STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. BUILDING _____ B. WING _____	C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #'s: NJ 160674, 165435, 165750, 174925 Census: 54 Sample Size: 17 + 3 Closed Records THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. 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 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete the Quarterly Minimum Data Set assessment in a	F 638	1. Corrective Action: - MDS Completed for Resident #43 was verified immediately upon identification to	8/12/24

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

Electronically Signed | 07/12/2024

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

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F 638	Continued From page 1 timely manner for 2 residents. This deficient practice was identified for 2 of 2 Residents (Residents #43 and #4) reviewed for Resident Assessment and was evidenced by the following: Resident #43 was admitted with diagnoses that included but was not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). On NJ Ex Order 26.4(b)(1), the surveyor reviewed the electronic medical record (EMR) for resident #43. The Quarterly Minimum Data Set (QMDS), an assessment tool completed every 3 months, revealed an Assessment Reference Date (ARD), a date used as the last day of a look-back period, of NJ Ex Order 26.4(b)(1). The EMR revealed that the QMDS for Resident #43 had been completed on NJ Ex Order 26.4(b)(1), NJ days late. Resident #4 was admitted with diagnoses that included but was not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 On NJ Ex Order 26.4(b)(1), the surveyor reviewed the EMR for Resident #4. The QMDS revealed an ARD of NJ Ex Order 26.4(b)(1). The EMR revealed that the QMDS for Resident #4 had been completed on NJ Ex Order 26.4(b)(1), NJ days late. During an interview with the surveyor on 6/27/2024 at 9:35 AM, the U.S. FOIA (b) (6) acknowledged that the QMDS's for Residents #43 and #4 were completed late. NJ Ex Or stated it is important to have the MDS completed on time to be sure the resident is being assessed according to regulation. Review of the facility policy titled Resident Assessments with a revision date of March 2022 reflected that the U.S. FOIA (b) (6) is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews	F 638	assure it was completed and summitted. - MDS completion for Resident #4 was verified immediately upon identification to assure it was completed and submitted - Upon identification an audit of all current residents was completed by the MDS Coordinator to assure that they were due for completion were completed and submitted timely. - On 6/27/24, the MDS Coordinator was educated on the importance of timely completion and submission of the MDS 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents 3. Measure put in place: - Random audits of 10% of MDS assessments that are due each week will audited by the MDS Coordinator and/or designee to assure that all MDS assessments are completed and submitted timely - Results of the weekly audits will be reviewed by the DON (Director of Nursing) and/or Designee to assure compliance of timely completion 4. How will these actions be measured - The DON (Director of Nursing) and/or Designee will report the results of the weekly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be	

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F 638	Continued From page 2 according to the following requirements: (2) quarterly assessment. Review of the facility provided policy MDS Completion and Submission Timeframes revised October 2023 which reflected our facility will conduct and submit resident assessments in accordance with correct with current federal and state submission timeframes. NJAC 8:39-11.1	F 638	made regarding the need for continued submission and reporting.	
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	F 656		8/12/24

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F 656	Continued From page 3 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document 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, record review, and review of pertinent facility documents, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives, timelines, and interventions to meet resident's medical and nursing needs specifically by failing to implement a care plan for a.) the use of and Nj ex order 26.4b1 (b/l) Nj ex order 26.4b1 for 1 of 1 resident (Resident #47) reviewed for NJ Ex Or [redacted], b.) Nj ex order 26.4b1 for 1 of 1 resident (Resident #19) reviewed for Nj ex orde, and c.) an Nj ex order 26.4b1 for 1 of 1 resident reviewed for Nj ex order 26.4b1 [redacted] The deficient practice was evidenced by the	F 656	1. Corrective Action: - Upon identification, on Nj ex order 26.4b, a care plan and interventions were added for resiidient #47 to include Nj ex order 26.4b1 [redacted] - Upon identification, on Nj ex order 26.4b, a care plan, goals and interventions were added to address resident #19's Nj ex order 26.4b1 - Upon identification, on Nj ex order 26.4b1, resident #207's Nj ex order 26.4b1 care plan was updated to include information regarding the resident's Nj ex order 26.4b1 [redacted] - An audit was conducted by the US FOIA (b [redacted] and/or Designee for	

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F 656	Continued From page 4 following: a.) On 06/25/2024 at 7:53 AM, Surveyor #1 observed Resident #47 lying in bed. Resident #47 stated that his/her NJ ex order 26.4b1 . Resident #47 further stated that he/she told the staff t NJ ex order 26.4b1 A review of Resident #47's Admission Record revealed that he/she had a NJ ex order 26.4b1. A review of Treatment Administration Record (TAR) dated NJ ex order 26.4b1 included an entry dated NJ ex order 26.4b1, to apply [name redacted] NJ ex order 26.4b1 and NJ ex order 26.4b1. The times plotted were to apply at 6:30 AM and remove at 6:30 PM. Documentation on the TAR indicated that on NJ ex order 26.4b1, the was not removed and that from NJ Exec Order 26.4b1 NJ ex order 26.4b1, the was not applied or removed. The TAR showed "2" or "9" which reflected either or see notes. A review of Resident #47's resident-centered, on-going Care Plan failed to include a focus area for the need of NJ Exec Order 26.4b1 related to the diagnosis of any focus area to address the resident's of the NJ Exec Order 26.4b1, any measurable goals, and any initial or revised interventions. b.) On 06/25/2024 at 8:05 AM, Surveyor #1 observed Resident #19 sleeping in his/her bed. The bed was in the low position. A review of Resident #19's Admission Record revealed that he/she had diagnoses which	F 656	all resident care plans related to falls, residents wit treatment orders with/or without compliance and residents with indwelling urinary catheters to assure the care plans were written and updated. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the ptoential to affect all residents 3. Measure put in place: - The DON/Designee will audit 10% of resident care plans on a weekly basis to assure care plans and interventions are implemented timel related to bi-lateral leg wraps/noncompliance, actual falls and residents with indwelling urinary catheters and interventions are implemented timely with patient centered interventions. - On 6/27/24, education was provided by the DON and /or Designee to the interdisciplinary team (social work, U.S. FOIA (b) (6), dietitian) physician and all licensed nursing staff on the need to assure care plans are implemented timely and accurately upon resident admission and changes to resident's care. 4. How will these actions be measured - The US FOIA (B) (6) and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued	

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F 656	Continued From page 5 included but were not limited to; NJ Ex Order 26.4 NJ Ex Order [redacted], and NJ Ex Order 26.4(b)(1 A review of Resident #19's Quarterly Minimum Data Set (MDS) an assessment tool to facilitate resident care dated NJ ex order 26.4b1, revealed a Brief Interview of Mental Status (BIMS) of NJ ex out of 15 which indicated NJ Ex Order 26.4(b)(1) . Resident #19 NJ ex order 26.4b1 [redacted]. It was documented that the resident NJ ex order 26.4b1 [redacted] A review of the facility provided, "Pos NJ ex ord [redacted] dated NJ ex order 26.4b1, indicated an NJ ex order 26.4b1 in the resident's room which NJ ex order 26.4b1 The Care Planning section NJ ex order 26.4b1 [redacted] There were no Care Plan indications for NJ ex order 26.4b1 . A review of the facility provided, NJ ex order 26.4b1 [redacted], indicated an NJ ex order 26.4b1 in the resident's room with NJ ex . The Care Planning section NJ ex order 26.4b1 [redacted] There were no Care Plan indications for NJ ex order 26.4b1 [redacted] A review of Resident #19's resident-centered, on-going Care Plan included a focus area initiated NJ ex order 26.4b1, "NJ ex order 26.4b1 [redacted]" this focus was not revised. The Goal was for the resident to be NJ ex order 26.4b1 [redacted] through the review date and was initiated on NJ ex order 26.4b1 and revised on NJ ex order 26.4b1. The care plan failed to initiate a focus area for either	F 656	submission and reporting.	

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F 656	Continued From page 6	F 656		

of the [redacted], no goals, and no interventions for the [redacted] and no revisions after the [redacted]

c.) A review of Resident # 207's Admission Record revealed that he/she was admitted to the facility on at the [redacted].

A review of Resident # 207's Minimum Data Set (MDS; An assessment tool) dated [redacted] revealed that he/she [redacted]

A review of Resident # 207's Electronic Medical Record (EMR) under physician's orders revealed an order to [redacted] The orders also included an order to [redacted]

A review of Resident # 207's EMR under diagnoses revealed a diagnoses of [redacted]).

A review of Resident # 207's EMR under Care Plan revealed a focus that Resident # 207 [redacted] The focus was initiated on [redacted] The focus and interventions did not reveal any specific information regarding the [redacted] or how to care for the [redacted]

On 06/27/2024 at 10:05 AM, during an interview with Surveyor #1, the [redacted] stated that a resident Care Plan should include areas such as Activities of Daily Living, [redacted] of medication or treatments, [redacted], and [redacted] She further stated that

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F 656	Continued From page 7	F 656		

the Supervisors were responsible for initiating and updating Care Plans.

On 06/27/2024 at 11:26 AM during an interview with Surveyor #2, Registered Nurse (RN) # 1 confirmed that Resident # 207 should have a care plan focus for the NJ ex order 26.4b1. RN # 1 stated, "Yes, [he/she] is supposed to. Anyone with a [NJ Exec Order 26.4b] should have one mentioning the NJ Exec at least." RN # 1 reviewed the care plan in the presence of the surveyor. RN # 1 confirmed Resident # 207 had one for NJ Exec Order 26.4b1 but not specifically for the NJ Exec Order 26.4b

On the same date at 12:32 PM during an interview with Surveyor #2, the US FOIA (B) (6) replied, "Yes, [he/she] should" when asked if a resident with an NJ Exec Order 26.4b1 should have a care plan focus for it. Secondly, the US FOIA (B) replied, " We would document NJ Exec and date it was NJ Ex Order 26.4(b) care and how NJ Exec Order 26.4b1 it NJ Exec Order 26.4b1 and quality of NJ Exec Order 26 Further, she added the care plan should include any type of issues that may come when NJ ex order 26.4b1 and education for the resident on proper care of the NJ ex order 26.4b1 Lastly, the surveyor asked when should it [care plan] be added to the comprehensive if it was identified upon admission. The US FOIA (B) replied, "On admission."

On 06/28/2024 at 9:19 AM, during an interview with Surveyor #2, the US FOIA (B) stated that Resident # 207 was provided education directly, the care plan was updated and orders were reconciled regarding the NJ ex order 26.4b1. At that time, the US FOIA (B) provided a copy of the care plan to the surveyor. The copy of the care plan revealed a focus, "NJ ex ord

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F 656		F 656		

Continued From page 8

NJ ex order 26.4b1 The date initiated was NJ ex order 26.4b1

On NJ ex order 26.4b1 at 9:21 AM, the US FOIA (B in the presence of the survey team, stated that upon being made aware by the surveyors, Resident #47's Care Plan was updated. The US FOIA (B further stated that there would be a NJ ex order 26.4b1 and acknowledged that there was no Care Plan for Resident #19's NJ ex order 26.4b1. The US FOIA (B established that she was responsible to ensure that after a NJ ex order 26.4b1, the nurses were implementing Care Plans with interventions.

US FOIA (B) (6) was also present and stated that there was no documentation that Resident #47's physician or representative was made aware of the NJ ex order 26.4b1. The US FOIA (B) (6 stated, "there was no documentation, and we have to work on our documentation". She further stated that education was being provided regarding family and physicians being notified.

A review of the facility policy titled, "Care Plans, Comprehensive Person-Centered" revised March 2022 revealed under "Policy Interpretation and Implementation" that, "2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Minimum Data Set] assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission."

A review of the facility policy, "Requesting, Refusing and/or Discontinuing Care or Treatment" revised 02/2021, included but was not limited to; Policy Interpretation and

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F 656	Continued From page 9 Implementation: 1. Resident ... are informed ... of: a. the care that will be furnished ... based on his/her assessment and plan of care. A review of the facility policy, "Assessing Falls and Their Causes" revised 03/2018, included but was not limited to; "Preparation: 1. Review the resident's care plan to assess for any special needs of the resident." "Documentation: ... the following information should be recorded in the resident's medical record: 13. Interventions ... 16. Appropriate interventions taken to prevent future falls. § 8:39-11.2 (e)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide education to a resident who was NJ Exec Order 26 a treatment and to notify the resident's physician and family. This deficient practice was identified for 1 of 1 residents (Resident #47) reviewed for NJ ex order 26.4b1. The deficient practice was evidenced as follows: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states:	F 658	1. Corrective Action: - Upon identification, Resident #47's physician was notified on NJ ex order 26.4 by the US FOIA (B) of resident #47's refusa NJ ex order 26 The NJ ex order 26.4b1 . - Upon identification, Resident #47, is NJ Ex O own decision maker and was educated to the risks vs benefits of NJ ex order 26.4b1 prescribed by their attending physician. - Upon identification, the US FOIA (B /designee	8/12/24

