a. The Maintenance Director/Designee will report compliance at the Quality Assurance Committee at quarterly meetings or sooner as needed compliance with this standard and any findings. b. The Maintenance Director/Designee will, as part of their daily rounds ensure compliance in accordance to NFPA 101:2012 Edition, Sections 19.3.2.5.4 and 19.3.2.5.3(1) through (10 and (13). c. Any issues identified by the Maintenance Director/Designee will be addressed with the Administrator/Designee immediately. Criteria #5: Date by which corrective action will be completed: March 31, 2025.	
K 342 SS=F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual	K 342		3/31/25

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 _____	03/05/2025

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 342	Continued From page 14 means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that the operable part of each manual fire alarm pull station was not less than 42-inches and not more that 48-inches above the floor level in accordance with NFPA 72:2010 Edition, Section 17.14.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:15 AM revealed that the operable part of the manual pull station near the rehab gym was installed at 54 inches above the floor level. In an interview at the time, the U.S. FOI [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 72	K 342	Criteria #1: What corrective action will be accomplished for those residents found to be affected by the deficient practice: a. In accordance with NFPA 72:2010 Edition, Section 17.14.4, this deficient practice has the potential to affect all residents. b. The Facility contracted with Contractor, to assess the placement and installation of fire alarm pull stations on March 7, 2025, to not be less than 42 inches and not more than 48 inches above the floor level in accordance with NFPA 72:2010 Edition, Section 17.14.4. c. Contractor discussed lowering the fire alarm pull stations with the Maintenance Director and Administrator on March 7, 2025, in accordance with NFPA 72:2010 Edition, Section 17.14.4, d. Contractor will begin work to lower all fire alarm pull stations beginning March	

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 _____	**03/05/2025**

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 342	Continued From page 15	K 342	17, 2025 and complete work by March 31, 2025. Criteria #2: How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a.All residents have the potential to be affected by this deficient practice in accordance with NFPA 72:2010 Edition, Section 17.14.4. b. The Facility has contracted with Contractor to assess the placement and installation of all fire alarm pull stations on March 7, 2025, to not be less than 42 inches and not more than 48 inches above the floor level in accordance with NFPA 72:2010 Edition, Section 17.14.4. C. Contractor discussed lowering all fire alarm pull stations with the Maintenance Director and Administrator on Friday, March 7, 2025, in accordance with NFPA 72:2010 Edition, Section 17.14.4. d. Contractor will begin work to lower all fire alarm pull stations on March 17, 2025 and complete by March 31, 2025. Criteria #3: What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? a.Contractor did an assessment of all fire	

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 _____	**03/05/2025**

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 342	Continued From page 16	K 342	alarm pull stations on March 7, 2025 and will begin installation in accordance with NFPA 72:2010 Edition, Section 17.14.4 fo all fire alarm pull stations identified with this deficient practice with completion on March 31, 2025 or sooner. b. The Maintenance Director will report on compliance at the Quarterly Quality Assurance Committee, Department Managers and Monthly Resident Council Meetings. Criteria #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? a. Contractor did an assessment of all fire alarm pull stations on March 7, 2025 and will begin installation in accordance with NFPA 72:2010 Edition, Section 17.14.4 of all fire alarm pull stations identified with this deficient practice with completion on March 31, 2025 or sooner. b. The Maintenance Director will report on compliance at the Quarterly Quality Assurance Committee, Department Manager and Monthly Resident Council Meetings. Criteria #5: Date by which corrective action will be completed: March 31, 2025.	

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 _____	**03/05/2025**

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 761	Continued From page 17	K 761		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 02/26/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that fire door assemblies were inspected and tested annually in accordance with NFPA 80 Standard for Fire Door and Other Opening Protectives. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 02/26/2025 revealed that annual inspections to verify compliance with NFPA 80 5.2.4.2 (1)- (11) were not conducted in 2024. In an interview at the time, the U.S. FOI [redacted] confirmed the observation. The U.S. FOI [redacted] provided a quote from a vendor dated 02-19-25 for the inspections and stated that they have not been completed yet.	K 761	Criteria #1: What corrective action will be accomplished for those residents found to be affected by the deficient practice? a. This deficient practice had the potential to affect all residents in accordance to NFPA 80 Standard for Fire Door and other Opening Protectives. b. The Facility contracted with a Contractor for all fire door inspections in accordance to NFPA 80 Standard for Fire Door and other Opening Protectives on March 12, 2025, to inspect all doors and do initial and annual inspections going forward. Completion will be March 12, 2025.	3/12/25

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 _____	**03/05/2025**

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 761	Continued From page 18 The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 80	K 761	Crtieria #2: How you identify other residents having the potential to be affected by the deficient practice and what corrective action wil be taken?: a. All residents have the potential to be affected by this deficient practice in accordance to NFPA 80 Standard for Fire Door and other Opening Protectives. b. The Facility contracted with a Contractor on March 12, 2025, to inspect all fire doors and do intial and annual inspections going forward of all fire doors assemblies. Completion will be March 12, 2025, and annual inspections thereafter will be conducted. Criteria #3: What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur? a. The Facility contracted with a Contractor on March 12, 2025, to inspect all fire doors and do intial and annual inspections in accordance to NFPA 80 Standard for Fire Door and other Opening Protectives going forward fo all fire door assemblies. Completion will be March 12, 2025, and annual inspections thereafter will be conducted. b. The Maintenance Director/Designee will report on compliance at the quarterly Quality Assurance Committee Meetings with all findings and annual inspections in	

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 _____	**03/05/2025**

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 761	Continued From page 19	K 761	accordance to NFPA 80 Standard for Fire Door and other Opening Protectives. c. The Maintenance Director will conduct inspections of doors during monthly rounds findings to the Administrator/Designee. The inspections will be part of their logs for preventative maintenance done monthly. Criteria #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? a. Administrator will ensure annual inspections are done and any findings identified are in aligment and in accordance with NFPA 80 Standard for Fire Door and other Opening Protectives. b. Contractor has been contracted to provide and completed inspection services of all fire doors in accordance to NFPA 80 Standard for Fire Door and other Opening Protectives on March 12, 2025. Completion of initial inspection of all fire doors was performed on March 12, 2025 and annual inspections thereafter will be conducted by the contracted company. c. The Maintenance Director/Designee will report on compliance with the quarterly Quality Assurance Committee with all findings and annual inspections. d. the Maintenance Director will conduct inspections of doors during monthly rounds, report findings to the	

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 _____	**03/05/2025**

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 761	Continued From page 20	K 761	Administrator. The inspections shall be part of his logs for preventative maintenance done monthly or sooner as needed. Criteria #5: Date by which corrective action will be completed: March 12, 2025.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 02/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that electrical panels were guarded to prevent unauthorized access, tampering, or potential hazards in resident accessible areas in accordance with NFPA 101: 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99: 2012 Edition, Section 6.3.2.1, 6.3.2.2.1.3 (A), 15.5.1.2 and NFPA 70: 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 911	Criteria #1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?: a. This deficient practice has the potential to affect all residents in accordance with NFPA 101: 2012 Edition, Section 19.5.1, 19.5.1.1,, 9.1, 9.1.2, NFPA 99:2012 Edition, Sections 6.3.2.1., 6.3.2.2.1.3(A),15.5.1.2 and NFPA 70:2011 Edition, Section 110.26,110.27 and 110.16.	3/14/25

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 _____	**03/05/2025**

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 911	Continued From page 21 An observation at 10:20 AM revealed that 3 of 3 electrical breaker panels in the corridor near resident room 231 were unlocked. An observation at 10:28 AM revealed that the electrical breaker panel near the social services/ MDS coordinator's office was unlocked. An observation at 10:39 AM revealed that 2 of 2 electrical breaker panels in the corridor near resident room 202 were unlocked. In interviews at the time, the [U.S. FOI redacted] confirmed the observations and stated that they were instructed by the local fire Marshall to keep the electrical breaker panels unlocked. The facility's [U.S. FOIA (b) (6) redacted] was informed of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 70, 99	K 911	b. All electrical panels will be guarded against any unauthorized access, tampering or potential hazards in resident accessible areas by installing locks. c. The Maintenance Director/Designee will ensure all accessible electrical panels will always be locked as stipulated in the NFPA regulatory guidelines. d. The Maintenance Director/Designee will provide a key on a Supervisor's keyring to unlock all electrical panel locks in the event the panels need to be accessed. Criteria #2: How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents have the potential to be affected by this deficient practice in accordance with NFPA 101: 2012 Edition, Section 19.5.1, 19.5.1.1,, 9.1, 9.1.2, NFPA 99:2012 Edition, Sections 6.3.2.1., 6.3.2.2.1.3(A),15.5.1.2 and NFPA 70:2011 Edition, Section 110.26,110.27 and 110.16. b. All electrical panels will be guarded against any unauthorized access, tampering or potential hazards in resident accessible areas by installing locks. c. The Maintenance Director/Designee will ensure all accessible electrical panels will always be locked as stipulated in the	

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 _____	**03/05/2025**

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 911	Continued From page 22	K 911	NFPA regulatory guidelines. d. The Maintenance Director/Designee will provide a key on a Supervisor's keyring to unlock all electrical panel locks in the event the panels need to be accessed. Criteria #2: How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken?: a. All residents have the potential to be affected by this deficient practice in accordance with NFPA 101: 2012 Edition, Section 19.5.1, 19.5.1.1,, 9.1, 9.1.2, NFPA 99:2012 Edition, Sections 6.3.2.1., 6.3.2.2.1.3(A),15.5.1.2 and NFPA 70:2011 Edition, Section 110.26,110.27 and 110.16. b. All electrical panels will be guarded against any unauthorized access, tampering or potential hazards in resident accessible areas by installing locks. c. The Maintenance Director/Designee will ensure all accessible electrical panels will always be locked as stipulated in the NFPA regulatory guidelines as part of their daily rounds. d. The Maintenance Director/Designee will provide a key on the Supervisor's keyring to unlock all electical panels in the event the panels need to be accessed.	

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 _____	**03/05/2025**

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 911	Continued From page 23	K 911	Criteria #3: What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur? a. All electric panels were assessed throughout the facility and locked to prevent accessibility, tampering or potential hazards to resident accessible areas by the Maintenance Director/Designee. A key to access will be provided to all supervisors 24/7 for any necessary event that requires it to be unlocked. b. The Maintenance Director/Designee will ensure upon daily rounds that all panels continue to be locked and ensure access is always available to authorized personnel. c. The Maintenance Director/Designee will report compliance to the quarterly Quality Assurance Committee in accordance with NFPA 101: 2012 Edition, Section 19.5.1, 19.5.1.1,, 9.1, 9.1.2, NFPA 99:2012 Edition, Sections 6.3.2.1., 6.3.2.2.1.3(A),15.5.1.2 and NFPA 70:2011 Edition, Section 110.26,110.27 and 110.16. Criteria #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be in place? a. All electric panels were assessed	

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 _____	**03/05/2025**

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 911	Continued From page 24	K 911	throughout the facility and locked to prevent accessibility, tampering or potential hazards to resident accessible areas by the Maintenance Director/Designee. A key to access will be provided to all supervisors 24/7 for any necessary event that requires it to be unlocked. b. The Maintenance Director/Designee will ensure upon daily rounds that all panels continue to be locked and ensure access is always available to authorized personnel. c. The Maintenance Director/Designee will report compliance to the quarterly Quality Assurance Committee in accordance with NFPA 101: 2012 Edition, Section 19.5.1, 19.5.1.1,, 9.1, 9.1.2, NFPA 99:2012 Edition, Sections 6.3.2.1, 6.3.2.2.1.3(A),15.5.1.2 and NFPA 70:2011 Edition, Section 110.26,110.27 and 110.16. Criteria #5: Date by which corrective action will be completed: March 14, 2025.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918		3/11/25

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 _____	**03/05/2025**

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 918	Continued From page 25 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 observation and interview on 02/28/2025 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance of generators was in accordance with NFPA 99 Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 Edition, Section 8.3.7.1. This	K 918	Criteria #1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. All residents have the potential to be	

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 _____	03/05/2025

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 918	Continued From page 26 deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 02/28/2025 at 11:55 AM revealed that the emergency backup generator contained a lead acid battery. In an interview at the time, the surveyor asked for monthly testing and recording of electrolyte specific gravity for the lead-acid batteries. The U.S. FOI confirmed that the battery was a lead acid battery and stated that the monthly recording of electrolyte specific gravity is not conducted. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K 918	affected by the deficient practice in accordance to NFPA 99 Sections 6.4.4, 6.5.4,6.6.4, and NFPA 110:2010 Edition, Section 8.3.7.1. b. The Maintenance Director/Designee conducted a "specific gravity test" to check generator battery on March 11, 2025, and will conduct test monthly and record findings on log checklist. c. The Maintenance Director/Designee will report compliance with this standard to the Administrator with monthly log test results and findings. Criteria #2: How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents have the potential to be affected by the deficient practice in accordance to NFPA 99 Sections 6.4.4, 6.5.4,6.6.4, and NFPA 110:2010 Edition, Section 8.3.7.1. b. The Maintenance Director conducted a "specific gravity test" to check generator battery on March 11, 2025, and will conduct monthly and record findings on a log checklist and report to the Administrator/Designee accordingly. Criteria #3: What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not	

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 _____	**03/05/2025**

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 918	Continued From page 27	K 918	recur?: a. The Maintenance Director/Designee conducted the "specific gravity test" on March 11, 2025, to check the generator battery and will conduct monthly and address any issues. b. The Maintenance Director/Designee will report on compliance with this standard to the Administrator monthly by reviewing log with test results and findings. c. The Maintenance Director/Designee will report on compliance to the Quality Assurance Committee regarding this standard at quarterly meetings and as necessary to alert the Administrator/Designee of any issues. Criteria #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? a. The current maintainable battery was tested for "specific gravity" on March 11,2025, and will be conducted monthly by the Maintenance Director/Designee. Once the battery is changed to a sealed maintainable battery the monthly "specific gravity testing" will be changed to conductive testing. The conductive testing will be done monthly. b. The Maintenance Director/Designee will maintain a log checklist of monthly testing/monitoring and review compliance	

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 _____	**03/05/2025**

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 918	Continued From page 28	K 918	with the Administrator/Designee for findings. c. The Maintenance Director will report on compliance with the QUality Assurance Committee regarding this NFPA standard at quarterly meetings and as necessary to alert the Administrator of any issues. Criteria #5: Date by which corrective action will be completed: March 11, 2025.	

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	5/20/2025 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	03/31/2025	LSC K0321	05/15/2025	LSC K0324	03/31/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0342	03/31/2025	LSC K0761	03/12/2025	LSC K0911	03/14/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	03/11/2025	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	
3/5/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO