

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

PRINTED: 12/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/06/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE ORANGE, NJ 07050</b>
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F 000	<p>INITIAL COMMENTS</p> <p>Complaint #s NJ 165538, 166378</p> <p>STANDARD SURVEY: 5/30-6/6/24</p> <p>CENSUS: 159</p> <p>SAMPLE SIZE: 32+3</p> <p>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.</p>	F 000		
F 711 SS=E	<p>Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)</p> <p>§483.30(b) Physician Visits The physician must-</p> <p>§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;</p> <p>§483.30(b)(2) Write, sign, and date progress notes at each visit; and</p> <p>§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to</p>	F 711	F711	7/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>06/21/2024</b>
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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 711	<p>Continued From page 1</p> <p>a.) ensure the physician signed and dated monthly medication orders and b.) ensure the physician or the non-physician practitioner (NPP) performed face-to-face monthly visits. The deficient practice was identified for 19 of 32 residents reviewed (#29, 129, 22, 51, 65, 121, 97, 116, 53, 10, 101, 11, 2, 69, 33, 80, 138, 75, 118) and occurred over a 6 month period.</p> <p>The deficient practice was evidenced by the following.</p> <p>1. A review of the hybrid medical record for Resident #29 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for [redacted] or [redacted].</p> <p>2. A review of the hybrid medical record for Resident #129 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for [redacted] or [redacted]. One physician progress note [redacted] was electronically entered into the medical record, however, no other physician or NPP progress notes were documented for [redacted] or [redacted].</p> <p>3. A review of the hybrid medical record for Resident #22 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for [redacted] or [redacted].</p> <p>4. On 5/30/24 at 10:48 AM, the surveyor observed Resident #51 in bed in their room and</p>	F 711	<p>The identified residents in the statement of deficiencies records were reviewed. All identified residents were seen and examined by the physician. The physician's orders were certified. The resident overall plan of care and condition were assessed and evaluated by the attending physician. There were [redacted] in resident's status and condition reported.</p> <p>An audit of all residents assigned to affiliated physicians was performed. Medical record coordinator and licensed nurses to follow up monthly physician orders are electronically sign and dated as scheduled in PCC</p> <p>The medical record coordinator will monitor all affiliated physicians using tracking tool and PCC scheduler to ensure that the resident is seen and examined as scheduled and the monthly physician orders are certified, signed and dated.</p> <p>A physician meeting is scheduled by administration to discuss, imply certification of the resident total program of care including medications and treatments at each visit as required, electronically write, sign and date progress notes at each visit and electronically sign and date all orders in monthly basis.</p> <p>The medical record coordinator will report findings to QAPI monthly for 3 months. Issues identified will be addressed by the medical director and administration.</p> <p>Date of completion 7/1/24</p>	

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F 711	<p>Continued From page 2</p> <p>the resident was <b>NJ Ex Order 26.4b1</b>.</p> <p>The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #51.</p> <p>A review of the resident's Admission Record, (one page summary of important information about a resident) revealed diagnoses that included <b>NJ Ex Order 26.4(b)(1)</b>, <b>NJ Ex Order 26.4(b)(1)</b>, and <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>A review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated <b>NJ Ex Order 26.4(b)(1)</b>, revealed that the resident had had a Brief Interview for Mental Status (BIMS) score of <b>NJ Ex Order 26.4(b)(1)</b> out of 15, indicating a <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>A review of the monthly physician's orders revealed that the resident's primary care physician had not signed the resident's monthly orders for the months of <b>NJ Ex Order 26.4(b)(1)</b> through <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>5. On 5/30/24 at 10:52 AM, the surveyor observed Resident #65 in a bed in their room. The resident stated that he/she went for <b>NJ Ex Order 26.4(b)(1)</b> every Monday, Wednesday and Friday.</p> <p>The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #65.</p> <p>A review of the resident's Admission Record revealed diagnoses that included <b>NJ Ex Order 26.4(b)(1)</b>, <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>A review of the quarterly MDS (QMDS), dated</p>	F 711			

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F 711	<p>Continued From page 3</p> <p>NJ Ex Order 26.4, revealed that the resident had a BIMS score of NJ Ex out of 15, indicating an NJ Ex Order.</p> <p>A review of the monthly physician's orders revealed that the resident's primary care physician had not signed the resident's monthly orders for the months of NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1).</p> <p>6. On 5/30/24 at 10:36 AM, the surveyor observed Resident #121 in a wheelchair in their room. The resident stated that he/she was waiting for his/her aide who then walked into the room.</p> <p>The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #121.</p> <p>A review of the resident's Admission Record revealed diagnoses that included NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).</p> <p>A review of the QMDS dated NJ Ex Order 26.4(b)(1), revealed that the resident had a BIMS score of NJ Ex out of 15, indicating an NJ Ex Order 26.4(b)(1).</p> <p>A review of the monthly physician's orders revealed that the resident's primary care physician had not signed the resident's monthly orders for the months of NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1).</p> <p>7. A review of the hybrid medical record for Resident #97 revealed the resident's physician had not hand signed or electronically signed the</p>	F 711			

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F 711	<p>Continued From page 4</p> <p>monthly physician's orders for [redacted], [redacted], or [redacted]. There were no physician or NPP progress notes entered into the record for [redacted], or [redacted].</p> <p>8. A review of the hybrid medical record for Resident #116 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for [redacted], [redacted], [redacted], [redacted], or [redacted]. There were no physician or NPP progress notes entered into the record for [redacted], [redacted], or [redacted].</p> <p>9. Resident #53's hybrid medical record review revealed no monthly physician-signed or electronically signed monthly orders for [redacted], [redacted], [redacted], [redacted], and [redacted].</p> <p>10. Resident #10's hybrid medical record review revealed that the physician electronically signed the monthly physician orders for [redacted], [redacted], and [redacted]. There were no other signed monthly physician orders for [redacted], [redacted], and [redacted]. Additionally, no monthly physician progress notes were written by the physician in [redacted], [redacted], and [redacted].</p> <p>11. Resident #101's hybrid medical record review revealed that the physician electronically signed the [redacted] monthly physician orders. No other signed monthly physician orders for [redacted], [redacted], [redacted], and [redacted].</p>	F 711		

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F 711	Continued From page 5  12. Resident #11's hybrid medical record review revealed no monthly physician-signed or electronically signed monthly orders for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).  13. Resident #2's hybrid medical record review revealed no monthly physician-signed or electronically signed monthly orders for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).  14. Resident #69's hybrid medical record review revealed no monthly physician-signed or electronically signed orders for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).  15. Resident #33's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).  16. Resident #80's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).  17. Resident #138's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly	F 711			

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F 711	<p>Continued From page 6</p> <p>physician's orders for [redacted], [redacted], and [redacted].</p> <p>18. Resident #75's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for the months of [redacted] through [redacted] and [redacted].</p> <p>19. Resident #118's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for the months of [redacted] through [redacted].</p> <p>On 6/4/24 at 11:02 AM, the surveyor interviewed the [redacted] (U.S. FOIA (b) (6)), [redacted] (U.S. FOIA (b) (6)), on the [redacted] (NJ Exec Order 26.4b1), who has been working in the facility for four years. She stated, "The doctors mostly document in the Electronic Health Records (EHR) and the monthly orders are signed electronically."</p> <p>On 6/5/24 at 10:37 AM, interviewed the [redacted] (U.S. FOIA (b) (6)), on the [redacted] (NJ Exec Order 26.4b1) who has been working in the facility for 13 years. The [redacted] (U.S. FOIA (b) (6)) stated, "The physicians document in the EHR and some have a hard copy in the chart. Doctor [Name Redacted] still documents in the chart. The physicians sign their monthly orders electronically."</p> <p>On 6/5/24 at 12:14 PM, the survey team met with the administration: [redacted] (U.S. FOIA (b) (6)), [redacted] (U.S. FOIA (b) (6)), [redacted] (U.S. FOIA (b) (6)), two [redacted] (U.S. FOIA (b) (6)) and the</p>	F 711		
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F 711	Continued From page 7 <b>U.S. FOIA (b) (6)</b> , regarding concerns with the completion of physician visits and monthly signage of physician orders.  On 6/6/24 at 9:37 AM, the survey team met with the <b>U.S. FOIA</b> who acknowledged no improvements on the current concerns regarding physician visits, progress notes completion and monthly signage of physician orders.  A review of the most current facility policies and procedures titled, "Physician's Orders, and Physician Services" stated, "The attending physician must certify physician's orders monthly" and "Physician visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy."	F 711			
F 756 SS=D	NJAC 8:39-23.2 (b), (d) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)  §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  §483.45(c)(2) This review must include a review of the resident's medical chart.  §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		6/20/24	

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F 756	<p>Continued From page 8</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined that the <b>U.S. FOIA (b) (6)</b> failed to report irregularities found in the medical records to the facility. This deficient practice was observed for the following resident.</p> <p>On 6/4/24 at 12:21 PM, the surveyor reviewed the hybrid medical record (paper and electronic) for Resident #83. The resident's Admission Record (AR) reflected that the resident was admitted with diagnoses including but not limited to <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b>.</p>	F 756	<p>F756</p> <p>Resident # 83 is in <b>NJ Exec Order 26.4b1</b>. The medication timing was changed to follow manufacturer's specifications.</p> <p>An audit of all residents using the same class medication regimen was conducted. All orders are currently in EMAR system and are being administered according to facility policy and manufacturer's guidelines.</p> <p>An education in-service was given to all professional nurses by the ADON and/or DON on following manufacturer's</p>		

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F 756	Continued From page 9  A review of the resident's Medicare 5 Day Minimum Data Set (MDS) (a standardized assessment tool that measures health status in nursing home residents) dated [redacted], which reflected that the resident had a Brief Interview for Mental Status (BIMS) (a tool used to screen and identify the [redacted] NJ Exec Order 26.4b1) Score of [redacted] NJ Ex Order 26.4(c) which reflects [redacted] NJ Ex Order 26.4(b)(1)  The surveyor reviewed the [redacted] NJ Ex Or and [redacted] NJ Ex Order 26.4(b)(1) electronic medication administration record (eMAR) and the current Physician's Order sheet which reflected orders for [redacted] NJ Ex Order 26.4(b)(1) [redacted] 1gm tablet by [redacted] NJ Ex Order 26.4(b)(1) four (4) times a day, [redacted] NJ Ex Order 26.4(b)(1) by [redacted] NJ Ex Order 26.4(c) in the morning, NJ Ex Order 26.4(b)(1) [redacted] by [redacted] NJ Ex Order 26.4(b)(1) once a day, and an order for [redacted] NJ Ex Order 26.4(b)(1) [redacted] (given a one time) five (5) times per day. The eMAR reflected the administration times of the [redacted] NJ Ex Order 26.4(b)(1) as 6 AM, 1 PM, 3 PM and 8 PM, the [redacted] NJ Ex Order 26.4 as 6 AM, the [redacted] NJ Ex Order 26.4(b)(1) at 6 AM, and the [redacted] NJ Ex Order 26.4 as 12 midnight, 6 AM, 12 PM, and 9 PM.  The Surveyor reviewed the manufacturer package information sheet for [redacted] NJ Ex Order 26.4(b)(1) which reflected that the medication should be given on an empty stomach and that there was a potential for a drug interaction between the [redacted] NJ Ex Order 26.4(b)(1) and the [redacted] NJ Ex Order 26.4(b)(1) which could be avoided by giving the [redacted] NJ Ex Order 26.4(b)(1) two (2) hours before the [redacted] NJ Ex Order 26.4(b)(1). The Surveyor reviewed the manufacturer package information sheet for	F 756	guidelines The [redacted] US FOIA (b)(6) has been in-service education by his office. Nursing administration will conduct monthly audit report all finding that pertain EMAR orders at our monthly QAPI meeting for 3 months for follow-up. Issues identified will be addressed by the Director of Nursing.  Date of completion 6/20/24		

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NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE</b> <b>ORANGE, NJ 07050</b>		
(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 756	<p>Continued From page 10</p> <p><b>NJ Ex Order 26.4</b> which reflected that the medication should be given at least 1 hour before meals.</p> <p>The surveyor reviewed the <b>U.S. FOIA (b) (6)</b> Review sheet <b>NJ Ex Order</b> for the resident. The <b>U.S. FOIA</b> responsibility was to review all resident's medication monthly for discrepancies, continued monitoring and correct dose of medications. The <b>NJ Ex Order</b> sheet did not reflect any comment related to timing of medications and the <b>NJ Exec Order 26.4b1</b>. The Surveyor reviewed the <b>U.S. FOIA (b) (6)</b> Monthly Report <b>NJ Ex Order 26.4</b> for <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b>. The <b>NJ Ex Order 26.4</b> reflected that the <b>U.S. FOIA</b> had made recommendations on other unrelated irregularities for the resident during those months but did not make a recommendation on the potential drug interaction or the timing of <b>NJ Ex Order 26.4</b> or <b>NJ Ex Order 26.4(b)</b>.</p> <p>On 6/5/24 at 11:58 AM, The surveyor interviewed the <b>U.S. FOIA</b> by telephone. The surveyor asked the <b>U.S. FOIA</b> if he was aware of the manufacturer dosing recommendations for <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4</b> with food and interactions with <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b>. The <b>U.S. FOIA</b> stated that <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4</b> should be given sixty (60) minutes before a meal and <b>NJ Ex Order 26.4(b)(1)</b> should be separated by two (2) hours from <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>On 6/5/24 at 1:56 PM, the surveyor interviewed the <b>U.S. FOIA (b) (6)</b> and the medication nurse on duty on the unit where Resident #83 resides. The medication nurse stated that she gives medications to residents as they are ordered in the eMAR. The <b>U.S. FOIA</b> stated that the <b>U.S. FOIA</b> had just called him to have medication times changed for Resident #83.</p>	F 756		

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

PRINTED: 12/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE</b> <b>ORANGE, NJ 07050</b>		
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F 756	Continued From page 11 On 6/5/24 at 2:15 PM, the surveyor in the presence of the survey team informed the facility administrative team of the concern with Resident #83's medication timing and the failure of the [REDACTED] to report the irregularity.  NJAC 8:39-29.3(a)(1)	F 756			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>060721</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/06/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE</b> <b>ORANGE, NJ 07050</b>
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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 deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care  (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.  This REQUIREMENT is not met as evidenced by: Complaint NJ00165538  Based on observation, interview, and record review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following:  Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.  Be It Enacted by the Senate and General	S 560	Every resident was taken care of and not one resident had any complaints during the shift mentioned in the Statement of deficiencies. The facility will address the issue as follows: The facility will make every effort to staff according to the direct care staff to resident ratio. Administration provided an in-service on 6/19/24 to the Staffing coordinator on the ratios. The staffing coordinator will monitor facility nursing schedule to ensure the State required ratios are met. The administrator will review nursing schedule weekly for the next 3 months, to	6/20/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/21/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>060721</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/06/2024</b>
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S 560	<p>Continued From page 1</p> <p>Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.</p> <p>1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:</p> <p>(1) one certified nurse aide to every eight residents for the day shift.</p> <p>(2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and</p> <p>(3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties.</p> <p>b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.</p> <p>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.</p>	S 560	<p>ensure the State regulations ratios are met.</p> <p>If the facility is below the State required direct care staff to resident ratio, agency staff will be utilized to fill the requirement until adequate staff are hired.</p> <p>Findings will be reported at the facility's monthly QAPI meeting for the next 3 months for monitoring and follow-up.</p>	

New Jersey Department of Health

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S 560	<p>Continued From page 2</p> <p>(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.</p> <p>(3) All computations shall be based on the midnight census for the day in which the shift begins.</p> <p>d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...</p> <p>A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the three weeks of staffing in two segments by dates for the 6/6/2024 Standard survey with Complaints on 7/7/23 at White House Healthcare and Rehabilitation Center reflected:</p> <p>1. For the 1 week of Complaint staffing from 7/2/2023 to 07/08/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows:</p> <p>- 7/2/23 had 17 CNAs for 151 residents on the day shift, required at least 19 CNAs.</p> <p>2. For the 2 weeks of staffing prior to survey from</p>	S 560		

New Jersey Department of Health

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S 560	<p>Continued From page 3</p> <p>5/12/2024 to 05/25/2024, there were no deficient practices identified as submitted.</p> <p>On 6/4/24 at 10:33 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) on the 1st floor South Wing, who has been working full time in the facility <span style="background-color: black; color: black;">[REDACTED]</span> NJ Ex Order 26.4b1. She stated, "Staffing is pretty good here, weekend is pretty good too but only short sometimes. We know how to manage the time to take to care of the residents when we're short."</p> <p>On 6/5/24 at 9:00 AM, the surveyor observed the staffing sheet on the hallway lobby posted daily during the re-certification survey of 6/6/24.</p> <p>On 6/5/24 at 12:14 PM, the survey team met with the administration and informed the License Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON (ADON), two Assistant LNHA's, and the Administrator in Training (AIT), of the shift when the minimum direct care staff to resident ratio was not met. No other information was provided by the facility.</p> <p>A review of the most current facility Staffing policy and procedure stated, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment."</p>	S 560		
S1405	<p>8:39-19.5(a) Mandatory Infection Control and Sanitation</p> <p>a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed</p>	S1405		6/20/24

New Jersey Department of Health

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S1405	<p>Continued From page 4</p> <p>physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review of 10 recently hired employee files it was determined that the facility failed to ensure that 1 of 10 recently hired employees completed a health history or receive an <sup>NJ Ex Order 26.4(b)(1)</sup> by a Physician, an Advanced Practice Nurse, or a licensed Physician Assistant within two weeks prior to employment or upon employment as evidenced by the following:</p> <p>On 6/5/24 at 10:30 AM, the surveyor reviewed the employee files for 10 employees hired within the last <sup>NJ Ex Order 26.4b1</sup>. The files revealed the following:</p> <p>A Certified Nursing Assistant (CNA), with the date of hire of <sup>NJ Ex Order 26.4</sup> revealed the CNA did not have a health history or received a <sup>NJ Ex Order 26.41</sup> completed by a Physician or a Registered Nurse (RN) within two weeks prior to employment or upon employment.</p>	S1405	<p>S1405</p> <p>The identified employee in statement of deficiency has had a physical . In-service education was given to the ADON and the HR director in reference to mandatory requirements for a new employee to start working.</p> <p>Administration along with the Infection preventionist will audit new employee's records for the next 3 months to ensure that the necessary tests and physicals have been completed prior to the start of their employment.</p> <p>Findings will be reported at the facility's monthly QAPI meeting for the next three months for monitoring and follow-up.</p>	

New Jersey Department of Health

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S1405	<p>Continued From page 5</p> <p>On 6/6/24 at 10:00 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who provided and stated, "The Employee Health Examination was completed on [REDACTED] the employee's previous employer [Name Redacted] and I have no other information."The LNHA acknowledged that the employee did not have a history and physical exam completed within the time frame of two weeks prior to employment or upon employment as determined by the state regulation.</p> <p>On 6/6/24 at 10:57 AM, the surveyor interviewed [Name Redacted], Registered Nurse (RN), Assistant Director of Nursing (ADON), who has been working in the facility for [REDACTED]. The ADON discussed the process for new hires, "I am responsible for the employee health screening for new hire employees. When we interview new employees, we do background checks that the assistant administrator or nursing secretary will do, if it comes back okay, I'll ask them for a current physical exam. The physical exam will be done here before they start working. There is a problem with this CNA when we took him, we didn't do another physical because he had one done at a previous facility but a most current one should have been done, that was my fault. Yesterday was the first time I heard that State regulations required physical exams to be done within two weeks of hire, I thought it was one year."</p> <p>On 6/6/24 at 11:35 AM, the surveyor reviewed the most current facility policy and procedure for Employee Health Program which reflected, "Pre-employment physical examinations and testing shall focus on occupational health and remain relevant to job requirements and the work</p>	S1405		

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S1405	Continued From page 6  place."  NJAC 8:39-19.5 (a)	S1405		
S1420	8:39-19.5(b)(3) Mandatory Infection Control and Sanitation  (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:  3. Any employee with positive results shall be referred to the employee's personal physician or advanced practice nurse and if active tuberculosis is suspected or diagnosed shall be excluded from work until the physician or advanced practice nurse provides written approval to return.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was	S1420	S1405/S1402	6/20/24

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S1420	<p>Continued From page 7</p> <p>determined that the facility failed to ensure 1 of 10 <sup>NJ Ex Order 26.4(b)(1)</sup> employees received the required <b>NJ Ex Order 26.4(b)(1)</b> upon employment. Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a <b>NJ Ex Order 26.4(b)(1)</b> with <sup>NJ Ex Order 26.4(b)(1)</sup> of <sup>NJ Ex Order 26.4(b)(1)</sup>. The deficient practice was evidenced by the following:</p> <p>On 6/5/24 at 10:30 AM, the surveyor reviewed the employee health files for 10 employees hired within the <sup>NJ Ex Order 26.4(b)(1)</sup>. The files revealed the following:</p> <p>A Certified Nursing Assistant (CNA), with the date of hire of <sup>NJ Ex Order 26.4(b)(1)</sup> did not receive the <sup>NJ Ex Order 26.4(b)(1)</sup> upon employment.</p> <p>On 6/6/24 at 10:00 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated, "The employee came from another facility and had the <sup>NJ Ex Order 26.4(b)(1)</sup> there on <sup>NJ Ex Order 26.4(b)(1)</sup> and <sup>NJ Ex Order 26.4(b)(1)</sup>. I have no other information." The LNHA acknowledged that the employee did not have the <b>NJ Ex Order 26.4(b)(1)</b> completed within the time of employment as determined by the state regulation.</p> <p>On 6/6/24 at 10:57 AM, the surveyor interviewed [Name Redacted], Registered Nurse (RN), Assistant Director of Nursing (ADON), who has been working in the facility for <sup>NJ Ex Order 26.4(b)(1)</sup>. The ADON discussed the process for new hires, "I am responsible for the employee health screening for new hire employees. When we interview new employees, we do background checks that the assistant administrator or nursing secretary will</p>	S1420	<p>The identified employee in statement of deficiency has had a two-step Mantoux tuberculin skin test completed. In-service education was given to the ADON and the HR director in reference to mandatory requirements for a new employee to start working.</p> <p>Administration along with the Infection preventionist will audit new employee's records for the next 3 months to ensure that the necessary tests and physicals have been completed prior to the start of their employment. Findings will be reported at the facility's monthly QAPI meeting for monitoring and follow-up.</p>	
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New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE</b> <b>ORANGE, NJ 07050</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1420	<p>Continued From page 8</p> <p>do, if it comes back okay, the skin test will be done here before they start working. There is a problem with this CNA when we took him, we didn't do another skin test because he had one done at a previous facility but a most current one should have been done, that was my fault."</p> <p>On 6/6/24 at 11:35 AM, the surveyor reviewed the most current facility policy and procedure for Employee Health Program which reflected, "Pre-employment examinations shall also be used to screen employees for signs, symptoms, and/or risk factors for communicable diseases."</p> <p>NJAC 8:39-19.5 (b)</p>	S1420		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315372	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 7/11/2024	Y3
NAME OF FACILITY WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 560 BERKELEY AVENUE ORANGE, NJ 07050		

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 F0711	Correction	ID Prefix F0756	Correction	ID Prefix	Correction
Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. #	Completed
LSC	07/01/2024	LSC	06/20/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/6/2024

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 060721	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 7/11/2024
NAME OF FACILITY WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 560 BERKELEY AVENUE ORANGE, NJ 07050

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	Correction	ID Prefix S1405	Correction	ID Prefix S1420	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. # 8:39-19.5(b)(3)	Completed
LSC	06/20/2024	LSC	06/20/2024	LSC	06/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/6/2024	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE ORANGE, NJ 07050</b>	
(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	E 000		
K 000	INITIAL COMMENTS  LIFE SAFETY CODE 101:2012  THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R.  Whitehouse Care Center is a 2- story building with a basement and is of Type II protected construction. The facility has a 400 KW exterior diesel generator that does 100% of the facility. The facility's Maintenance Director indicated the building still has the original 150 KW generator located in the basement. The fire sprinkler system has a (1) wet system and (1) dry system and is supplied by city pressure.  The building has 9-smoke zones  The facility has 176 licensed beds, and at entrance was occupying 159.	K 000		
K 293 SS=F	Exit Signage CFR(s): NFPA 101  Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.	K 293		6/20/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/21/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE ORANGE, NJ 07050</b>		
(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 293	<p>Continued From page 1</p> <p>19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 6/3/24, in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to provide exit signs that included a continuous illumination indicator showing the direction of travel, in every location, where the direction of travel to reach the nearest exit was not apparent, in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 6 of 6 exit signs and could affect 158 residents residing in the facility and was evidenced by the following:</p> <p>From 09:30 AM, to approximately 1:05 PM, the surveyor, U.S. FOIA (b) (6) and U.S. FOIA (b) (6) observed in the exit/egress corridors of the facility that when the set of smoke doors were closed from the electro magnetic door open device, the exit sign through the set of doors could not be seen. Residents in these areas in the event of an emergency evacuation and power outage would not be able to exit safely as the nearest exit was not apparent for 1 of 2 sides of the smoke doors in the following areas:</p> <p>Floor #2 South by resident room #231 Floor #2 North by resident room #222 Floor #1 South by resident room #131 Floor #1 North by resident room #122 Basement South by the boiler room</p>	K 293	<p>All missing exit signs that were identified on the Statement of Deficiencies were installed. Maintenance staff was provided with in-service education by Administration, on 6/19/20 on the requirement that when the fire doors are closed there should be a visible illuminated exit sign Maintenance staff and/or Assistant Administrators will inspect all fire doors throughout the facility monthly for the next 3 months to ensure all exit signs are visible. Repairs will be made as needed. Findings will be reported at the facility's monthly QAPI meeting for the next 3 months for monitoring and follow-up.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE ORANGE, NJ 07050</b>	
(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 293	Continued From page 2 Basement North by the Physical Therapy room  The <b>U.S. FOIA (b) (6)</b> and <b>U.S. FOIA (b) (6)</b> both confirmed the findings at the time of the observations.  The <b>U.S. FOIA (b) (6)</b> and cooperate staff were informed of the findings at the Life Safety Code exit conference on 6/3/24.  NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. NJAC 8:39-31.2(e)	K 293		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101  Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 5/31/24, in the presence of the <b>U.S. FOIA (b) (6)</b> and <b>U.S. FOIA (b) (6)</b> , it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection.	K 374	smoke door that was identified on the Statement of Deficiencies was repaired. Maintenance staff was provided with in-service education by Administration, on 6/19/24 on the requirement that when the fire doors are closed there should be no	6/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE ORANGE, NJ 07050</b>		
(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 374	Continued From page 3  This deficient practice was identified for 1 of 6 smoke barrier door sets observed, and had the potential to affect 10 residents residing in the facility and was evidenced by the following:  At 12:28 PM, the surveyor observed in the facility basement that the set of South smoke barrier doors, when released from the electro-magnetic hold open device. The doors closed properly, but when the double doors met, a gap was observed approximately 1/4" compromising the intergerity of the smoke door requirements.  The <b>U.S. FC</b> and <b>U.S. FOIA (b)</b> both confirmed the findings above during the observation.  The <b>U.S. FOIA (b) (6)</b> and Corporate staff were informed of the findings during the Life Safety Code survey exit conference on 6/3/24..	K 374	gaps greater than a 1/4". The maintenance staff and assistant administrator conducted an audit of all fire doors in the facility to ensure there are no large gaps appearing when the doors are closed.  The Maintenance and Assistant Administrators will inspect all fire doors throughout the facility monthly for the next 3 months to ensure no large gaps appear when the doors are closed. Repairs will be made as needed Findings will be reported at the facility's monthly QAPI meeting for the next 3 months for monitoring and follow-up.		
K 918 SS=E	NJAC 8:39-31.1(c), 31.2(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	K 918		6/20/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE ORANGE, NJ 07050</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	<p>Continued From page 4</p> <p>day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review on 5/31/24, in the presence of the <b>U.S. FOIA (b) (6)</b>, it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 &amp; 110 for emergency electrical generator systems. This deficient practice was evidenced for 1 of 1 generators and had the potential to affect 158 residents residing in the facility and was evidenced by the following:</p> <p>At 9:44 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten</p>	K 918	<p>Administration updated the weekly generator log.</p> <p>Maintenance staff was provided with an in-service by Administration on 6/19/20 how to document properly and complete the generator log. This entails the documentation of the number of seconds it takes to switch from electrical power to power from the generator, as well as the precise start and end time.</p> <p>The administration will audit the generator logs to ensure that all required generator inspections are completed monthly in accordance with regulations, for the next</p>		

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

PRINTED: 12/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 BERKELEY AVENUE ORANGE, NJ 07050</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	<p>Continued From page 5</p> <p>seconds for 12 of 12 times on the provided generator log. Currently, the [U.S. FOIA (b) (6)] was performing monthly generator load testing, but did not indicate the required transfer times on the provided log dates: 4/19/23, 5/18/23, 6/24/23, 8/1/23, 8/13/23, 9/20/23, 10/31/23, 12/30/23, 1/17/24, 2/17/24, 3/22/24, and 4/17/24.</p> <p>An interview was conducted with the [U.S. FOIA (b) (6)] during document review, where he stated that currently he was just checking yes for the 10-second requirement and did not log the amount of time the system is capable of supplying within 10 seconds in accordance with NFPA 110.</p> <p>The [U.S. FOIA (b) (6)] and Corporate Staff were informed of the deficient practice at the Life Safety Code exit conference on 6/3/24.</p> <p>NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110</p>	K 918	<p>3 months.</p> <p>All findings will be reported at the facility monthly QAPI meeting for 3 months to ensure compliance.</p>		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315372	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 7/11/2024	Y3
NAME OF FACILITY WHITE HOUSE HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 560 BERKELEY AVENUE ORANGE, NJ 07050		

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # NFPA 101 LSC K0293	Correction Completed 06/20/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0374	Correction Completed 06/20/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0918	Correction Completed 06/06/2024
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/6/2024

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