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F 658	Continued From page 10 "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 06/25/2024 at 7:53 AM, the surveyor observed Resident #47 lying in bed with a sheet and blanket over him/her. At that time, Resident #47 stated that NJ ex order 26.4b1 [redacted]". The resident further stated that the staff had them NJ ex order 26.4b1 but NJ ex order 26.4b1, so he/she told them [the staff] to NJ ex order 26.4b1. A review Resident #47's Admission Record revealed that he/she had diagnoses which included but were not limited to; NJ ex order 26.4b1 [redacted].	F 658	audited the treatment administration record (TAR) to assure residents with documented treatement refusals, were educated to the risks vs benefits, had their physcian and responsible parties notified. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents 3. Measure put in place: - The Director of Nursing (DON) and/or designee will perform weekly random audits of 10% of the Treatment Administration Record of residents that have documented refusals to assure that the resident has been educated to the risks vs benefits of their decision, had their physician and responsible party notified. - All licensed professional nurses (RN/LPN), physician and therapy were educated, by the DON and/designee, on 7/9/24, on the facilities policy of requesting, refusing and/or discontinuing care or treatment. 4. How will these actions be measured - The DON (Director of Nursing) and/or Designee will report the results of the weekly random audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. BUILDING _____ B. WING _____	C 06/28/2024

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ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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F 658	Continued From page 11	F 658		

A review of the Minimum Data Set (MDS) an assessment tool used to facilitate care dated NJ ex order 26.4b1, included but was not limited to; a Brief Interview for Mental Status (BIMS) of NJ ex out of 15 which indicated NJ ex order 26.4b1

A review of the Treatment Administration Record (TAR) for NJ ex order 26.4b1 included the order dated NJ ex order 26.4b1 to apply [name redacted] NJ ex order 26.4b1 and remove per schedule. The times plotted were to apply at 6:30 AM and remove at 6:30 PM. The TAR identified that on NJ ex order 26.4b1, the NJ ex order 26.4b1 from NJ ex order 26.4b1 NJ ex order 26.4b the NJ ex order 26.4b1 removed. The correlating codes on the TAR were either "2" or "9" which reflected either NJ ex ord or see notes.

A review of the Progress Notes (PN) revealed that on NJ ex order 26.4b1, the U.S. FOIA (b) (6) documented the NJ ex order 26.4b1 The PN dated NJ ex order 26.4b1 documented by the U.S. FOIA that there were NJ ex A Physician's PN dated NJ ex order 26.4b1, documented NJ ex order 26.4b1 . An U.S. FOIA PN dated NJ ex order 26.4b1, documented "NJ Exec Order 26 to have his/her NJ Exec O NJ Exec Order 26.4 this morning, NJ Exec Order 26.4b1." A U.S. FOIA (b) (6)) PN dated NJ ex order 26.4b1, documented resident NJ ex order 26.4b1. A Physician's PN dated NJ ex order 26.4b1, documented the resident was NJ ex order 26.4b1 .

There were no PN's that the physician was made aware prior to NJ ex order 26.4b1, that the family representative was made aware, or that the

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F 658	Continued From page 12	F 658		

resident was educated regarding the risks vs. benefits of [redacted].

On 06/27/2024 at 9:56 AM, the [redacted] on the unit stated that if a resident were to refuse a treatment, the process was to notify the physician for orders.

On 06/27/2024 at 10:05 AM, the [redacted] stated the process for a resident refusing a treatment would be to educate the resident, call the physician, document in the medical record.

A review of the facility policy, "Requesting, Refusing and/or Discontinuing Care or Treatment" revised 02/2021, included "Policy Interpretation and Implementation" "5. If a resident/representative ... refuses care or treatment, an appropriate member of the interdisciplinary team (IDT) will meet with the resident/representative to: a. determines why he or she is requesting, refusing or discontinuing ...; c. discuss the potential outcomes or consequences of the decision." "6. ... b. the IDT will assess the resident's needs and offer ... alternative treatments, if available and pertinent, while continuing to provide other services outlined in the care plan." "8. Detailed information relating to ... the refusal ... are documented in the resident's medical record." "9. Documentation pertaining to a resident's ... refusal of treatment includes at least the following: a. the date and time the ... treatment was attempted; b. the type of care or treatment; c. the resident's ... stated reason ... for the refusal; d. the name of the person who attempted to administer ... the treatment; e. that the resident was informed ... of the purpose of the treatment and the potential

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ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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F 658	Continued From page 13 outcome of not receiving the medication/or treatment; f. the resident's condition and any adverse effects due to the request; g. the date and time the practitioner was notified ... the practitioner's response; h. all other pertinent observations; and i. the signature and title of the person recording the data." NJAC 8:39-27.1(a)(b)	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		8/12/24

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	315297	A. BUILDING _____ B. WING _____	C 06/28/2024

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F 755	Continued From page 14 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to A. maintain accurate accountability of a controlled medication and B. properly acquire a NJ Ex Order 26.4(b)(1) NJ ex order 26.4b1 that staff borrowed for an unsampled resident. This deficient practice was identified for 1 of 2 medication carts and was evidenced by the following: A. On 6/25/2024 at 11:03 AM, the surveyor reviewed Cart 1 with the US FOIA (B) (6) The Individual US FOIA (B) (6) record for unsampled Resident # 154 reflected that there were NJ ex order 26.4b1 The U.S. FOIA and the surveyor reviewed the corresponding medication card (bingo card) for the NJ ex order 26.4b1 which reflected there were NJ ex order 26.4b1. The U.S. FOIA acknowledged that NJ ex order 26.4b1 NJ ex ord. On 6/25/24 at 11:03 AM, the surveyor reviewed the NJ Ex Order 26.4(b)(1) Medication Administration Record for Resident #154 with the U.S. FOIA There was no documentation that the NJ ex order 26.4b1 to the resident. During an interview with the surveyor on 6/25/2024 at 11:08 AM, the US FOIA (B) (6) stated that there should be NJ ex	F 755	1. Corrective Action: - Upon identification, the Director of Nursing (DON) immediately initiated an in-service/education, to all licensed clinical nurses, related to the controlled substance policy, the process to be initiated when a resident does not have a medication available based on the physicians order and the process of re-ordering medications to assure mediation is available timely. -Upon identification, 6/26/24 the Director of Nursing (DON) initiated an in-service/education, to all licensed clinical nurses (RN/LPN), were educated on signing out narcotic medication at the time of administration - The DON provided individual education to the US FOIA on the cart (on 6/26/24) that borrowing of NJ Ex Order 26.4(b) is prohibited and that if a resident NJ ex order 26.4b1 , the physician must be notified immediately, a script obtained and faxed to the pharmacy. - On 6/25/24, the Pharmacy representative from the facility's pharmacy, completed a cart to mar (medication administration record) audit to assure that all prescribed medications were available in the facility. 2. Identification of other residents or	

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	315297	A. BUILDING _____ B. WING _____	C 06/28/2024

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ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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F 755	Continued From page 15 During an interview with the surveyor on 6/25/2024 at 11:38 AM, the US FOIA stated that she counted the NJ ex order 26.4b1 in the cart by herself. She stated she must have missed the NJ ex order 26.4b1 During an interview with the surveyor on 6/25/2024 at 11:47 AM, the US FOIA (B) (6) stated that the IPCSA should be signed out when administering medication. On NJ ex order 26.4b1 at 9:30 AM the US FOIA (B) stated that after an audit, she found that the NJ ex order 26.4b1 was administered to Resident #154 however NJ ex order 26.4b A review of the facility policy titled, "Controlled Substances", revised November 2022 reflected: 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between the loss/diversion and detection/follow up. B. On 6/25/2024 at 11:03 AM, the surveyor reviewed Cart 1 with the US FOIA (B) (6) US FOIA (B) (6) record for unsampled Resident # 154 reflected that on NJ ex order 26.4b1 was borrowed for unsampled Resident #1. On 6/25/2024 at 11:25 AM, the surveyor and the Registered Nurse #1 reviewed the Medication Administration Record (MAR) for Resident #1. The MAR reflected that Resident #1 was administered NJ ex order 26.4b1 at 9:03 PM which corresponds to the NJ Exec Order 2 of Resident #154. When asked at that time if medication	F 755	areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents that are prescribed narcotic medications. 3. Measure put in place: -On the week of 7/22/24 the Pharmacy representative from the facility's pharmacy, is scheduled to come to facility to complete an additional cart to mar (medication administration record) audit to assure that all prescribed medications were available in the facility. - Upon completion of the visit, Weekly MAR to Cart audits and individual patient controlled substance administation record will be randomly completed on 10% of the residents, by the DON and/or Designee to assure that all prescribed medications are available in the facility. 4. How will these actions be measured - The DON (Director of Nursing) and/or Designee will report the results of the weekly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 755	Continued From page 16 should be borrowed, the [U.S. FOIA (b) (6)] and RN#1 stated, "No." During an interview with the surveyor at 6/25/2024 at 11:47 AM, the [U.S. FOIA (b) (6)] stated that the nurses should not borrow [NJ Ex Order 26.4(b)] if the medication is not available. A review of the facility policy titled, "Controlled Substances", revised November 2022 reflected 4. An individual resident-controlled substance record is made for each resident who will be receiving a controlled substance. This record contains: a. name of resident... NJAC: 8:39-29.7(k), 29.7(c)	F 755		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		8/12/24

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F 812	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 06/25/2024 from 07:30 AM to 07:50 AM the surveyor, accompanied by the U.S. FOIA (b) (6) observed the following in the kitchen: 1. The meat slicer was observed uncovered with pink food scraps on it. The U.S. FOIA (b) said, "We just finished cutting ham for breakfast, and haven't had time to clean it yet." 2. In the walk-in refrigerator an open package of hard-boiled eggs was wrapped in plastic wrap with no open or use by date label. The U.S. FOIA (b) removed them from the refrigerator and stated, "It should have a label on it." 3. In the freezer, an unidentified frozen food was wrapped in plastic wrap without a label or date. The U.S. FOIA (b) removed the food from the Freezer and stated, "Yes, this should be labeled also." 4. In the dry storage area, a dented can of baked beans was observed on the can rack. The U.S. FOIA (b) said it should not have been there and pulled it from the rack. A review of an undated facility policy titled " Labeling and Dating Inservice", revealed under	F 812	1. Corrective Action: - Upon identification, the meat slicer was cleaned and "food scraps" were removed by the Food Service Assistant Director - Upon identification, the hard boiled eggs that did not have a use-by date was discarded by the Food Service Assistant Director - Upon identification, the dented can of baked beans was removed from the rack and placed in the dented can storage bin to be returned to the sending company. -Upon identification, the unidentified frozen food that was wrapped in plastic wrap with no open or use by date label was discarded. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents 3. Measure put in place: - Education of the Dietary Process related to Labeling and Dating/Use By Dates, proper placement of dented cans and proper cleaning of the meat slicer was initiated to all dietary staff by the Food Service Director and will be completed by 7/16/24. - The Food Service Director and/or Designee will do a weekly audit to ensure that the meat slicer is cleaned after each meal is prepared. - The Food Service Director and/or Designee will do a weekly audit of use by	

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	315297	A. BUILDING _____ B. WING _____	C 06/28/2024

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F 812	Continued From page 18 "Importance of labeling and dating" that "Proper labeling and dating ensure that all foods are stored, rotated, and utilized in a First IN First Out (FIFO) manner. This will minimize waste and ensure that items that are passed their due date are discarded." Also revealed under "Guidelines for Labeling and Dating" that "Food labels must include: the food name, the date of preparation receipt removal from freezer and, the "use by "date outlined in attached guidelines". N.J.A.C. 8:39-17.2(g)	F 812	dates and unlabeled food in the kitchen - The Food Service Director and/or Designee will do a weekly audit to assure that dented cans are placed in the proper storage bin sot that it can be returned to the send company. 4. How will these actions be measured - The Food Service Director and/or Designee will report the results of the weekly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		8/12/24

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ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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F 883	Continued From page 19 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documents, it was	F 883	1. Corrective Action: - Upon identification, the DON (Director	

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F 883	Continued From page 20 determined that the facility failed to ensure documentation in the resident's medical record of the information provided regarding the benefits and risks of NJ Exec Order 26.4b1 and the administration or the NJ Exec Order of the NJ Exec Order 26 specifically the US FOIA (B) (6) The deficient practice was identified for 1 of 5 resident's reviewed for NJ Exec Order 26.4b1 (Resident #45). This deficient practice was evidenced by the following: According to the Admission Record, Resident #45 was admitted to the facility with diagnoses including but not limited to: NJ ex order 26.4b1 A Review of Resident #45's admission Minimum Data Set (MDS) an assessment tool used to facilitate care, dated NJ ex order 26.4b1 revealed a Brief Interview for Mental status score of NJ ex order 2, indicating Resident #45 was NJ ex order 26.4b1 Section NJ ex order 26 indicated Resident #45's NJ ex order 26.4b1 The MDS further revealed that the reason the NJ ex order 26.4b1 was not assessed. During an interview with the surveyor on 06/27/2024 at 09:32 AM, the US FOIA (B) (6) said they had requested NJ Ex files from NJ Ex Order 26.4(b)(1) that morning. The facility could not produce a NJ Exec Order 26 or NJ Exec Order 2 form for the NJ ex order 26.4b1. During an interview with the surveyor on NJ ex order 26.4b1 at 12:33 PM, The US FOIA (B) stated, "yes"	F 883	of Nursing) and the Infection Preventionist spoke with resident #45, on US FOIA (B) (6), who is alert and oriented to ascertain whether or not he would like to receive the Influenza immunization. Resident stated he previously received the vaccination prior to admission and declined to have the immunization administered at the facility. - The Infection Preventionist updated the Decliniation of Influenza Vaccination Form on 6/27/24 based on the residents preference. - The DON educated the U.S. FOIA (b) (6) on 6/27/24 as to the importance of assuring all resident immunization documentation and forms are completed timely. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the ptoential to affect all residents 3. Measure put in place: - The DON/Designee initiated education to all licensed clinical staff beginning on 6/28/24 and was completed on 7/1/24 as to the importance of assuring all resident immunication documentation status and/or refusals are completed timely. - The infection preventionist will do a weekly audit of 10% of residents (both new admissions and current residents)to assure immunication documentation is completed timely. 4. How will these actions be measured	

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	315297	A. BUILDING _____ B. WING _____	C 06/28/2024

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(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 883	Continued From page 21 when asked if Resident #45's NJ Exec Order 26.4b1 should have been assessed on admission. A review of a facility provided policy titled "Influenza Vaccine", revealed under the "Policy Interpretation and Implementation" section, that "1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized." A review of a facility provided policy titled "Vaccination of Residents" revealed under the "Policy Interpretation and Implementation" section, that " 3. All new Residents shall be assessed for current vaccination status upon admission." N.J.A.C. 8:39-19.4 (h)	F 883	- The Infection Preventionist and/or designee and/or Designee will report the results of the weekly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060419	A. BUILDING: _____ B. WING _____	C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

(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 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: Complaint #'s NJ 160674 and NJ 165750 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for day, evening, and night shifts as mandated by the State of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1. Corrective Action: - Staffing Coordinator was educated on the New Jersey State Staffing ratio requirements on 7/9/24. - Efforts to hire facility staff will continue until there is adequate staff to meet the minimum staff to resident ratios. Until that time, the facility will use staffing agencies and offer additional shifts to current staff with bonuses as required. - Facility Administrator worked and will continue to work with Human Resources, as required, to secure additional staffing contracts. Interdisciplinary tem met on 7/9/24 to discuss recruitment and retention interventions	8/12/24

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

Electronically Signed | 07/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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 CNA and perform CNA duties. 1. For the 3 weeks of Complaint staffing from 12/25/2022 to 01/14/2023, the facility was deficient in CNA staffing for residents on 19 of 21-day shifts and deficient in CNAs to total staff on 6 of 21 evening shifts as follows: -12/25/22 had 2 CNAs for 53 residents on the day shift, required at least 7 CNAs. -12/26/22 had 3 CNAs for 53 residents on the day shift, required at least 7 CNAs. -12/28/22 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -12/29/22 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -12/30/22 had 4 CNAs for 52 residents on the day shift, required at least 6 CNAs. -12/31/22 had 3 CNAs for 52 residents on the day shift, required at least 6 CNAs. -01/01/23 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs. -01/01/23 had 2 CNAs to 6 total staff on the	S 560	2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the ptoential to affect all residents 3. Measure put in place: - Weekly recruitment, retention and employee appreciatio meeting was initiated and will be led by the Director of Human Resources and/or Designee - Hiring and recruiment efforts including pay for experience, online job listings, job fairs, shift differentials and referral bonsuses are being utilized to continue to be competitive in the market place. - Focus on retention efforts include, but are not liited to incentive programs, career grwoth and educational training opportunities and employee morale incentives. - The facility administrator and/or designee will continue to track and document all recruitment and retention efforts weekly. - The administrator, Director of Nursing and/or designee will review staffing schedules weekly to ensure adequate staff for all shifts. 4. How will these actions be measured - The results of the weekly recruitment and retention and staffing audits, will be submitted to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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S 560	Continued From page 2 evening shift, required at least 3 CNAs. -01/02/23 had 3 CNAs for 46 residents on the day shift, required at least 6 CNAs. -01/03/23 had 5 CNAs for 46 residents on the day shift, required at least 6 CNAs. -01/03/23 had 4 CNAs to 10 total staff on the evening shift, required at least 5 CNAs. -01/05/23 had 5 CNAs for 46 residents on the day shift, required at least 6 CNAs. -01/05/23 had 4 CNAs to 10 total staff on the evening shift, required at least 5 CNAs. -01/06/23 had 5 CNAs for 46 residents on the day shift, required at least 6 CNAs. -01/06/23 had 3 CNAs to 9 total staff on the evening shift, required at least 4 CNAs. -01/07/23 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. -01/08/23 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs. -01/09/23 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs. -01/09/23 had 2 CNAs to 6 total staff on the evening shift, required at least 3 CNAs. -01/10/23 had 4 CNAs for 45 residents on the day shift, required at least 6 CNAs. -01/10/23 had 3 CNAs to 9 total staff on the evening shift, required at least 4 CNAs. -01/11/23 had 3 CNAs for 45 residents on the day shift, required at least 6 CNAs. -01/12/23 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs. -01/13/23 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs. -01/14 23 had 4 CNAs for 46 residents on the day shift, required at least 6 CNAs. 2. For the 2 weeks of Complaint staffing from 07/02/2023 to 07/15/2023, the facility was deficient in CNA staffing for residents on 10 of	S 560		

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S 560	Continued From page 3 14-day shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -07/02/23 had 3 CNAs for 51 residents on the day shift, required at least 6 CNAs. -07/02/23 had 2 total staff for 51 residents on the overnight shift, required at least 4 total staff. -07/05/23 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -07/06/23 had 4 CNAs for 49 residents on the day shift, required at least 6 CNAs. -07/07/23 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs. -07/08/23 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. -07/08/23 had 3 CNAs to 8 total staff on the evening shift, required at least 4 CNAs. -07/09/23 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs. -07/10/23 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs. -07/11/23 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs. -07/12/23 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs. -07/14/23 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. 3. For the 2 weeks of staffing prior to survey from 06/09/2024 to 06/22/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -06/09/24 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -06/10/24 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -06/11/24 had 5 CNAs for 48 residents on the day	S 560		

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S 560	Continued From page 4	S 560		

shift, required at least 6 CNAs.
-06/12/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs.
-06/13/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs.
-06/14/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs.
-06/15/24 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs.

-06/16/24 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs.
-06/17/24 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs.
-06/18/24 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs.
-06/19/24 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs.
-06/20/24 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs.
-06/21/24 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs.
-06/22/24 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs.

On 06/25/2024 at 10:32 AM, the surveyor was in the nursing unit office and reviewed the staffing assignements. There were four CNAs scheduled to work with a census of 56. The Licensed Practical Nurse (LPN) Unit Manager was present and stated that only four CNAs were scheduled. The LPN Unit Manager stated she was unaware of the minimum staffing ratios.

On 06/26/2024 at 9:58 AM, during a Resident Council meeting conducted by a surveyor, there were five residents present and it was noted that the residents informed the surveyor that the facility was short staffed on weekends a nd holidays. The residents reported that there may

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S 560	Continued From page 5 only be two CNAs on Saturdays and Sundays. On 06/27/2024 at 8:50 AM, during an interview with the surveyor, one CNA stated that he had worked at the facility for about 7 months and that "for the most part" staffing is ok but "people sometimes call out" and that "mostly" you can finish your assignment. On 06/27/2024 at 9:02 AM, the Staffing Coordinator stated that the ratio for CNA to resident care was 1 CNA to eight residents on day shift; 1 CNA to 10 residents on evening shift; and 1 CNA to 14 residents on the night shift. The Staffing Coordinator stated that "we try but don't always" meet the minimum staffing ratios. She stated there may be call outs and that the facility would try to get the staff to stay or to use Agency staff.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315297 Y1	A. Building B. Wing Y2	8/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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 F0638	Correction	ID Prefix F0656	Correction	ID Prefix F0658	Correction
Reg. # 483.20(c)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	08/12/2024	LSC	08/12/2024	LSC	08/12/2024
ID Prefix F0755	Correction	ID Prefix F0812	Correction	ID Prefix F0883	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	08/12/2024	LSC	08/12/2024	LSC	08/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/28/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060419 Y1	A. Building B. Wing Y2	8/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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 08/12/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/28/2024	☐ 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
	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

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K 000	INITIAL COMMENTS LIFE SAFETY CODE 101:2012 THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R. The facility is currently named: Allegria at the Fountains and soon to be named: At the Fountains in the near future. The areas observed were the building utilities, kitchen, laundry & skilled nursing wing with resident rooms: 101 to 112, 201 to 208 and 301 to 312. The 301 to 312 wing leads into the assisted living wing of the facility. The interior diesel 125 KW generator does approximately 30% of the building as per the Maintenace Director. The building utilizes an electric fire pump to support the fire sprinkler system. The building is Type II unprotected construction. The facility has 60 LTC licensed beds and currently is occupying 54 at entrance.	K 000		
K 222 SS=D	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	K 222		8/12/24

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

Electronically Signed | 07/12/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 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 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	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

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K 222	Continued From page 2 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 interviews on 6/25/24, in the presence of the U.S. FOIA (b) (6) [redacted],). it was determined that the facility failed to ensure that egress doors equipped with a delayed 15-second egress feature were labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1. This deficient practice was identified for 1 of 6 exit/egress discharge doors observed and had the potential to affect 30 residents who resided at the facility and was evidenced by the following: At 10:21 AM, the surveyor and U.S. FOIA (b) (6) [redacted] observed that the exit/egress door in the day/dining room was provided with a 15-second delayed door open device, it was observed that the door, did not have a sign indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds." An interview was conducted with the U.S. FOIA (b) (6) [redacted], during the observations. The U.S. FO[redacted] indicated he was not sure why the delayed egress device door device, did not have a sign indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds." The U.S. FOIA (b) (6) was notified of the findings at	K 222	1. Corrective Action: - Upon identification, a new sign was ordered and installed to the one (1) identified door that did not have signage, upon delivery to the facility on 7/29/24 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect 30 residents 3. Measure put in place: - A monthly audit will be conducted by the Maintenance Director and/or designee to assure that exit/egress doors are labeled with a sign that reads "Push until alarm sounds, door can be opened in 15-seconds." 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

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K 222	Continued From page 3 the Life Safety Code exit conference on 6/26/24. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews conducted on 6/25/24, in the presence of the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. This deficient practice was observed in 2 of 2 areas and had the potential to affect 22 residents who resided at the facility and was evidenced by the following: 1. At 12:23 PM, the surveyor, in the presence of the U.S. FOI [redacted] observed in the occupied 200 wing lounge, that 3-wall light switches shut-off all 7-ceiling light fixtures. 2. At 12:43 PM, the surveyor, in the presence of the U.S. FOI [redacted] observed in the South/North, day/dining room that 3-wall light switches shutoff all 5-light fixtures.	K 281	1. Corrective Action: 1. Upon identification, the 200 wing lounge 3 wall light switches have been repaired and are fully functioning, shutting off all 7 ceiling light fixtures. A new control board and battery were updated and installed in the boiler/generator room. 2. Upon identification, the South and North day/dining room 3 wall light switches have now been repaired and are fully functioning. All 5 light switches are shut off. A new control board and battery were updated and installed in the boiler/generator room. - The Independent Alarm contract was updated for yearly Battery Inspection. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect 22 residents	8/12/24

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K 281	Continued From page 4 The areas were not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The [redacted] confirmed the findings at the time of observations. The [redacted] was informed of these findings at the Life Safety Code survey exit conference on 6/26/24. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	3. Measure put in place: - A monthly audit will be conducted by the Maintenance Director and/or Designee to ensure that the emergency lighting is fully functional in the following areas: the 200 wing lounge 3 wall light switches and the South/North, day/dining room, and the 3 wall light switches. 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/25/24, in the presence of the [redacted], it was determined that the facility failed to maintain a battery back-up emergency light above the interior emergency generator and fire pump transfer switches, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1.	K 291	1. Corrective Action: - Upon identification, the 2 identified "bad batteries" were replaced and confirmed to be operable. - The [redacted] was educated on 6/27/24, by the administrator on the requirement to have monthly or 90-minute annual test inspection log and assure the batteries in the emergency light were	8/12/24

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

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K 291	Continued From page 5 This deficient practice was identified for 2 of 2 interior transfer switches and could affect all residents residing in the facility and was evidenced by the following: 1). At 10:55 AM, the surveyor and the US FOIA observed in the lower level electrical room where the generator and transfer switch were located, that the room was equipped with battery back-up emergency lighting of at least a 90 minute duration and was provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 but when the US FOIA tested the emergency light, it did not activate due to a bad battery. 2). At 11:15 AM, the surveyor and the US FOIA observed in the lower level electric fire pump location, that the transfer switch area, was not equipped with battery back-up emergency lighting of at least a 90 minute duration and was provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 but when the US FOIA tested the emergency light, it did not activate due to a bad battery. The US FOIA (B) (6) indicated during an interview, that the emergency lighting over the 2-transfer switches did not activate when tested due to a bad battery, he stated he currently did not have a monthly or 90 minute annual test inspection log to provide to the surveyor at this time. The US FOIA (B) (6) was informed of the finding at the Life Safety Code exit on 6/26/24. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, section 7.9	K 291	operable. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents 3. Measure put in place: - A monthly audit will be conducted by the Maintenance Director and/or Designee to assure the battery back up emergency lighting is operable and activates when tested 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

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K 324	Continued From page 6	K 324		
K 324 SS=D	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 by: Based on observation, interview and record review, on 6/25/24, in the presence of the US FOIA (B) (6) it was determined that the facility failed to ensure that 1 of 1 kitchen class K fire extinguishers were inspected monthly in accordance with NFPA 96 and NFPA 10. The deficient practice was evidenced by the following:	K 324	1. Corrective Action: - Upon identification, the class K fire extinguisher was immediately inspected with documentation placed on the monthly inspection tag. - The US FOIA (B) (6) was educated on 6/27/24 to the importance to maintain monthly inpsection of the class K fire	8/12/24

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

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K 324	Continued From page 7 At 11:27 AM, the surveyor, observed in the facility kitchen that the portable class K fire extinguisher was last inspected in September 2023. The last 10 inspections lacked documentation of monthly "quick check" or inspections as required by NFPA 96. At that time, the surveyor interviewed the US FOIA who confirmed that the class K- fire extinguisher monthly inspection tags were not completed since September 2023. The US FOIA (B) (6) was informed of the finding at the Life Safety Code exit conference on 6/26/24. NJAC 8:39-31.2(e) NFPA 96 and NFPA 10.	K 324	extinguisher 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents 3. Measure put in place: - A monthly audit will be conducted by the Maintenance Director and/or Designee to assure that the class K fire extinguisher is inspected with proper documentation 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 345		8/12/24

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

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K 345	Continued From page 8 Based on observation, interview, and document review on 6/25/24, in the presence of the US FOIA (B) (6), it was determined that the facility failed to ensure: a.) that their fire alarm system was inspected on a semi-annual basis in accordance with NFPA 70 and 72. b.) smoke detection sensitivity testing was not completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The deficient practice was identified for 1 of 1 inspection reports and could affect all residents residing in the facility and was evidenced by the following: a.) At approximately 09:50 AM, the surveyor reviewed all documentation from the fire alarm vendor. The document indicated date of inspection: 5/19/23 only and was not performed on a semi-annual basis in accordance with NFPA 70 and 72. The fire alarm system has sealed lead acid batteries and requires a semi-annual inspection. The US FOIA could not confirm it the fire alarm system was inspected on a semi-annual basis and he could not provide any further documentation for review. b.) At 10:15 AM, the surveyor and US FOIA confirmed that no fire alarm smoke detector sensitivity report was provided in the Life Safety Code Inspection book. The last semi-annual fire alarm inspection report was dated: 5/19/23, and did not indicate when the last smoke detector sensitivity test was conducted in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2.	K 345	1. Corrective Action: - Upon identification, the fire alarm vendor agreement was updated to include semi-annual inspections, inclusive of smoke detector inspections. - Upon identification, the fire alarm vendor agreement was updated to include semi-annual testing of the fire alarm smoke detector sensitivity testing/report -Testing of the fire alarm testing was completed on 7/29/24 and 7/30/24. - Testing of the fire alarm testing was completed on 7/29/24 and 7/30/24. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents 3. Measure put in place: - A semi- annual audit will be conducted by the Maintenance Director and/or designee to assure that semi- annual testing of the fire system occurs inclusive of sensitivity testing and smoke detector testing. 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the semi-annual audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

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K 345	Continued From page 9 The US FOIA was interviewed during the document review, where he stated currently, that no smoke detector sensitivity report was performed and he could not provide any documentation on when it was last conducted. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code Exit conference on 6/26/24. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345		
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 6/26/24, in the presence of the US FOIA (B) (6), it was determined that the facility failed to ensure a testing and maintenance of battery-operated smoke detectors in resident rooms, in an existing structure. This deficient practice was evidenced for 32 of 32 observed battery-operated smoke detectors, observed in resident rooms and could affect all residents residing in the facility and was evidenced by the following: The US FOIA stated that resident rooms had battery operated smoke detectors, but could not provide	K 347	1. Corrective Action: - On 6/27/24, the Administrator re-educated the US FOIA (B) (6) on the importance of documenting the testing, maintenance, and battery replacement for resident room smoke detectors - Resident room smoke detectors were audited by the Maintenance Director on June 27, 2024 no other resident room smoke detectors were found to be out of compliance or required replacement. - Resident room smoke detector monthly check was completed on 7/8/24. no other resident room smoke detectors were found to be out of compliance or required	8/12/24

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

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K 347	Continued From page 10 a monthly testing log. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance and testing document, for the testing of the detectors for the make, model, installation date, type of battery required to power the smoke detector. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 6/26/24. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347	replacement. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect 32 residents 3. Measure put in place: - A monthly testing log was implemented for the testing for the detectors for the make, model, installation date, type of battery required to power the smoke detector. - The Maintenance Director and/or designee will do a random monthly audit of 10% of resident room smoke detectors 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are	K 353		8/12/24

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

(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 353	Continued From page 11 maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview conducted on 6/26/24, in the presence of the[redacted] a). it was determined that the facility failed to ensure that their automatic sprinkler system was inspected/tested at the required fifth-year interval according to NFPA 25. b). it was determined that the facility failed to ensure the fire sprinkler system was inspected quarterly as per NFPA 13 & 25. c). it was determined that the electric fire pump monthly flow (churn test) was not performed as per NFPA 25. This deficient practice was identified for 2 of 2 fire sprinkler systems observed in the facility and could affect all residents residing in the facility and was evidenced by the following: a). At 10:30 AM, the surveyor reviewed the facility's annual automatic sprinkler system inspection report's dated: 9/19/23, The report did not indicated when the last fifth-year internal obstruction investigation of the pipe was completed.	K 353	1. Corrective Action: - On 6/28/24, the [redacted] was educated on the importance of ensuring all inspections are performed timely according to regulatory and life safety requirements. - On 6/21/24, the Maintenance Director was provided with an inspection work sheet to track and document completion of all required regulatory inpsections. - The sprinkler contract was revised to include a quartley, semi-annul, quarterly, and annual inspection, an annual fifth year interval inspection. - Upon identification, the Maintenance Director scheduled the Sprinkler System vendor to perform the last fifth-year interval inspection, set to occur on 7/17/24 -Upon identification, the Maintenance Director scheduled the Sprinkler System vendor to perform the quarterly fire sprinkler inspection, set to occur on 7/17/24. Upon identification, the Maintenance Director scheduled the electric fire pump	

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 12 An interview was conducted with the US FOIA during the document review where he stated, he was not sure when the last 5-year internal investigation of the pipe was conducted and could not provide any updated documentation. b). At 11:10 AM, during the surveyors document review of the fire sprinkler quarterly inspection report dated: 6/21/24 (2nd quarter of 2024) & 9/19/23 (4th quarter of 2023). It was observed that 2 of 4 quarterly inspection documents were missing: 1st quarter of 2024 and 3rd quarter of 2023. The US FOIA (B) (6) indicated the missing inspections was not performed and he stated that it was most likely due to a scheduling issue with the facility vendor. c). At 11:32 AM, the US FOIA (B) (6) was asked to provide a monthly flow (churn) test inspection document. The US FOIA (B) (6) indicated he was not aware of this requirement and could not provide any further documentation. The Annual fire pump inspection report from the facility vendor dated: 9/19/23 did not indicate any fire pump deficiencies. The US FOIA (B) (6) was informed of the finding at the Life Safety Code exit conference on 6/26/24. NFPA (National Fire Protection Association) 25 requires an internal inspection of the fire sprinkler system piping every 5 years, this is to be conducted to inspect for the "presence of foreign organic material" foreign materials can cause obstructions to pipe and sprinklers. NFPA 13, 25	K 353	monthly flow test to occur on 8/1/24 and 8/2/24 and monthly there after. - Upon identification, the US FOIA (B) (6) was educated to the regulatory requirement of facillitating a monthly flow (chum) inspection and scheduled the vendor for inspection on 7/17/24. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents 3. Measure put in place: - A monthly audit of sprinkler system inpsections will be conducted by the maintenance director and/or designee to ensure inspections are completed timely. 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

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K 353	Continued From page 13 NJAC 8:39-31.2(e)	K 353		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, and interview on 06/25/2024, in the presence of U.S. FOIA (b) (6) [redacted], it was determined facility failed to ensure that corridors walls were constructed to resist the passage of smoke in accordance with the requirement of NFPA 101,2012 Edition, Section 19.3.6.2 and 19.3.2.7. This deficient practice was evidenced for 1 of 8 corridor walls observed could affect all residents residing at the facility by the following:	K 362	1. Corrective Action: - On 6/28/24, a fire rated plexi-glass panel was installed between the 3 panel window. Fire rating of the window was confirmed for 20 minute fire rating. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents	8/12/24

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

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K 362	Continued From page 14 At 12:29 PM, the surveyor and U.S. FOIA (b) (6) observed in the exit/egress corridor by the 200 nurse station, that a gray 3-panel window was missing the center glass, approximately 3' x 2'. The left and right glass panels were not identified as fire rated glass. The open center panel would allow the transfer of smoke from the room to the exit/egress corridor. The US FOIA indicated that he was not sure why the center glass panel was missing and stated the 2-side glass panels did not have a fire rating on the glass, during the observation. The US FOIA (B) (6) was informed of the findings at the Life Safety Code exit conference on 06/26/2024. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition: 8.3.4.1 Opening Protectives	K 362	3. Measure put in place: - The Maintenance Director and/or Designee will perform a monthly audit to assure that the plexi-glass panel remains in place. 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that	K 363		8/12/24

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	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

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ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

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K 363	Continued From page 15 do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/25/24, in the presence of the U.S. FOIA (b) (6) [redacted] it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 12 of 32 resident rooms observed and had the potential to affect 32 residents who resided at the facility and was evidenced by the following:	K 363	1. Corrective Action: - Upon identification, the following doors were measured and the vendor was at the facility on 7/10/24 to facilitate the order and replacement of doors- [redacted] and [redacted] An additional 4 doors were identified on the 6/28/24 audit and were also measured and ordered. - On 6/28/24, an audit of resident room doors was completed to identify any additional doors that would require replacement and/or repair (see the first	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. BUILDING **01** B. WING _____	**06/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	**114 HAYES MILL ROAD** **ATCO, NJ 08004**

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K 363	Continued From page 16 During the building tour, conducted from 9:15 AM to 12:45 PM, the surveyor, in the presence of the [U.S. FOI] toured the facility and observed the following compromised resident room doors in the following areas: # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # [NJ Ex O] rubs onto the door frame. # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # [NJ Ex O] the top of door was warped, leaving a gap that was not smoke resistant. # 111 the top of door was warped, leaving a gap that was not smoke resistant. At the time of observations, the surveyor interviewed the US FOIA (B) (6), who confirmed the above findings. The US FOIA (B) (6) was informed of the findings at the Life Safety Code exit conference on 06/26/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6,	K 363	response). 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect all residents 3. Measure put in place: - Maintenance Director and/or designee will perform a monthly audit of resident room doors to assure the doors are able to resist the passage of smoke. 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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K 363	Continued From page 17 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 6/25/24, in the presence of the US FOIA (B) (6)), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets, annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was identified for 20 of 32 resident rooms observed and had the potential to affect 40	K 914	1. Corrective Action: - Upon identification, the Maintenance Director contacted the electrician to schedule the annual electrical inspection. The inspection will take place on 7/12/24 and functionality testing for electrical receptacles in resident rooms that had non hospital grade outlets were tested for grounding, polarity and blad tension. - On 6/28/24, the US FOIA (B) (6)	8/12/24

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K 914	Continued From page 18 residents who resided at the facility and was evidenced by the following: During record review on 5/16/24, the surveyor reviewed documentation provided by the US FOIA which included the facility's electrical inspection report, dated 10/31/22, from the facility's vendor, which had not indicated that the rooms with non-hospital grade electrical outlets were annually inspected for grounding, polarity, and blade tension in accordance with NFPA 99. The last electrical inspection was conducted over 19 months ago. In an interview during the tour observations, the US FOIA stated that the annual electrical inspection was not conducted in 2023 and he would notify them ASAP, and have the non-hospital grade outlets tested for grounding, polarity, and blade tension in accordance with NFPA 99. The US FOIA (B) (6) was informed of the findings at the Life Safety Code exit conference on 6/26/24. NJAC 8:39-31.2(e) NFPA 99	K 914	was educated to the importance of assuring the annual electrical inpsectin is scheduled and perfomred. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: - The deficient practice has the potential to affect 40 residents 3. Measure put in place: - An annual audit to assure that the annual electrical inspection was scheduled and performed will be performed by the Administrator and/or designee 4. How will these actions be measured - The Administrator and/or Designee will report the results of the annual audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		8/12/24

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K 918	Continued From page 19 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, interview and record review on 6/26/24, in the presence of the US FOIA (B) (6)), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 & 110 for emergency electrical generator systems. This deficient practice was evidenced for 1 of 1 generators and had the potential to affect 54 residents residing in the facility and was evidenced by the following:	K 918	1. Corrective Action: - On 6/28/24, the US FOIA (B) (6) was educated on the requirement to assure documented certification that the generator would start and transfer power to the building within ten seconds as well as to assure a monthly load test is performed and documented. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:	

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K 918	Continued From page 20 At 9:44 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds for 12 of 12 months and it was noted that currently the US FOIA was not conducting a monthly load test as per NFPA 99 & 110, at this time and he could not produce any further documentation. The US FOIA (B) (6) was informed of the findings at the Life Safety Code exit conference on 6/26/24. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	- The deficient practice has the potential to affect all residents 3. Measure put in place: - A monthly audit will be performed by the Maintenance Director and/or Designee to assure that documented certification and monthly load test are being peformed and documented. 4. How will these actions be measured - The Maintenance Director and/or Designee will report the results of the monthly audit, on a monthly basis to the Quality Assurance and Process Improvement Committee (QAPI) meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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
315297 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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	08/12/2024	LSC K0281	08/12/2024	LSC K0291	08/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	08/12/2024	LSC K0345	08/12/2024	LSC K0347	08/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	08/12/2024	LSC K0362	08/12/2024	LSC K0363	08/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0914	08/12/2024	LSC K0918	08/12/2024	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	
6/28/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO