STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING ______ B. WING ______	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE BRIDGETON, NJ 08302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS STANDARD SURVEY: 3/28/23 CENSUS: 97 SAMPLE SIZE: 21+3 COMPLAINT # NJ 157626, NJ 161370, NJ 161436 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		4/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/14/2023

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

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F 584	Continued From page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was identified that the facility failed to provide residents with a clean, home like environment. This deficient practice was identified on one of three nursing units, (the AB unit) and for two (2) of 21 resident's, (Resident #45 and Resident #48) reviewed for environment and was evidenced by the following: 1.) On 03/20/23 at 10:23 AM, the surveyor observed Resident #48 laying in bed in his/her	F 584	F584 1. The NJ Ex Order 26. 4B1 in resident # 48 □s room was cleaned as well as the floors under the bed. The privacy curtains in resident # 48 as well as the privacy curtain in resident # 45□s room where changed. The rest of the room floors, NJ Ex Order 26. 4B1 and privacy curtains throughout the facility were thoroughly checked and cleaned, curtains changed where necessary.	

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F 584 Continued From page 2

room. The surveyor further observed a NJ Ex Order [redacted] in the resident's room. The bottom of the NJ Ex Order 26. 4B1 had caked, tan material imbedded on it. The surveyor saw that the resident's beige colored privacy curtain was pushed back towards the wall by the head of the resident's bed and had a large brown, circular stain on it. At that time the surveyor attempted to interview Resident #48, but the resident was NJ Exec Order 26.4b1.

On 03/21/23 at 11:05 AM, the surveyor observed Resident #48 in his/her room seated in a reclining chair next to the bed. The surveyor further observed NJ Ex O NJ Exec Order 26.4 on the bottom of the resident's NJ Ex Order 26. 4B1 and brown stains on the privacy curtain. The surveyor looked underneath the resident's bed and saw grey colored dust and debris.

On 03/22/23 at 10:42 AM, the surveyor entered Resident #48's room. The resident was not in his/her room at the time of the surveyor's observation. The surveyor observed the same caked on NJ Ex O material on the bottom of the residents NJ Ex Order 26. 4B1. The surveyor saw the same brown colored stain on the resident's privacy curtain and further observed dust and debris underneath the resident's bed.

On 03/22/23 at 10:44 AM, the surveyor entered Resident #48's room with the AB unit Housekeeper (HK) who stated that the bottom of the NJ Ex Order 26. 4B1, "looked rusted and had tan stuff on it that was probably food". The HK further observed the dust and debris underneath the resident's bed and stated that she didn't work yesterday, but underneath the resident's bed should be cleaned daily by a housekeeping staff member. The HK

F 584

2. These deficient practices affect all residents in the building, due to the fact that an unsanitary environment creates an infection control problem, in addition to affecting a proper home like environment for the residents.

3. The housekeeping, staff were in-serviced that it is their responsibility to clean the feeding poles and the floors in the rooms as well as to inspect the privacy curtains and report any dirty curtains to be changed. The nursing staff as well as the maintenance personnel were in-serviced to report any dirty poles and privacy curtains dirty areas in the rooms that they observe, the Housekeeping Director. This communication is important as to maintain the cleanliness of the resident rooms and environment.

4. The Housekeeping Director, as well as the Administrator and quality assurance personnel will inspect the resident rooms daily for one quarter to assure that these deficient practices do not reoccur. All findings will be reported to the quality assurance committee on a monthly basis.

5. Date of completion April 28, 2023.

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F 584	Continued From page 3 told the surveyor that she noticed the stain on the resident's privacy curtain and sometimes they would change and wash them, but the stains would still be there. The HK further stated that the Porters were responsible for changing the resident's privacy curtain daily and the Certified Nursing Aides (CNA)s were responsible for cleaning the bottom of the NJ Ex Order 26. 4B1 in the resident's room. On 03/22/23 at 10:51 AM, the surveyor entered the room with the resident's CNA#5 who stated that the HK was responsible for cleaning the NJ Ex O , the privacy curtains in the resident's room and cleaning the floor underneath the resident's bed. On 03/22/23 at 11:11 AM, the surveyor entered Resident #48's room with the Licensed Practical Nurse/Infection Preventionist (LPN/IP) who stated that she observed the stains on the resident's privacy curtain and, "they would be fixed immediately". The LPN/IP further stated that the HK staff were responsible for cleaning the NJ Ex O and underneath the bed in the resident's room. 2. On 03/20/23 at 11:07 AM, the surveyor observed Resident #45 in his/her room. The privacy curtains were closed shut between the two roommates who resided in the room. The surveyor observed brown/tan-colored stains throughout the resident's whitish-beige privacy curtain. On 03/21/23 at 11:11 AM, the surveyor observed the same brown-tan colored stains on the privacy curtain in the resident's room.	F 584		

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F 584	Continued From page 4	F 584		

On 03/22/23 at 10:38 AM, the surveyor observed Resident #45 laying in bed in his/her room. The surveyor observed the same brown-tan stains on the privacy curtain in the resident's room. At that time, the resident pointed to a bottom portion of the privacy curtain and stated that there was a red stain that he/she noticed on the curtain, and he/she had noticed the brown-tan colored stains before as well. The resident told the surveyor that he/she had asked staff working at the facility to change it, "but they never got around to it". The resident further told the surveyor that he/she didn't ask the staff again because he/she didn't want to bother them.

On 03/22/23 at 10:48 AM, the surveyor entered the resident's room with the AB unit HK who stated that the privacy curtains in the resident's room, "had stains all over them and needed to be changed". The HK further stated that the curtains could have been old, washed, and has the stains embedded in them. The HK told the surveyor that if that was the case, "they should buy new curtains for these residents."

On 03/22/23 at 11:08 AM, the surveyor entered Resident #45's room with the LPN/IP who stated that the privacy curtains were cleaned on a scheduled basis when the resident's room was assigned to be carbolized (deep cleaning). She further stated that the privacy curtains could also be cleaned as needed.

On 03/22/23 at 11:16 AM, the surveyor interviewed the AB unit Licensed Practical Nurse/Unit Manger (LPN/UM)#1 who stated that the CNAs were responsible for making sure the residents overbed and end tables were clean. LPN/UM#1 further stated that the HK department

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F 584	Continued From page 5 was responsible for cleaning the floors in the resident's rooms and changing the privacy curtains. On 03/22/23 at 11:20 AM, the surveyor interviewed the facility's Housekeeping Director (HKD) who stated that the CNAs were responsible for cleaning the bottom of the NJ Ex O [redacted] in the resident's rooms. The HKD told the surveyor that the HK staff were responsible for cleaning the floors in the resident's rooms and underneath the resident's beds. The surveyor asked the HKD about the stains on the privacy curtains and the HKD stated that the Maintenance and Housekeeping Department were both responsible for the changing the privacy curtains. The HKD stated that the resident's rooms were checked daily for cleanliness and the privacy curtains could be changed as needed. The HKD told the surveyor that the facility had a carbonization schedule, which was a deep cleaning, and the privacy curtains were changed at that time. On 03/23/23 at 12:10 PM, the surveyor interviewed the facility's Maintenance Director (MD) who stated that the Housekeeping Department was responsible for cleaning the floors and changing the privacy curtains n the resident's rooms. The MD stated that he was unsure who cleaned the NJ Ex Order 26. 4B1, but if anyone in nursing or housekeeping saw that the NJ Ex Order 26. 4B1 were dirty, they should have cleaned it. On 03/28/23 at 10:37 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the nurses were responsible for cleaning the NJ Ex Order 26. 4B1 if there was a spill and they could also contact the HK staff if	F 584		

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F 584	Continued From page 6	F 584		

additional cleaning was needed. The ADON told the surveyor that ultimately it was housekeeping's job to maintain the cleanliness of the resident's rooms and the housekeeper's would changed the privacy curtains weekly. The ADON further stated that if staff identified in rounds that the privacy curtain needed to be changed, they would change them at that time.

A review of the facility's Feeding Pole Policy dated 01/01/23 indicated, "It is the policy of the facility to provide feeding poles to the residents that need tube feeding and other appropriate needs. The nursing staff will provide the tube feeding pole and maintain it in a clean manner. The nursing staff, as well as the housekeeper cleaning that room will monitor these polls to ensure that they are not dirty and clean them when necessary. The housekeeping staff will clean the poles on a daily basis while they are cleaning the rooms. The housekeeping Director will monitor the cleanliness of these polls."

A review of the facility's Privacy Curtain Policy dated 01/01/23 indicated, "It is the policy of this facility to ensure that all residents have privacy in their rooms by providing clean privacy curtains to every resident. The curtains must provide complete privacy all around the resident's area. The housekeeping department will make daily rounds to inspect these curtains, in order to assure that they are clean and not damaged. The nursing staff departments, as well as the housekeeping staff are instructed to monitor the cleanliness of these curtains, and report to housekeeping when they are soiled stained or damaged cubical curtains. The housekeeping department will then bring a clean curtain to replace the soiled one so that at no time is there

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F 584	Continued From page 7 no privacy curtain around the bed. The Housekeeping Director will check all cubical curtains on monthly bases to ensure that policy is being followed." A review of the facility's Housekeeper Responsibilities dated 01/01/23 indicated, "It is the responsibility of each housekeeper to keep the resident's rooms, clean, and sanitary. The housekeeper will sweep and mop the room, as well as the resident bathrooms daily ... The housekeepers were instructed to report any damages or soiled curtains that they see in the room." A review of the facility's Housekeeping Directors Job Description dated 01/01/23 indicated that the Housekeeping Director would, "Do daily rounds throughout the facility, inspect the environment and share his findings with the employees and other departments." NJAC 8:38-31.4(a)(f)	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS- an assessment tool utilized to facilitate the management of care) for 2 of 21 residents reviewed (Residents #45 and #65).	F 641	F641 1. All residents PASRRS Levels were reviewed by Social worker and MDS coordinator and compared to MDS coding. 2. All residents have the potential to be affected by this deficiency practice of	4/28/23

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F 641	Continued From page 8 This deficient practice was evidenced by the following: 1. On 3/20/23 at 11:03 AM, the surveyor observed Resident #45 seated in his/her room eating breakfast. According to the Medical Record, Resident #45 was admitted with a diagnosis that included NJ Ex Order 26. 4B1 The surveyor reviewed the Pre-Admission Screening and Resident Review (PASRR) NJ Ex Order 26. 4B1 for Resident # 45. It reflected that the resident had a NJ Ex Order 26. 4B1 . The surveyor reviewed Resident #45's Significant Change in Status MDS dated NJ Ex Order 26. . Section NJ Ex Order 26. Preadmission Screening and Resident Review reflected that Resident #45 was currently NOT considered by the state NJ Ex Order 26. PASRR process to have NJ Ex Order 26. 4B1 and/or NJ Exec Order 26.4b1 . It also reflected that the resident had NJ Ex Order 26. 4B1 . On 3/27/23 at 10:24 AM, the surveyor interviewed the MDS Coordinator (MDSC)who stated that Resident #45's Significant Change in Status MDS dated NJ Ex Order 26. should have reflected that the resident was considered by the state NJ Ex Order 26. PASRR process to have NJ Ex Order 26. 4B1 and/or NJ Exec Order 26.4b1 . The MDSC acknowledged that she coded the MDS incorrectly. 2. On 3/21/23 at 10:42 AM, the surveyor observed Resident #65 in the main dining room	F 641	failing accurately complete the minimum data set (MDS- an assessment tool utilizing to facilitate the management of care). 3. The Director of Nursing will in-service social worker, MDS coordinator and Admission coordinator on filling PASRR documentation into residents charts, on admission and accurately complete MDS. 4. The DON or designee will monitor all admission PASRRS Levels I and II input and coding in MDS on a weekly basis for one quarter and will review MDS assessments annually. All finding will be reported to the quarterly assurance meeting. 5. Date of completion April 28, 2023.	

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F 641	Continued From page 9 engaged in a game of bingo. According to the Medical Record, Resident #65 was admitted to the facility with diagnoses which included, but were not limited to: NJ Ex Order 26. 4B1 . A review of Resident #65's PASRR revealed the resident had a NJ Exec Order 26.4 PASRR NJ Ex Order 26. 4B, dated NJ Ex Order 26. 4B1, and a PASRR NJ Ex Order 26. 4B, dated NJ Ex Order 26. 4B1, which reflected that the resident had a NJ Ex Order 26. 4B . The surveyor reviewed Resident #65's Annual MDS dated NJ Ex Order 26. 4B1. Section A1500 Preadmission Screening and Resident Review reflected that Resident #65 was currently NOT considered by the state NJ Ex Order 26. PASRR process to have NJ Ex Order 26. 4B and/or NJ Exec Order 26.4b1 On 3/27/23 at 10:24 AM, the surveyor interviewed the MDSC who acknowledged that Resident #65's Annual MDS Assessment, dated NJ Ex Order 26. 4B1, was coded incorrectly and stated, NJ Exec Order 26.4b1 " NJAC 8:39-27.1(a)	F 641		
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:	F 658		4/28/23

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F 658	Continued From page 10 Based on observation, interview, review of medical records, and review of other pertinent facility documentation, it was determined that the facility failed to provide necessary services, consistent with professional standards of clinical practice by not a.) performing NJ Ex Order 26. 4B1 for a resident that NJ Ex Order 26. 4B1 and b.) following facility policy and procedures. This deficient practice was identified for 1 of 4 residents (Resident # 28) reviewed for accidents and was evidenced by the following: Reference: New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "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, 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 task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 658	F658 1. Fall incident Report policy and Neurological check policy were reviewed and nurses were in-serviced on the policies and procedures by the Director of Nursing (DON). 2. All residents have the potential to be affected by this deficiency practice of failing to provide necessary services consistent with professional standards of clinical practice. 3. The Director of Nursing and the Assistant Director of Nursing (ADON) reviewed Fall incident Report and Neurological checks Policies. All nurses will be in-serviced on policies and procedures and how to initiate and perform neurological checks. 4. The DON and the ADON will be notified of the incident report immediately and all incident report will be reviewed within 24 hours for all proper documentation and assessment in a daily meeting on a daily basis. Policies will be reviewed yearly by the DON and employees will be in-serviced on yearly based and as needed. All findings will be reviewed with the quality assurance committee on a quarterly basis for a year. 5. Date of completion April 28, 2023.	

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According to Resident #28's Admission Face Sheet, Resident #28 was admitted to the facility with the diagnoses that included but was not limited to NJ Ex Order 26. 4B1 .

The annual Minimum Data Set (MDS-an assessment tool utilized to facilitate the management of care) dated NJ Ex Order 26. 4B1, indicated that the resident had NJ Ex Order 26. 4B1 and NJ Ex Order 26. 4B1 with NJ Exec Order 26.4b1. The MDS also reflected that the resident was NJ Exec Order 26.4b1

On 03/20/23 at 10:00 AM, during the initial tour, the surveyor observed the resident ambulating in the hallway. The Licensed Practical Nurse (LPN #3) on the unit was interviewed at that time and stated that the resident was NJ Exec Order 26.4b1. The surveyor attempted to interview the resident; however, the resident was NJ Exec Order 26.4b1 and continued to NJ Exec Order 26.4b1 .

The surveyor reviewed the facility Incident Report dated NJ Ex Order 26. 4B1 at 08:30 PM. The incident report indicated that Resident #28 was witnessed NJ Ex Order 26. in the breezeway. There was a witness that observed the resident NJ Ex Order 26. and NJ Exec Order 26.4b1 the resident was observed to have NJ Ex his/her NJ Ex Order. The report also reflected that the resident had NJ Exec Order 26.4b1.

The surveyor reviewed the untimed nurse's note (NN) dated NJ Ex Order 26. 4B1, which indicated that Resident #28 NJ Ex O and NJ Ex his/her NJ Ex Order. The NN reflected that the resident appeared to have had a NJ Ex Order 26. 4B and that NJ Exec Order 26.4b was noted during the assessment. The physician was notified, and the

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NAME OF PROVIDER OR SUPPLIER: SOUTH JERSEY EXTENDED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE: 99 MANHEIM AVENUE BRIDGETON, NJ 08302	

(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 658	Continued From page 12 resident was sent to the emergency room (ER) for further evaluation. There was no documentation that the nurse performed NJ Exec Order 26.4b1 during the assessment for the resident after the resident NJ Ex O and NJ Ex O his/her NJ Ex Order 2. The surveyor reviewed the NN dated NJ Ex Order 26. 4B1 at 03:40 AM, which indicated the resident had returned from the ER. There was no documentation in the NN that the resident had a NJ Ex Order 26. 4B1 after the resident returned from the hospital. The surveyor reviewed all the NN dated NJ Ex Order 26. 4B1 and there was no documentation that NJ Ex Order 26. 4B1 were performed after the resident returned from the hospital. The surveyor reviewed Resident #28's Medication Administration Record (MAR) and Treatment Administration Record (TAR). There was no documentation on the MAR or the TAR dated NJ Ex Order 26. 4B1 that NJ Ex Order 26. 4B1 were performed after the resident NJ Ex O and NJ Ex O his/her. On 03/21/23 at 12:38 PM, the surveyor interviewed the Certified Nursing Assistant (CNA #4) for the NJ Exec Order 26.4b who stated that she had been employed in the facility for approximately NJ Exec Order 26. She stated that she was familiar with Resident #28. She stated that the resident was NJ Exec Order 26.4b1 and was able to NJ Exec Order 26.4b1 but that the resident could not NJ Exec Order 26.4b1 She stated that the resident used to reside on NJ Exec Order 26 until about a NJ Ex Order 26. 4B1. CNA #4 stated that the resident was	F 658		

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F 658	Continued From page 13 moved because of his/her NJ Exec Order 26.4b1 and that NJ Exec was smaller unit where the resident was able to be monitored more closely. She also stated that the NJ Exec unit was locked and the only way the resident could leave the unit was if someone took him/her out of the unit. She stated that Resident #28 required complete to extensive assistance with activities of daily living (ADL's). She stated that the resident had experienced NJ Exec Order 26 or NJ Exec Order 26.4b1 since residing on NJ Exec Order 26.4. On 03/21/23 at 12:48 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #3) for the NJ Exec unit who stated that she had been employed in the facility for NJ Ex Order 26. 4b years. LPN #3 stated that Resident #28 was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. She stated that the resident took his/her medications whole with water and was NJ Exec Order 26.4b1 She stated that the resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 LPN #3 added that the resident had NJ Exec Order 26.4b1 at times and could become NJ Exec Order 26.4b1; however, it has been a while since the resident displayed any NJ Exec Order 26.4b1 behaviors. She explained that the resident had a NJ Ex Order 26. 4B1 and when they needed to rest, they would utilize the wheelchair to sit down. She continued to add that the resident did not like to rest and would continue to NJ Exec Order 26.4b and walk around the unit. She stated that the resident would sit and rest a bit but would get back up and walk. She stated that the facility added an intervention and provided the resident with a baby doll and stroller for walks around the unit. LPN #3 stated that Resident # 28 did not try to go outside or leave the unit and did not have a history of trying to NJ Exec Order 2 LPN #3 explained to the surveyor what the nurse would do after a resident NJ Exec 2 and what was to occur according to the facility	F 658		

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F 658	Continued From page 14 process. She explained that if a resident NJ Exec, the resident would have been assessed for NJ Exec Order, an incident report would have been completed, the supervisor would have been notified, and the nurse would have notified the physician and the family. She stated that if the resident NJ Exec Order 26.4b that they were sent to the hospital and that NJ Exec Order 26.4b1 would have been initiated. She further revealed that NJ Exec Order 26.4b1 were to be continued when the resident returned from the hospital for 24 hours NJ Exec Order 26.4. She said that NJ Exec Order 26.4b1 would also have been initiated for NJ Exec Order 26.4b1 for 24 hours. She stated that NJ Exec Order 26.4b1 were important to conduct to assure that the resident did not have any NJ Exec Ord or NJ Exec Order 2. On 03/22/23 at 12:06 PM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist/Administrative Nurse (LPN/IP/AN) who stated that she did not know if the facility had a neuro-check policy and stated that she would have to look for one. She stated that the nurses follow the instructions on top of the neuro-check sheet and that was how the nurse knew how and when to perform neuro-checks. She confirmed that neuro-checks should have been performed when a NJ Exec Order 26.4b1 On 03/22/23 at 1:20 PM, the LPN/IP/AN provided the surveyor with the facility neuro-check policy and procedure. On 03/23/23 at 10:42 AM, the surveyor interviewed the Minimum Data Set Coordinator (MDSC) who stated that when a resident NJ Exec O and NJ Exec Order 26.4b1 the nurse was to initiate NJ Exec Order 26.4b1 and if the resident was sent to the	F 658		

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F 658	Continued From page 15	F 658		

hospital and returned to the facility, the NJ Exec Order 26.4b1 would continue after the resident got back from the hospital as per facility protocol.

On 03/27/23 at 09:12 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who explained the facility process that should occur after a resident NJ Exec in the facility. She stated that after a resident NJ Exec, the resident was assessed by the nurse on duty, first aid would have been provided if the resident was NJ Exec Order 26, vital signs (VS) were taken, and the physician and family were notified regarding the NJ Exec She explained that if the resident NJ Exec Order 26 or was NJ Exec Order 26 the nurse would send the resident to the hospital immediately. She stated that if the resident NJ Exec Order 26.4b1, VS and NJ Exec Order 26.4b1 were done immediately and then NJ Exec Order 26.4b1 would continue for 24 hours. She stated that NJ Exec Order 26.4b1 would continue after the resident returned from the hospital if the resident returned before 24 hours. The surveyor informed the ADON that when Resident # 28 NJ Ex O on NJ Ex Order 26. 4B1 and NJ Ex his/her NJ Ex Order that NJ Ex Order 26. 4B1 were not completed and the ADON responded with "NJ Ex". The ADON did not provide any addition information.

The surveyor reviewed the facility policy titled; "Neurological Checks" dated 03/22/23, which indicated that the purpose of the policy was to assess for changes of level of consciousness. The procedure for neurological checks indicated that all residents who have hit their head were to be assessed for a change in the level of consciousness for 72 hours in the following increment:

- Every 15 minutes for 1 hour, then
- Every 30 minutes for 1 hours, then

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F 658	Continued From page 16 - Every hour for 4 hours, then - Every 4 hours for 24 hours. The policy also reflected that all pertinent observations were to be documented. NJAC 8:39-11.2(b)	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records, and review of other pertinent facility documentation it was determined that the facility failed to a.) conduct a complete and thorough NJ Exec Order 26.4b1 and b.) update and implement NJ Exec prevention interventions on a resident's Care Plan (CP). This deficient practice was identified for 1 of 4 residents (Resident #28) reviewed for accidents and was evidenced by the following: According to Resident #28's Admission Face Sheet, Resident #28 was admitted to the facility with diagnoses that included but was not limited to NJ Ex Order 26. 4B1 . The Annual Minimum Data Set (MDS-an assessment tool utilized to facilitate the	F 689	F689 1. Fall incident Report policy and Care Plan policy were reviewed by the facility administrator and the Director of Nursing (DON). In-service was provided to the Director of Nursing, the Assistant Director of Nursing(ADON) and nursing staff. All incident report were reviewed by the Director of Nursing to ensure fall investigations were completed, care planned and interventions were implemented. 2. All residents have the potential to be affected by this deficiency practice of failing to conduct complete fall investigation and update and implement fall prevention interventions on a resident□s plan of care.	4/28/23

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F 689	Continued From page 17 management of care) dated NJ Ex Order 26. 4B1, indicated that the resident had NJ Ex Order 26. 4B1 with NJ Exec Order 26.4b1. The MDS also reflected that the resident was NJ Exec Order 26.4b1 On 03/20/23 at 10:00 AM, during the initial tour, the surveyor observed the resident NJ Exec Order 26.4b1 in the hallway. The Licensed Practical Nurse (LPN #3) on the unit was interviewed at this time and stated that the resident was NJ Exec Order 26.4b1 The surveyor attempted to interview the resident; however, the resident was NJ Exec Order 26.4b1 and continued NJ Exec Order 26.4b1 through the hallways of the NJ Exec Order 26.4. The surveyor reviewed the facility Incident Report (IR) dated NJ Ex Order 26. 4B1 at 08:30 PM. The incident report indicated that Resident #28 had a NJ Exec Order 26.4b1 in the breezeway. The witness observed the resident NJ Ex O and on the NJ Exec Order 26.4b1 resident was observed to have NJ Ex his/her NJ Ex Order. The report also reflected that the resident had NJ Exec Order 26.4b1 The IR also indicated to prevent reoccurrences the staff would encourage frequent rest periods. The surveyor reviewed the facility form dated NJ Ex Order 26. 4B1 and titled, 'NJ Exec Order 26.4b1 which included a section in which the Director of Nursing (DON) was to review the CP and was to include interventions. The section was observed to be blank. There was also a signature section for the DON to sign and date that the section was completed, which was also blank. The surveyor reviewed the facility form dated NJ Ex Order 26. 4B1 and titled, 'NJ Exec Order 26.4b1 which was provided to the	F 689	3. Fall incident Report policy and Care Plan policy were reviewed by the facility administrator and the Director of Nursing. In-service was provided to the Director of Nursing, the Assistant Director of Nursing and nursing staff. 4. Al incident reports will be brought to the clinical meeting for the review. Incident reports will be monitored by the DON or designee for complete investigation, intervention implementation and update Care Plan (CP) within 24 hours of the incident. All findings will be reviewed at the Quality Assurance meeting x 4 quarters. 5. Date of completion April 28,2023.	

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F 689	Continued From page 18 surveyor by the Licensed Practical Nurse/Infection Preventionist/Administrative Nurse (LPN/IP/AN) and was included in the investigation packet. The NJ Exec Order 26 included sections in which the Director of Nursing (DON) and Nursing Supervisor/Unit Manager (NS/UM)were to complete for follow-up, assessment, and recommendations and both these sections were blank. There were also signature and date sections for the DON and the NS/UM to sign indicating that this was complete and there were no signatures noted. The surveyor reviewed Resident #28's CP and there was no documentation that new interventions were implemented to prevent NJ Exec Ord after the resident NJ Ex O on NJ Ex Order 26. 4B1. On 03/21/23 at 12:48 PM, the surveyor interviewed LPN #3 for the NJ Exec unit who stated that she had been employed in the facility for NJ Exec . LPN #3 explained the process of what the nurse would do if a resident NJ Exec O. She explained that if a resident NJ Exec, the resident was assessed for NJ Exec Order 2, an incident report would have been completed, the supervisor would have been notified, and the nurse would have notified the physician and the family. She stated that if the resident NJ Exec Order 26.4b1 that they were sent to the hospital and NJ Exec Order 26.4b1) would be initiated and were continued when the resident returned from the hospital for 24 hours post NJ Exec. She said that NJ Exec Order 26.4b1 would also be initiated for NJ Exec Order 26.4b1 for 24 hours. She stated that NJ Exec Order 26.4b1 were important to conduct as they assured that the resident did not have any NJ Exec Orde	F 689		

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F 689	Continued From page 19 NJ Exec Order 26.4 or NJ Exec Order 26. She continued to explain that an investigation would be conducted and that a responsibility of the DON would have been to obtain statements from the nurse and the CNA responsible for taking care of the resident, and collect statements from any other witness involved. LPN #3 stated that the Unit Manager (UM) or Assistant Director of Nursing (ADON) would update the Care Plan (CP) with any new interventions to prevent NJ Exec Ord. LPN #3 reviewed the CP with the surveyor and confirmed that there was not a new intervention implemented after Resident #28 NJ Ex O on NJ Ex Order 26. 4B1. On 03/23/23 at 10:42 AM, the surveyor interviewed the Minimum Data Set Coordinator (MDSC) who stated that when Resident #28 NJ Ex O the resident's CP should have been updated with an intervention on NJ Ex Order 26. 4B1. She confirmed that the CP was not updated to include a new intervention to prevent NJ Ex Ord after Resident # 28 NJ Ex O on NJ Ex Order 26. 4B1. On 03/23/23 at 10:55 AM, the surveyor interviewed the Assistant Licensed Nursing Home Administrator (ALNHA) who stated that the ADON and DON were not available for an interview, however it was their responsibility to have completed all investigations related to incidents and accidents in the facility. She stated that she "was sure" that an investigation was completed for the NJ Exec that occurred with Resident # 28 on NJ Ex Order 26. 4B1 but could not speak to why the DON signature section on the form titled, NJ Exec Order 26.4b1 was blank. The ALNHA confirmed that the section of the NJ Exec form that should have been filled out by the DON that included CP updates was blank. She also confirmed that the form titled, NJ Exec Order 26.4b1	F 689		

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F 689	Continued From page 20 NJ Exec Order 26.4b1 " dated NJ Ex Order 26.4B1, had investigational sections that were to be completed by the DON and the NS/UM and that both areas on the form were blank and the signature sections were blank. The ALNHA stated that if the DON and the NS/UM signed and dated the signature sections of the NJ Exec Order 26.4b1 that it would have indicated that they performed the investigation, and that the investigation was completed. The ALNHA could not speak to why these sections of the investigation were blank or why there were no signatures from the DON or the NS/UM. On 03/27/23 at 09:12 AM, the surveyor interviewed the ADON who explained the facility process that should occur after a resident NJ Exec in the facility. She stated that after a resident NJ Exec, the resident would have been assessed by the nurse on duty, first aid would have been provided if the resident was NJ Exec Order 26, Vital Signs (VS) would have been taken, and the physician and family would have been notified. She stated that she or the DON would have been notified of the NJ Exec O and would have initiated a NJ Exec investigation which would include checking to assure that nurse's notes were completed as well as the incident report. She also stated that the resident's CP for NJ Exec Ord would have been updated with a new NJ Exec prevention intervention. She also stated that she or the DON would sign the NJ Exec O form that would have indicated that the investigation was complete. The surveyor showed the ADON the NJ Exec O form and the NJ Exec Order 26 form that was included in the investigation packet dated NJ Ex Order 26.4B1. The ADON confirmed that the NJ Exec form and the NJ Exec Order 26 form were not filled out and were not signed by the DON or ADON. The ADON could not provide the surveyor with an explanation as to why the	F 689		

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F 689	Continued From page 21 forms were not completed. The ADON also confirmed that the CP was not updated to include a new NJ Ex.Order 26.4(b)(1) on NJ Ex Order 26.4B1. The surveyor reviewed the facility policy, "Accidents and Incidents-Investigating and Reporting," dated 04/12/2022, which indicated that all accidents or incidents involving residents, employees, visitors, vendors, etc. occurring on the facility premises shall be investigated and reported to the Administrator. The policy indicated that the investigation must include: -Any corrective action taken. -Follow-up information. -Other pertinent data as necessary. -The signature and title of the person completing the report. The surveyor reviewed the facility policy, "Care Plans," dated 03/03/2022, which indicated that a CP will be developed for each resident using the resident assessment instrument as a guide. The CP will be specific for each individualized resident and will be revised and updated as new approaches become necessary or old interventions become ineffective. The policy indicated that the CP must be individualized to each resident and strive to assist the resident to reach his/her highest level of functioning and quality of life. The policy also indicated that the CP shall be updated as events occur with new interventions added or old ones removed. NJAC 8:39-27.1(a)	F 689		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services.	F 800		4/28/23

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F 800	Continued From page 22 The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure residents received the food on the meal ticket and adhered to resident preferences. This deficient practice was identified for 1 of 1 resident (Resident # 38) reviewed for food preferences and accuracy of meal tickets and was evidenced by the following: On 3/20/23 at 10:16 AM, the surveyor observed Resident #38 lying in bed resting. According to the Medical Record, Resident #38 was admitted to the facility with diagnoses which included, but not limited to: NJ Ex Order 26. 4B1 . A review of the most recent Quarterly Minimum Data Set (MDS- an assessment tool used to facilitate the management of care) dated NJ Ex Order 26. 4B1, revealed a Brief Interview for Mental Status score of NJ Ex out of 15, indicating Resident #38 was NJ Ex Order 26. 4B1. A review of Resident #38's care plan dated NJ Ex Order 26. 4B1, revealed NJ Ex Order 26. 4B1 , with interventions that included, 'NJ Exec Order 26.4b1 On 3/23/23 at 11:37 AM, the surveyor interviewed the Dietary Director (DD) about resident snacks	F 800	F800 1. The issue with resident #38 tray card was immediately resolved. All preferences on her card, and all other cards were reviewed, and all the preferences were highlighted on the cards and made legible to the employees in the kitchen. Food Service Director was in-serviced to carefully inspect trays before it leaves the kitchen so that the cards are properly adhered to the Food Service Director as well as the dietician. They are instructed to communicate and review the diet cards and compare them to RD notes on a regular basis as to the preferences of the residents. 2. This deficient practice can affect all residents to the fact that their quality of life is affected by them, not receiving the food that they like, and receiving the food that they dislike. The clarity of the cards are important, so as to prevent a mistake that will cause harm to the resident. 3. The Dietary Director, as well as the dietary staff were in-serviced to pay attention to the accuracy of the tray cards to ensure that the residents are satisfied, and that no harm comes to a resident when they get the wrong food. The cards	

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F 800 Continued From page 23

and food preferences who stated, "if it is a one time thing [food change], the nurse can call down to us, but if it is a standing change, the dietitian will submit for it [with dietary communication form]."

On 03/23/23 at 12:18 PM, the surveyor interviewed Resident #38 whose lunch tray was still in the room. Resident #38 reported that they cannot have potatoes, which were identified on the resident's plate. The surveyor reviewed the Resident's Meal Card which listed under dislikes revealed: No Potatoes.

On 3/23/23 at 12:29 PM, the surveyor approached the Licensed Practical Nurse/Infection Preventionist/Administrative Nurse (LPN/IP/AN) and the Licensed Practical Nurse/Unit Manager (LPN/UM #1) at the nursing desk. The surveyor discussed Resident #38's lunch preferences. Both the LPN/IP/AN and LPN/UM #1 confirmed that the resident should have received food that corresponded with their preferences.

On 3/23/23 at 2:04 PM, the Registered Dietitian (RD) was interviewed. The surveyor informed the RD that the resident had potatoes on their plate. The surveyor produced a picture of the resident's meal card. The RD confirmed that the meal card had "no potatoes" listed on it. The surveyor also reviewed the RD dietary note dated NJ Ex Order 26. 4B1 that stated, "[Resident #38] is requesting soup on menu." The RD confirmed that the meal card also identified soup as a dislike. When asked who was responsible for updating food preferences, the RD stated, "I do meal preferences- my recommendation goes on the paper. Yes, I should have taken time for follow up to make sure

F 800

have to be legible and highlighted where necessary to ensure that there is no error. The cards have to be reviewed by the Dietary Director and the dietitian to assure that the card adheres to the nurses and dietitians notes.

4. The Food Service Director, as well as the dietitian, the nursing department and quality assurance personnel will monitor these cards on a daily basis to avoid mistakes and will immediately inform the kitchen when an error is made. The Food Service Director and quality assurance personnel will review diets on monthly basis. All findings will be reviewed at the Quality Assurance meeting x 4 quarters.

5. Date of completion April 28,2023.

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SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE BRIDGETON, NJ 08302**

(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 800	Continued From page 24 [Resident #38] was getting preferences and snacks." A review of an undated document titled, "The Role of the Dietitian and Nutritional Assessment". Under #4, it revealed, "A nutritional assessment will include, but not limited to: diet order; food preferences; food allergies; height; weight; ideal/unusual weight range; assessment of current lab values; presence of decubs; appetite; feeding skills; swallowing abilities; diet counseling; change of diet; height or weight change; noted progress or lack thereof; food-drug interaction; additional comments, as needed." A review of an undated document titled, "Job Description"; JOB TITLE: Food Service Director". Under #4 it revealed, "Prepares and heads menu for distribution/ Processes diet changes from nursing units. Checks tray cards with cardex to be sure resident's on therapeutic diets or with dietary restrictions comply with physician's orders. Counts menus (normal and therapeutic) and plans meals accordingly, using standard recipes for food preparation. Sees that food is obtained and ready for meal preparation by cooks and those supplies are ready for tray services." Under #6 it revealed, "Checks trays for accuracy prior to service." The facility was not able to provide a policy regarding Menu Choice or Preferences. NJAC 8:39-17.4(e)	F 800		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		4/28/23

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F 812 Continued From page 25

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.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner.

This deficient practice was evidenced by:

On 03/20/23 from 9:40 AM to 10:34 AM, the surveyor observed the following in the kitchen in the presence of the Dietary Director (DD):

1. The surveyor observed the Cook who wore gloves as he prepared cooked pork to be served during lunch that day. The Cook then doffed (removed) his gloves and failed to perform hand hygiene prior to taking the surveyor on a tour of the kitchen.

F 812

F812

1. The Cook as well as the entire Dietary staff were in-serviced as to proper hand washing procedures. They were instructed not to use alcohol-based hand rub, but rather antimicrobial hand soap. In the walk-in refrigerator the cook as well as the entire Dietary staff were in serviced to mark the open date and used by date on all items stored in the refrigerator. In addition, to discard any cooked items after 72 hours and also any items at the expiration date. The rest of the refrigerators in the kitchen area were inspected to ensure that all Foods had an open date as well as a used by date. Any personal food items kept for a resident should be marked with open date and

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F 812 Continued From page 26

2. In the walk-in refrigerator:

a. On the top shelf of a four-tiered rack, there was an eight-pound container of potato salad that was marked with a use by date of 04/02/23 and failed to contain an opened date. The Cook stated the item was required to be discarded within three days after it was opened, and he confirmed that the opened date could not be determined. The Cook then proceeded to remove the potato salad from the refrigerator for disposal.

b. On the top shelf of a four-tiered rack, there was an undated garden salad which had begun to wilt, inside of a disposable, clear plastic container. The Cook stated that the salad belonged to a resident and should have been labeled with the resident's name, dated and discarded after three days. The Cook then proceed to remove the garden salad from the refrigerator for disposal.

c. On the top shelf of a four-tiered rack, there was a ten-pound container of coleslaw that was marked with an opened date of 03/16/23 and failed to contain a use by date. The Cook stated that it should have been discarded after three days. The Cook then proceeded to remove the coleslaw from the refrigerator for disposal.

d. In the galley of the kitchen, the surveyor observed the following on the spice rack: a half-pound container of poultry seasoning had an opened date of 10/29/20, a half-pound container of rosemary had an opened date of 11/09/20, and a 16-ounce container of onion powder had an opened date of 03/28/19. A 16-ounce container of granulated garlic and parsley were not dated. The Cook explained that they had just come in and should have been dated. The Cook further

F 812

used by date and discarded at that date, but they must also inform the resident that they are throwing it away. The Cook proceeded to throw the personal food away. The 10 pound container of coleslaw that had no use by date was discarded by the cook. The refrigerator was checked for any additional salads and foods that have no open date and used by date. On the kitchen spice rack, the 16 ounce granulated garlic and parsley were dated. In the pantry refrigerator on AB unit the refrigerator was thoroughly cleaned and the hair removed. The shelves on the refrigerator door were thoroughly cleaned as well. The undated ice cream cup was discarded, as well as the frozen water that was not labeled and dated. The nursing staff was in serviced that they must keep that refrigerator clean and free of all unlabeled and undated foods. It is the responsibility of all shifts of nursing to maintain the refrigerator in a proper manner. The housekeeping staff was in serviced to clean the refrigerator inside and out as well as the pantry floors. All the other refrigerators in the facility, pantries as well as the pantry floors, were checked to ensure that they were properly maintained and all undated foods discarded. The nursing staff was also in-serviced that they must inform the residents of any private food that is being discarded due to expired dates from the pantry refrigerator. A self draining ice scoop holder was provided in order to store the ice scoop so that it can drain properly. The nursing staff were in-service that they cannot dry any kind of food

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stated that spices should be discarded within one year of the opened date to ensure that they were fresh when used and indicated that the spices would be discarded.

During an interview with the surveyor at 10:34 AM, the Cook stated that he should have washed his hands after he doffed his gloves worn during food preparation prior to the tour of the kitchen as failure to do so could have resulted in cross-contamination.

On 03/21/23 from 12:08 PM to 12:31 PM, the surveyor observed the following in the unit pantry where resident food was stored:

3. In the presence of the Licensed Practical Nurse Unit Manager (LPN/UM) #1, in the AB Unit Pantry, the surveyor inspected the unit refrigerator/freezer and noted that there was a single, long strand of hair, solid black particles and ice buildup in the bottom of the freezer where an undated ice cream cup, and a half bottle of frozen water that was not labeled or dated was stored.

In the refrigerator, there was a clear plastic food storage bag that was not labeled or dated and contained multiple pieces of a breaded, square shaped food item. There was a dried, brown substance noted on the bottom shelf of the refrigerator door. The surveyor observed signage on the outside of the refrigerator door which indicated: Personal food will only be kept for 72 hours of the date on it if it [sic.] not consumed it will also be thrown away to avoid the risk of contamination.

When interviewed at that time, the LPN/UM #1

F 812

utensils and containers with a paper towel, but rather let them air dry. They were also in-serviced about pooling water. All other ice scoops were checked to ensure that they have self draining containers. The kitchen staff were in serviced as to the proper use of the three compartment sink, and how to test it. Proper instructions were posted as per the manufacturer guidelines for the employees to refer to when testing the sanitizer water. The cook was in serviced as well as the kitchen staff how to properly wash their hands and not to use alcohol-based hand rub to sanitize their hands in the kitchen, in addition to the proper use of gloves .The FSD was also informed not to use the ABHR in the kitchen.

2. These deficient practices, affect all residents and personnel in the facility. Due to the fact that there is potential contamination and food borne illnesses that can severely affect the residents and staff.

3. The Dietary staffs were thoroughly in-serviced as to the proper handling and maintaining food items that are potentially hazardous and can result in food, contamination and food borne illnesses. They were also in-serviced on the property use of sanitizing the pots and the danger of improper use of the pot sink. They were also in-serviced on the proper hand washing procedure as well as only using antimicrobial soap. Additionally, they were in service, the procedure of

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stated that the 11-7 shift was responsible to check the refrigerator and freezer temperatures, ensure that all food items were labeled and dated and clean it out. LPN/UM #1 stated that she asked the staff to clean it out a couple of weeks ago. She stated, "It did look worse...still not great." LPN/UM #1 stated that she suspected the food item was pizza rolls and they should have been labeled and dated. LPN/UM #1 stated that the ice cream cup came from the facility, but the water bottle must have belonged to an employee and should not have been stored in the refrigerator. LPN/UM #1 stated that Housekeeping was responsible to clean the inside of the refrigerator and mop the floor in the nourishment room.

The surveyor observed an ice scoop that was stored inside of a clear, plastic storage bin that was covered with a lid on top of the ice machine. LPN/UM #1 stated that the storage bin was utilized to store the ice scoop since the summer, and she was unable to state why a self-draining wall mounted storage unit was not utilized as required. LPN/UM #1 stated that paper towels could be used to dry the ice scoop prior to returning it to the storage container to ensure it was dried after use.

During an interview with the surveyor, the Housekeeping Director (HD) stated that Housekeeping was responsible to clean the nourishment room every other day. He further stated that there was some confusion as to whether Housekeeping or the aides were supposed to clean the refrigerator and freezer. The HD stated that the presence of hair in the freezer could cause contamination. The HD further stated that he was not familiar with the ice

changing gloves and the danger that may result should these procedures not be done right. The nursing staff was in-serviced as to the proper storage of the pantry refrigerators, and to discard any potentially hazardous food in addition to maintaining the scoop in a self draining holder, and not drying it by hand. All shifts are mandated to monitor the refrigerators. The housekeeping staff were in-serviced how to properly clean, and sanitize the refrigerators in the pantry.

4. The Food Service Director, as well as the Administrator, Housekeeping Director and Quality Assurance personnel will monitor the kitchen and pantries daily to ensure that proper procedures are followed. All findings will be reviewed at the Quality Assurance meeting x 4 quarters.

5. Date of completion April 28, 2023.

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scooper storage protocol but if water pooled on the scoop, it could lead to bacterial growth.

During a follow-up visit to the AB Unit Pantry on 03/24/23 from 9:52 AM to 9:56 AM the surveyor observed the following:

During an interview with the surveyor on 03/24/23 at 9:52 AM, the Certified Nursing Assistant (CNA) # 5 stated that she had worked at the facility for four years and the ice scoop had always been stored in some type of container on top of the ice machine. CNA #5 further stated that the aides removed food from the refrigerator and housekeeping was responsible to clean it.

During an interview with the surveyor on 03/24/23 at 9:56 AM, LPN/UM #1 stated that housekeeping came and cleaned the refrigerator, but it was still dirty. LPN/UM #1 opened the freezer door and stated, "It looked like they only removed the hair, I guess I have to clean it myself." LPN/UM #1 then proceeded to remove a frozen bottle of water that was half empty, and a frozen bottle of water that contained an orange liquid from the freezer and discarded them both as she explained that they were not labeled or dated as required.

On 03/24/23 from 10:15 AM to 11:01 AM, during a follow-up visit to the kitchen the surveyor observed the following in the presence of the DD and the Nursing Administration Staffing Coordinator (NASC):

4. The three-compartment sink was in use to wash and sanitize pots and pans. Dietary Aide (DA) #1 stated that the desired level of sanitizer required for adequate sanitation was 200 PPM

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F 812	Continued From page 30 (parts per million). DA #1 demonstrated the concentration level of sanitizer and dipped a test strip into the sanitizer for five seconds and stated that the desired result was not achieved, and the test needed to be repeated. DA #1 then proceeded to dip the test strip into the sanitizer for ten seconds. When interviewed, DA #1 stated that the test strip was required to be submerged in the sanitizer for ten seconds to obtain an accurate result. Signage posted above the three-compartment sink instructed that test strips must be maintained within the sanitizer for a period of ten seconds to ensure proper sanitization. DD stated that the sanitizer strip could be dipped into the sanitizer for a period of five to ten seconds. DD then proceeded to dip the test strip into the sanitizer for a period of greater than ten seconds and stated that since the test strip did not change color, a new test strip was needed. At 10:28 AM, DA #1 drained and refilled the sink with both water and sanitizer. DD then proceeded to dip the test strip into the sanitizer for two seconds. When interviewed DD stated, "We probably should get an accurate result in two seconds." The DD then proceeded to immerse the test strip into the sanitizer for four seconds. At which point, DD stated that the test strip had yielded the desired result of 200 PPM when compared against the color-coded analysis chart that was printed on the outside of the test strip container for comparison. When interviewed at that time, DD stated that if the sanitizer level were not high enough it could result in bacterial growth and the residents could get sick. NASC stated that if the sanitizer level	F 812		

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F 812	Continued From page 31 were too high it could lead to poisoning.	F 812		

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were too high it could lead to poisoning.

On 03/24/23 from 11:46 AM to 1:01 PM, during a follow-up visit to the kitchen, the following was observed in the presence of the DD:

5. At 11:50 AM, prior to the tray line observation, the Cook washed his hands for 36 seconds, dried his hands on a paper towel and then used the same towel to turn off the faucet and wiped off the anterior (front) portion of the sink before he discarded it.

At 12:08 PM, the Cook washed his hands for 20 seconds, dried his hands on a paper towel and then used the same towel to turn off the faucet and wiped off the anterior portion of the sink before he discarded it.

At 12:27 PM and at 12:48 PM, DD was observed using alcohol-based hand rub (ABHR) to clean her hands instead of hand washing before she donned gloves and assisted in the tray line preparation.

At 12:38 PM, a Dietary Aide was observed using ABHR before she donned gloves and began to handle a block of yellow cheese in the food preparation area.

At 12:53, the Cook washed his hands for 20 seconds, dried his hands on a paper towel and then used the same towel to turn off the faucet and wipe off the anterior portion of the sink before he discarded it.

When interviewed, the Cook stated that he was required to dispose of the paper towel that he used to dry his hands and get a new paper towel

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to turn off the faucet to prevent cross-contamination.

When interviewed, DD stated that staff were required to wash their hands if their hands were dirty. She further stated that ABHR was permitted in the kitchen to be used when hands were not dirty and if staff were not touching food.

Review of an undated policy titled, "Refrigerated items and Leftovers" revealed the following:

All items dipped for meal consumption such as side salads, plated salads ...must be dated. No leftovers will be stored longer than 72 hours (3 days). Items dated past 3 days must be discarded.

Review of an undated, untitled policy revealed the following:

Spices: Once opened the spices will be dated. Spices will be good for one year from open date unless expiration indicates differently.

Review of the facility policy titled, "Policy and procedure for refrigerator cleaning" (Reviewed 12/20/22) revealed the following:
It is the policy of the facility that the housekeepers will clean the refrigerators in the building ...

Review of an undated facility policy titled, "Testing the 3-Compartment Sink for Proper Sanitizer." Procedure: ...The assigned individual will use the testing strip provided and follow manufacture directions which is to hold strip in water for 5 (five) seconds. Strip is then compared to chart provided on bottle, and the log for checking sanitizer is filled out by person checking it. If

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F 812	Continued From page 33 water does not properly measure to 200 ppm, assigned individual will not use the sink for sanitizing and notify the supervisor on duty. Review of an undated facility policy titled, "Handwashing" revealed the following: Thorough hand washing is considered the single most important factor in reducing germ count on the skin and therefore, in preventing transmission of infection. Hands and exposed arms are thoroughly washed at designated hand washing facilities (not salad or pot sink), with warm water and soap: when coming on duty; when hands are obviously soiled; after leaving and returning to the workstation; after touching any dirty or contaminated area ...before handling food or sanitary utensils or equipment; hand contact with food items is avoided, however, if absolutely necessary single service plastic gloves are worn. Handwashing Technique Proper procedure for handwashing: 1. Turn on the faucet 2. Wet hands and forearms and apply an antimicrobial soap 3. Scrub well with soap and additional water as needed for at least 20 seconds, scrubbing all areas thoroughly, Pay close attention to fingernails 4. Rinse thoroughly 5. Dry hands with paper towel and discard towel 6. Turn off faucet with clean paper towel. NJAC 8:39-17.2(g)	F 812		
F 850 SS=C	Qualifications of Social Worker >120 Beds CFR(s): 483.70(p)(1)(2) §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A	F 850		4/30/23

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F 850	Continued From page 34 qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to employ a Social Worker (SW) with the required one year of supervised social work experience in a healthcare setting working directly with the individuals per the facility's job description and Centers for Medicare and Medicaid Services (CMS). This deficient practice was identified for 1 of 1 SW employed and was evidenced by the following: On 03/22/23 at 10:16 AM, the surveyor interviewed the SW who stated that she worked in the facility for NJ Exec Order 26.4b1 and that she was the only SW in the facility and did not have a NJ Exec Order 26.4b1. The SW stated that her degree was a NJ Exec Order 26.4b1 and stated, "I did this (job) for people NJ Ex.Order 26.4(b)(1) before." On 03/24/23 at 11:00 AM, during a follow up interview with the SW, the surveyor inquired about the SW's job orientation. The SW stated	F 850	F850 1. Full □time Social Worker maintain NJ Exec Order 26.4b1 She will continue to receive quarterly consultation from MSW. 2. All residents have the potential to be affected by this deficiency practice of failing to employ a Social Worker with the required one year of supervised social work experience. 3. Social worker will continue to receive quarterly consultation from MSW. Have quarterly review of the Social Worker job compliance. 4. The administrator of the facility will schedule and will monitor for quarterly consultations of Social worker with MSW for one year. All findings will be reviewed at the Quality Assurance meeting x 4 quarters. 5. Date of Completion April 30, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(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 850	Continued From page 35 that she had "not much of an orientation" and that when she was hired that she shadowed another SW in another facility for one day. The SW stated when she was hired the facility had not had a SW for months and she believed the assistant was performing the SW duties in the interim. The SW further stated that when she had questions about her job duties she would have asked the former Human Resources Coordinator, the MDS Coordinator (MDS-Minimum Data Set, an assessment tool utilized to facilitate the management of resident care) and the MDS Nurse for instruction. On 03/27/23 at 10:58 AM, the surveyor interviewed the SW who stated her role was to make sure upon resident admission that the social history, smoking form, Ombudsman form, Resident Rights form, Advanced Directives form, and Notice of Privacy forms were reviewed and provided. She stated she also went to Utilization Review meetings, Resident Council meetings, was responsible for Care Conferences and, if needed, provided assistance with finding housing and assisted in obtaining social security cards or birth certificates. The surveyor inquired about oversight from a SW while in the facility. The SW again stated that she had shadowed another SW from another facility for a day and that she had received assistance in her role from the Physical Therapist, the MDS Coordinator and the previous Licensed Nursing Home Administrator (LNHA.) When the surveyor inquired as to whether the SW should have had oversight from a SW, the SW stated, "Maybe. I could have used it if I was here before the other SW left. I learned as I went along." On 03/27/23 at 11:11 AM, the surveyor	F 850		

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	315061	A. BUILDING ______ B. WING ______	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(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 850	Continued From page 36 interviewed the Nursing Administrator Staffing Coordinator (NASC) who stated that she had been in her role since NJ Ex Order 26. 4B1 but that she and the Assistant LNHA (ALNHA) would have been involved with hiring a SW. The surveyor inquired as to the qualifications for a SW and the NASC stated, "I do not know. I think they would have to have an MSW" (Masters degree in Social Work.) On 03/27/23 at 11:20 AM, the surveyor interviewed the ALNHA who stated that she had been employed at the facility since NJ Ex Order 26. 4B1 . The ALNHA stated that the manager of each department would have done initial interviews on potential new hires and that she would have done the criminal background checks. She further stated that she would have done the initial interviews along with the LNHA who would have done the SW hiring. The surveyor inquired as to what qualifications the SW would have needed and whether the current SW met the qualifications. The ALNHA stated she was not sure and that she would have had to check the qualifications. The surveyor inquired about the SW having had oversight from a SW for her role. The ALNHA stated she did not know. On 03/27/23 at 12:23 PM, in the presence of the LNHA, ALNHA, the Licensed Practical Nurse/Infection Preventionist/Administrative Nurse (LPN/IP/AN), Assistant Director of Nursing (ADON) and the survey team, the surveyor interviewed the LNHA who stated he had been in his role for NJ Ex.Order 26.4(b)(1). He stated that the facility did have a SW on staff and that he would have been responsible for hiring the SW with help with prescreening from his assistant. The LNHA stated that the SW qualifications would have included a	F 850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING ______ B. WING ______	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE BRIDGETON, NJ 08302**

(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 850	Continued From page 37	F 850		

type of degree in social services and that he was responsible to ensure that credentials were checked. The surveyor inquired if the SW had ever had any supervisory oversight in her role. The LNHA stated that there was a corporate MSW that came to the facility, "at least quarterly or every other month to evaluate services" and that she would have stayed for the day and would have provided documented reports.

On 03/27/23 at 12:39 PM, during the administration meeting with the surveyors, the surveyor requested from the LNHA any documentation from the MSW.

On 03/28/23 at 10:33 AM, during the exit meeting in the presence of the ALNHA, LPN/IP/AN, ADON, NASC and the survey team, the surveyor requested from the ALNHA documentation from the MSW for verification of visitation to the facility. The ALNHA stated, "I do not have anything, no."

A review of the Social Worker's resume indicated that the SW did not have one year of supervised social work experience in a health care setting working directly with individuals.

A review of the facility's undated Director of Social Services job description revealed, "He or she is supervised by the Social Work Consultant on a regular basis. The Director of Social Services with the Social Work Consultant, review and update the policy and procedures at least annually."

The facility was on record as being licensed for 167 beds. The CMS guidelines implemented 11/28/17, included but were not limited to a qualified SW full-time for a facility with over 120 beds. The qualifications included one year of

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	315061	A. BUILDING ______ B. WING ______	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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F 850	Continued From page 38 supervised social work experience in a health care setting working directly with individuals. N.J.A.C. 8:39-39.2, 40.1	F 850		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060602	A. BUILDING: ______ B. WING ______	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE BRIDGETON, NJ 08302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift, as mandated by the State of New Jersey. This was evident for 4 of 14 day shifts and was evidenced as follows: 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, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	S560 1. Four new employees were recently hired in Nursing Department to provide direct care to the residents. 2. All residents have the potential to be affected by this deficiency practice of failing to maintain the required minimum direct care staff to resident ration for the day shift. 3. The Administrator of the facility and the Director of Nursing continue to interview and hire people for the open positions, utilize agency for the open shifts. 4. The Administrator, the Director of Nursing or designee will continue to monitor daily and monthly schedules.	4/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 04/14/23

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060602	A. BUILDING: ____ B. WING ____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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S 560	Continued From page 1 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. As per the "Nurse Staffing Report" completed by the facility for the weeks of 03/05/2023 to 03/11/2023 and 03/12/2023 to 03/18/2023 for the 03/28/2023 standard survey, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: -03/12/23 had 11 CNAs for 98 residents on the day shift, required 12 CNAs. -03/13/23 had 11 CNAs for 97 residents on the day shift, required 12 CNAs. -03/17/23 had 11 CNAs for 95 residents on the day shift, required 12 CNAs. -03/18/23 had 11 CNAs for 95 residents on the day shift, required 12 CNAs. On 03/23/23 at 11:37 AM, the surveyor interviewed the Nursing Administration Staffing Coordinator who stated that the facility utilized "a	S 560	Available shifts will posted to the agencies. Designee will continue to advertise jobs on the social platforms on a weekly basis. All findings will be reviewed at the Quality Assurance meeting x 4 quarters. 5. Date of completion April 30, 2023.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060602	A. BUILDING: ______ B. WING ______	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE BRIDGETON, NJ 08302**

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S 560	Continued From page 2 lot" of agency and had been consistency using the same agency and same CNAs. She stated that the facility was continuing trying to recruit new employees through job fairs, posting on computer job sites and networking through "word of mouth". She added that the facility was also offering financial incentives to try and get employees to work. NJAC 8:39-5.1(a)	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315061	A. Building B. Wing	5/17/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 04/28/2023	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 04/28/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 04/28/2023
ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 04/28/2023	ID Prefix F0800 Reg. # 483.60 LSC	Correction Completed 04/28/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 04/28/2023
ID Prefix F0850 Reg. # 483.70(p)(1)(2) LSC	Correction Completed 04/30/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060602		5/17/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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 04/30/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON 3/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING 01 B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/21/2023 and 3/22/2023 and South Jersey Extended Care was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. South Jersey Extended Care is a Single-story, Type II Fire Resistant building that was built in January 1946. The facility is divided into 6 smoke zones. The facility has a diesel generator.	K 000		
K 241 SS=F	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/21/2023 and 03/22/2023, in the presence of facility management, it was determined that the facility failed to provide two exits, remote from each other, for each floor or fire section of the building.	K 241	K241 1. Regarding the exit door from the basement with the Bilco hatch doors near the kitchen receiving area- there is a time limited waiver in place for that basement egress.	3/29/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/14/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING **01** B. WING ______	**03/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 241	Continued From page 1 This deficient practice was evidenced by the following: On 03/21/2023 during the survey entrance at approximately 9:30 AM, a request was made to the facility's Maintenance Director (MD) if the facility had any waivers. The MD stated to the surveyor, "I am not sure". Starting at approximately 9:51 AM, in the presence of the MD a tour of the basement was conducted. The surveyor observed one acceptable means of egress from the basement. The second exit was a steep ladder with metal Bilko hatch doors. The basement was fully sprinklered and had a fire alarm system. The door to the basement was located within a locked kitchen receiving area and was not accessible to residents. On 03/22/2023 during the survey exit at approximately 2:15 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. The Administrator told the surveyor there was a Time Limited Waiver in place for the basement egress. NJAC 8:39 - 31.1(c)	K 241	2. This deficient practice can affect the entire facility. Should there be an employee trapped in that area without second possibility of safe egress. In addition, creating a lack of access by the fire department, should there be a fire in the basement. 3. The maintenance staff was in-serviced as to the danger of only having one means of egress from the basement. The facility engaged a licensed architect, who is in the midst of drawing up plans, and acquiring permits to proceed with this project. Once the plans are approved, the project will be given out for bid to numerous contractors so that the facility can begin the project. The facility will inform the state health department as to the progress of this project. 4. The maintenance department as well as the administrator. Will monitor the progress of this project and inform the state health department as to the ongoing progress on a quarterly basis. All findings will be reviewed by the air quality assurance committee on a quarterly basis.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K 321		5/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING **01** B. WING ______	**03/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 2 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 03/21/2023 and 03/22/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following:	K 321	K321 1. The door closer to the clean linen room on the CD unit was repaired and all other door closers to potentially hazardous areas were checked throughout the facility to ensure that the doors self close properly. 2. This deficient practice will affect the entire facility due to the fact that a door that does not properly close, can allow fire smoke and gases hazardous to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING 01 B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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K 321	Continued From page 3 On 03/21/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility was a single-story building with 64 Resident sleeping rooms and various common areas. Starting at approximately 9:51 AM on 03/21/2023 and continued on 03/22/2023, in the presence of the facility's MD a tour of the building was performed. Along the two day tour of the facility the surveyor observed the following hazardous areas that failed to have smoke resisting doors, On 03/22/2023 at approximately 11:48 AM, an inspection of the CD Unit Clean Linen room was performed. During a closure test of the corridor door leading into the Clean Linen room the door did not self-close into its frame. The surveyor observed evidence that the doors automatic door closure had been removed. At that time, the surveyor observed three rolling carts filled with combustible linens. During the observation, the surveyor recorded the measurements of the room. The room was four feet nine inches (4'-9") deep by thirteen feet (13) wide (61.75 square feet) which is larger than 50 square feet. With this corridor door not self-closing this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.	K 321	everybody□s health to spread throughout the facility. 3. The Maintenance Director, as well as all staff was in-service as to the danger of having a door from a hazardous area not close properly. The staff was in-serviced to report any broken door, closers or doors that are not latching properly to hazardous areas -to the maintenance department so that it can be immediately repaired. 4. The Maintenance Director, as well as the administrator and the quality assurance personnel will monitor all these hazardous area doors on a daily basis to assure that they close and latch properly. All findings will be reviewed with the quality assurance committee on a quarterly basis. 5. Date of completion May 1, 2023	

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K 321	Continued From page 4 The MD confirmed the finding at the time of observation. On 03/22/2023 during the survey exit at approximately 2:15 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/21/2023 and 03/22/2023, it was determined that the facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical	K 351	K351 1. The sprinkler heads to the 4 foot deep by 8 foot wide combustible overhang as well as the 5□10 deep by 6 foot wide	5/1/23

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	315061	A. BUILDING 01 B. WING ______	03/28/2023

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SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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K 351	Continued From page 5 environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 03/21/2023 during the survey entrance at approximately 9:30 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the building was a single story building with a basement. On 03/21/2023 (day one of survey) starting at approximately 9:51 AM and continued on 03/22/2023, in the presence of the MD a tour of the building was conducted. During the two day tour the surveyor observed the following areas that failed to have proper fire sprinkler coverage: 1.) On 03/22/2023 at approximately 12:05 PM, the surveyor observed no evidence of fire sprinkler coverage for the four (4) feet deep by eight (8) feet wide combustible over hang outside of the Dining room exit discharge door. At that time the surveyor asked the MD, "Do you see any fire sprinklers?" The MD looked and said, "no".	K 351	combustible overhang outside the dining room exit discharge doors were installed. All other overhangs and means of discharge exit doors throughout the facility where inspected to make sure that there are proper sprinkler heads in those areas. 2. This deficient practice will affect the entire facility due to the fact that there could be an impediment of egress should that exit be consumed by fire. The sprinkler heads will extinguish any fire blocking the exit. 3. The facility maintenance department was on serviced as to the danger of not having proper sprinkler coverage at these discharge exits. 4. The maintenance, Director the administrator and quality assurance personnel will monitor all these exits on going weekly basis to ensure that the sprinkler heads are present and in a good working condition. The sprinkle company will monitor the sprinkle heads along with others on a quarterly basis during quarterly inspections ensure they are function properly. All findings will be reviewed with this quality assurance committee on a quarterly basis for a year. 5. Date of completion May 1, 2023	

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K 351	Continued From page 6 2.) On 03/22/2023 at approximately 12:17 PM, the surveyor observed no evidence of fire sprinkler coverage for the five (5) feet 10 inch deep by approximately six (6) feet wide combustible over hang outside of the Dining room exit discharge door. The MD confirmed the finding at the time. On 03/22/2023 during the survey exit at approximately 2:15 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations on 03/21/2023 and 03/22/2023 in the presence of facility management, it was determined that the facility failed to install portable fire extinguishers with-in the required height for 10 of 18 fire extinguishers, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and	K 355	K355 1. The fire extinguisher #28 was lowered to 5 foot maximum from the floor. FI # 30-FI#31-FI in the laundry-FI#2-FI#5-FI in the soiled utility room -FI#18-FI#8-FI#10 were all lowered to a maximum of 5 foot high from the floor. The rest of the fire extinguishers in the facility were checked to ensure that they are all hanging no more than 5 foot high.	5/1/23

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K 355	Continued From page 7 N.J.A.C. 5:70. This deficient practice was evidenced by the following: Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. During the building tour on 03/21/2023 and 03/22/2023 in the presence of the facility Maintenance Director (MD) the surveyor observed and inspected eighteen (18) portable fire extinguishers in various locations and identified the following: 1.) At approximately 9:59 AM, one (1) ABC type portable fire extinguisher Facility Identification (FI) #28 in the stairwell leading up to the attic appeared to be mounted too high. The surveyor measured and recorded that the fire extinguisher was mounted at 6'- 1" (six feet, one inch) to the center of the pressure indicating needle. 2.) At approximately 10:02 AM, one (1) ABC type portable fire extinguisher FI #30 in the attic. The surveyor measured and recorded that the fire extinguisher was mounted 5'- 4" (five feet, four inches) to the center of the pressure indicating needle. 3.) At approximately 11:02 AM, one (1) ABC type	K 355	2. This deficient practice will affect the entire facility, due to the fact that if an extinguisher is mounted too high it may not be accessible to short people in which case the extinguisher may not be able to be used when needed. That can cause a shortage of time to extinguish the fire rapidly. 3. The maintenance staff was in-serviced as to the dangers of fire extinguishers that are mounted to high. 4. The maintenance Director, as well as the administrator and quality assurance personnel will monitor these fire extinguishers on a daily basis to ensure that they are mounted properly at the right height. All findings will be reviewed with the quality assurance committee on a quarterly basis. 5. Date of completion May 1, 2023	

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 355	Continued From page 8 portable fire extinguisher FI #31 in the attic. The surveyor measured and recorded that the fire extinguisher was mounted 5'- 2-1/2" (five feet, two and a half inches) to the center of the pressure indicating needle. 4.) At approximately 10:25 AM, one (1) ABC type portable fire extinguisher in the Laundry room. The surveyor measured and recorded that the fire extinguisher was mounted 5'- 1" (five feet one inch) to the center of the pressure indicating needle. 5.) At approximately 10:29 AM, one (1) ABC type portable fire extinguisher FI #2 near the MDS office. The surveyor measured and recorded that the fire extinguisher was mounted 5'- 4" (five feet, four inches) to the center of the pressure indicating needle. 6.) At approximately 10:36 AM, one (1) ABC type portable fire extinguisher FI #5 in the corridor. The surveyor measured and recorded that the fire extinguisher was mounted 5'- 5" (five feet, five inches) to the center of the pressure indicating needle. 7.) At approximately 10:50 AM, one (1) ABC type portable fire extinguisher in the corridor near the soiled linen room. The surveyor measured and recorded that the fire extinguisher was mounted 5'- 11" (five feet, eleven inches) to the center of the pressure indicating needle. 8.) At approximately 10:56 AM, one (1) ABC type portable fire extinguisher FI #18 in the corridor. The surveyor measured and recorded that the fire extinguisher was mounted 5'- 2-1/2" (five feet, two and a half inches) to the center of the	K 355		

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K 355	Continued From page 9 pressure indicating needle. 9.) At approximately 11:10 AM, one (1) ABC type portable fire extinguisher FI #8 in the main dining room. The surveyor measured and recorded that the fire extinguisher was mounted 5'- 6" (five feet, six inches) to the center of the pressure indicating needle. 10.) At approximately 11:10 AM, one (1) ABC type portable fire extinguisher FI #10 in the corridor. The surveyor measured and recorded that the fire extinguisher was mounted 5'- 8-1/2" (five feet, eight and a half inches) to the center of the pressure indicating needle. The MD confirmed the findings at the times of the surveyors observations. On 03/22/2023 during the survey exit at approximately 2:15 PM, the surveyor informed the Administrator of the deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 911		5/1/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 911	Continued From page 10 Based on observation on 03/21/2023 and 03/22/2023, in the presence of facility management, it was determined that the facility failed to ensure that one (1) of three (3) electrical outlets located next to a water source (with-in 6 feet) was equipped with safe and secured Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 03/21/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility was a single-story building with 64 Resident sleeping rooms and various common areas. Starting at approximately 9:51 AM on 03/21/2023 and continued on 03/22/2023, in the presence of the facility's MD a tour of the building was performed. During the two day tour, the surveyor observed and tested three (3) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: 1.) On 03/21/2023 at approximately 11:10 AM, the surveyor observed inside Salon one (1) GFCI electrical outlet located 20 inches to the left of the hair washing sink. When the surveyor tested the GFCI electrical outlet with a GFCI tester to de-energize, the GFCI electrical outlet did not	K 911	K911 1. The GFCI electrical outlet located in the beauty parlor near the handwashing sink was replaced, and all other GFCI outlets throughout the building were checked to ensure that they were working properly. 2. This deficient practice can affect the entire facility due to the fact that if a GFCI outlet malfunctions, it will not shut off a short in the electrical system thus creating a fire hazard. 3. Maintenance department was in-serviced as to the dangers of a failed GFCI outlet. 4. The maintenance Director, as well as the administrator and the quality assurance personnel will inspect all GFCI outlets throughout the building on a monthly basis to assure that they are working properly. All findings will be reviewed with the quality assurance committee on a quarterly basis. 5. Date of completion May 1, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING **01** B. WING ______	**03/28/2023**

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SOUTH JERSEY EXTENDED CARE	**99 MANHEIM AVENUE** **BRIDGETON, NJ 08302**

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K 911	Continued From page 11 de-energize as required by code. The MD confirmed the finding at the time of observation. On 03/22/2023 during the survey exit at approximately 2:15 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual 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	K 918		5/1/23

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K 918	Continued From page 12 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/21/2023 and 03/22/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for one (1) of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 03/21/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Maintenance Director (MD) if the facility had an Emergency Generator. The MD told the surveyor, "yes we have one Emergency Generator". On 03/22/2023 (day two of survey) at approximately 12:30 PM, in the presence of the MD an inspection outside of the building where the Emergency Generator was located, the surveyor observed that the emergency stop button was located inside the metal housing of the generator on the generator's control panel. At the time of the observation, the surveyor asked	K 918	K918 1. The emergency manual E stop button on the generator was installed outside, and away from the generator. 2. This deficient practice can affect the entire facility. Should there be an emergency where the generator must be stopped and the stop button is not accessible to do so. 3. The maintenance staff was in serviced as to the importance of a remote emergency stop button to the generator and the dangers that it could present should that emergency stop not be accessible. 4. The maintenance Director will monitor the emergency manual stop button on the weekly basis along with his generator exercise to assure that it is working properly. All findings will be reviewed with the quality assurance committee on a quarterly basis. 5. Date of completion May 1, 2023	

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 918	Continued From page 13 the MD, "Do you have a remote emergency stop button for the generator?" The MD stated, "no". The MD confirmed the finding at the time of observation. On 03/22/2023 during the survey exit at approximately 2:15 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315061	A. Building 01 - MAIN BUILDING 01 B. Wing	5/17/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0241	Correction Completed 03/29/2023	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 05/01/2023	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 05/01/2023
ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 05/01/2023	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 05/01/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 05/01/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO