STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315178	A. BUILDING _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE EAST ORANGE, NJ 07017

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F 000	INITIAL COMMENTS Standard Survey: 2/9/21 Census: 166 Sample Size: 36 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. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed	F 552		4/13/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/23/2022

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F 552	Continued From page 1 care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review facility documents, it was determined that the facility failed to maintain the rights of a resident during medication administration. This was found with 1 of 7 residents observed during medication pass, Resident # 14. The deficient practice was evidenced by the following: On 2/3/22 at 8:21 AM, the surveyor observed a Licensed Practical Nurse (LPN) preparing medication for Resident #14. The LPN crushed the following medication; EX Order 26 § 4b1 [redacted] After crushing the medication the LPN put the crushed medication in a cup of EX Order 26 § 4b1 [redacted] and stirred it. The LPN then brought the drink into the resident's room and stated "Here's your [redacted]" The resident sat up and drank all of the EX Order 26 § 4 [redacted] with the medication in it. On 2/3/22 at 8:31 AM, the surveyor asked the LPN why he crushed the medication and put it in the EX Order 26 § 4b [redacted] drink. The LPN said "[The resident]	F 552	Deficiency: F552 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Nurse involved will be educated on residents rights and a medication pass completed. Family and primary medical doctor of resident # 14 made aware. Resident # 14 will be made aware of all medications administered. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. Director of nursing/Designee will identify other residents having potential to be affected by same deficient practice by conducting audits 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Director of Nursing/Designee conducted facility wide In-service on resident rights and medication administration. Each resident in the facility will be made aware of	

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F 552	Continued From page 2 won't take the medication. [The resident] doesn't think [the resident] needs the medication. [The resident] thinks [the resident] is still driving trucks. The doctor wrote an order that we can crush the medication and put it in the [redacted]. The doctor is aware that the resident is getting the medication without [the resident's] knowledge." On 2/3/22 at 9:00 AM, the surveyor reviewed the resident's medical record which revealed the following: A physician's order sheet (POS) with an order that read "May crush medication and put it in [redacted]." The order date was 11/30/21. The POS also had an order that read [redacted] The order date was 1/30/22. The most recent completed assessment, the Admission Minimum Data Set Assessment dated 10/20/21, indicated that the facility performed a Brief Interview for Mental Status (BIMS) which the resident scored an [redacted] out of 15 which indicated that the resident had EX Order 26 § 4b1 [redacted] A Social Worker note dated 2/5/22 that read "BIMS assessment completed today. Resident BIMS score [redacted] BIMS category: [redacted] On 2/3/22 at 1:30 PM, the survey team spoke with the Director of Nursing (DON), The Administrator, and three regional nurses. The surveyor explained the concern with the LPN administering medication to Resident #14 in a	F 552	medications they are receiving. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Director of Nursing /Designee will perform Bimonthly medication pass will be conducted for all nurses x 1 month and then monthly. All findings will be discussed during monthly QAPI.	

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F 552	Continued From page 3 liquid supplement and not telling the resident that the resident was receiving medication. The DON stated "It's not proper. I have to speak to the nurse and the doctor about that. It's not right. It's not proper." On 2/9/22 at 10 AM, the surveyor reviewed the facility's undated policy and procedure titled "Resident Rights Policy and Procedure." Under "Policy" it read "It is the Facility's policy to ensure that each resident shall be entitled to all the rights as is required by applicable statutes and regulations." Under "Procedure" it read "All the Facility residents are entitled to the following rights d. To refuse medication and treatment after the resident has been informed, in a language that the resident understands, of the possible consequences of this decision." NJAC 8:39-4.1 (a) 4	F 552		
F 584 SS=E	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 independence and does not pose a safety risk.	F 584		4/18/22

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F 584	Continued From page 4 (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 record review, from 2/01/22 to 2/03/22, it was determined that the facility failed to maintain a clean and sanitary environment. This deficient practice was identified for 3 of 3 resident occupied floors in the facility. This deficient practice was evidenced by the following: 1. Resident room [redacted] dirty ceiling vent 2. Resident room [redacted] baseboard heater falling apart (missing covers) 3. Resident room [redacted] packaged terminal air conditioner (PTAC) unit dirty	F 584	F584 Safe/Clean/Comfortable Homelike Environment 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Corrections were made to all noted deficient areas. Completed 2/23/22 Ceiling tiles replaced to Resident room areas [redacted] and [redacted]. 2/23/22 PTAC units to Resident rooms [redacted], [redacted],	

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F 584	Continued From page 5 4. Resident room [redacted] PTAC louvers dirty 5. Resident room [redacted] dirty PTAC unit, with food embedded into top grill 6. Resident room [redacted] dirty PTAC unit, with food embedded into top grill 7. Resident room [redacted] ceiling tiles stained and dirty by the window 8. Resident room [redacted] holes in the sheetrock wall 9. Resident room [redacted] cove base falling off the lower wall 10. Resident room [redacted] bathroom ceiling tiles stained 11. Resident room [redacted] bathroom sink falling off the wall mount bracket 12. Resident room [redacted] linoleum sheet flooring damaged 13. Resident room [redacted] broken PTAC unit 14. Resident room [redacted] dirty ceiling tiles 15. Resident room [redacted] broken glass on resident photo 16. Resident room [redacted] damaged PTAC unit 17. Resident room [redacted] missing privacy curtain An interview with the Maintenance Director during the observations, where he stated and agreed that the above findings were confirmed. The Administrator was notified of the findings at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.4(a)	F 584	[redacted] and 117 repaired, cleaned and filters changed. Completed 2/23/22 Soiled ceiling vent to Resident room [redacted] properly cleaned 2/23/22 Baseboard repaired in room [redacted] 2/23/22 Resident room [redacted] wall with noted holes were repaired 2/23/22 Cove base to Resident room [redacted] repaired 2/23/22 Bathroom sink in Resident room [redacted] was repaired 2/23/22 Linoleum sheet flooring to Resident room [redacted] removed on 2/23/22 Broken glass was immediately cleaned up near photo frame to Resident room [redacted] on 2/3/22 Privacy curtain replaced to Resident room [redacted] on 2/23/22 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: This deficient practice has the potential to affect all Residents and Staff. Maintenance Director conducted Facility wide audits to all Resident areas to ensure PTACS, ceiling tiles, Resident room structures and bedroom curtains all had a plan for improvement. Immediate needs corrected same day. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:	

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F 584	Continued From page 6	F 584	Inspections on the following will be conducted by the maintenance director and/or designee and will be brought to QA meeting monthly for 12 months. " PTAC Filters (monthly) " Ceiling tiles (weekly) " Bathrooms vent (Monthly) " Bathroom sink *plumbing (daily) " Baseboard (Weekly) " Paint and drywall (monthly) " Privacy curtain (weekly) " Window Glass and Flooring (monthly) 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Daily , weekly and monthly inspections will be conducted by the Maintenance Director and/or designee and PMs conducted, this will be brought to the QA meeting monthly x12 months.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide nail care for residents who were unable to do it themselves. This was found with 2 of 2 residents reviewed for range of motion, Resident	F 677	Deficiency: F677 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	4/8/22

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F 677	Continued From page 7 # 23, and Resident # 128. The deficient practice was evidenced by the following: 1. On 1/31/22 at 10:33 AM, the surveyor observed Resident #23 laying in bed. The resident had [redacted] of the [redacted]. The [redacted] on the [redacted]. The surveyor was unable to see the [redacted] due to the [redacted] being in a [redacted] On 2/1/22 at 10:45 AM, the resident was in bed watching television. The hands were contracted. The [redacted] on the [redacted]. The surveyor was unable to see the [redacted]. On 2/2/22 at 9:00 AM, the surveyor reviewed the resident's medical record which revealed the following: An annual Minimum Data Set Assessment dated 1/15/22 which had a Brief Interview for Mental Status Assessment where the resident scored an [redacted] out of a possible 15. This indicated that the resident had EX Order 26 § 4b1 [redacted]. On 2/8/22 at 9:24 AM, the surveyor asked Certified Nursing Assistant # 1 (CNA) if she could help the surveyor see the residents fingers. CNA #1 was having trouble opening the residents hands. The surveyor asked CNA #1 how she cleaned the residents hands. CNA #1 said she put the wash cloth under the hands, into the palms, and through the digits. The surveyor asked CNA #1 when she cut the resident's nails. CNA #1 said she never cuts resident's nails. The	F 677	AFFECTED BY THE PRACTICE: The residents # 23 and #128 nails were assessed and cut. The wound care MD evaluated the residents #23 nails. CNAs and nurses were educated on resident rights and grooming. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Every resident can be affected by this deficient practice. DON/Designee will identify other residents having potential to be affected by same deficient practice by conducting audits. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Director of Nursing/Designee conducted facility wide in-services on resident rights and grooming, Adl book has been updated to reflect residents care, electronic point of care will be implemented with tasks updated accordingly. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Don/Designee will conduct audits will be conducted on 5 residents for grooming/nail care on each unit weekly x	

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F 677	Continued From page 8 surveyor asked CNA #1 who cuts the resident's nails. CNA #1 said someone at night must cut the resident's nails because sometimes when she would come in there would be nails all over the bed. On 2/8/22 at 9:31 AM, the surveyor asked the Licensed Practical Nurse (LPN) to observe the resident's [redacted]. The LPN gently opened the resident's [redacted]. The LPN agreed that the resident's [redacted] were [redacted]. The [redacted] on the [redacted] was [redacted] and [redacted] into a [redacted] The LPN said he hadn't noticed the [redacted] before. The surveyor asked the LPN when was the last time he did a skin check for the resident. The LPN said he did skin checks weekly but he didn't check the resident's [redacted] when he did a skin check. The surveyor asked the LPN who was responsible for cutting the resident's [redacted] The LPN said the [redacted] was responsible for cutting the residents [redacted] On 2/8/22 at 9:50 AM, the surveyor asked the Unit Manager/Licensed Practical Nurse (UM/LPN) who was responsible for cutting the residents nails. The UM/LPN said the CNAs were responsible for cutting the resident's [redacted] On 2/8/22 at 10:17 AM, the UM/LPN went into the residen'ts room to cut the residents [redacted] The surveyor went into the resident's room and observed the UM/LPN cutting the [redacted]. The resident was cooperating. The resident stated [redacted] On 2/8/22 at 10:30 AM, the UM/LPN came out of the resident's room and said the resident was letting her cut the resident's [redacted] but the resident	F 677	1 month. Then biweekly x 1 month, then monthly. All findings will be discussed at monthly QAPI.	

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F 677	Continued From page 9	F 677		

kept saying it hurt so she would stop and go back to it. The UM/LPN agreed that having [redacted] could further complicate the condition of the resident's contracted hands.

On 2/9/22 at 10:10 AM, the surveyor observed the [redacted] doctor examine the resident's [redacted]. The [redacted] doctor confirmed that there was no [redacted] on the resident's hands. The [redacted] doctor said the resident had an [redacted] of a [redacted] which caused the [redacted] to [redacted]. The [redacted] doctor said the best approach would be for him to [redacted] a [redacted] cut the [redacted] and then maintain the growth by trimming it periodically. The surveyor asked how long it would have taken the nail to become that overgrown. The [redacted] doctor said that it would take years for the nail to get like that.

On 2/8/22 1:50 PM, the surveyor spoke to CNA #2 who said that she didn't have time to cut anyone's nails because they didn't have enough staff. She further stated "It is ten to two and I haven't finished washing my residents yet and I haven't had lunch."

On 2/8/22 at 2:00 PM the surveyor asked CNA #2 where she would look to see what care tasks each resident required and where they documented the care that was given. CNA #2 showed the surveyor the Activities of Daily Living (ADL) Flow Sheet for January 2022. There was no ADL flow sheet for February 2022 in the binder that held the ADL flow sheets. For the whole month of January 2022 there were only 4 entries that showed that care was provided. The sheet indicated that on those shifts the resident received a bed bath. The opposite side of the

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sheet where the resident's care needs should have been checked off was left blank. There was no care need information.

2. On 1/31/22 at 11:22 AM, the surveyor observed Resident #128 laying in bed awake, the resident did not respond when spoken to. The resident's [redacted] appeared contracted. The [redacted] appeared tight against the [redacted].

On 2/4/22 at 11:11 AM, the surveyor observed the resident in bed. The resident did not respond when spoken to. The [redacted] remained in a closed position on [redacted].

On 2/8/22 at 10:43 AM, the surveyor checked the resident's [redacted] with the LPN. There were no [redacted] on the hands. The [redacted] were clean. The [redacted] were [redacted] on most fingers.

On 2/8/22 at 10:44 AM, the surveyor checked the resident's hands with the UM/LPN. The UM/LPN agreed that the residents [redacted] were [redacted] and some were [redacted] The UM said it was the CNAs responsibility to cut the resident's [redacted] The UM/LPN agreed that the residents [redacted] needed to be cut.

On 2/8/22 at 11:30 AM the surveyor reviewed the resident's medical record which revealed the following:

A quarterly Minimum Data Set Assessment dated 12/20/21 which had a Brief Interview for Mental Status Assessment where the resident scored a [redacted] out of a possible 15. This indicated that the resident had EX Order 26 § 4b1 [redacted].

On 2/9/22 at 11:00 AM the surveyor reviewed the

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F 677	Continued From page 11 Activities of Daily Living (ADL) Flow Sheet for January 2022. There was no ADL flow sheet for February 2022 in the binder that held the ADL flow sheets. For the whole month of January 2022 there were only 4 entries that showed that care was provided. The sheet indicated that on those shifts the resident received a bed bath. The opposite side of the sheet where the resident's care needs should have been checked off was blank. There was no care need information. On 2/9/22 at 11:20 AM, the surveyor reviewed the facility's policy and procedure titled "Activities of Daily Living," updated 6/2021. Under Policy it read "Patient's ADLs are evaluated by a licensed nurse and members of the interdisciplinary team upon admission and with significant change. A program of assistance and instruction in ADL skills is implemented as appropriate. Assistive devices and adaptive equipment are provided as needed. ADL care is documented every shift by the nursing assistant on an ADL flow sheet." Under "Practice Standards" it read "1. Facility must ensure that: 1.2 A patient who is unable to carry out ADLs receives the necessary services to maintain good nutrition, grooming, and personal and oral hygeine." NJAC 8:39-27.1 (a)	F 677		
F 711 SS=F	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §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	F 711		4/8/22

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F 711	Continued From page 12 section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §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 interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders to ensure that the residents current medical regimen was appropriate. This deficient practice was observed for 18 of 33 residents (Resident #48, #59, #76, #34, #100, #51, #71, #144, #41, #32, #86, #99, #149, #128, #137, #78, #55, and #60) reviewed and occurred over several months. This deficient practice was evidenced by the following: The surveyors reviewed the hybrid medical records (paper and electronic) for the residents listed above that revealed the residents primary physician had not hand signed the Order Summary Reports (monthly physician's orders) located in the residents chart. In addition there were no electronic signatures under the physician's orders for the following residents: 1. Resident #48's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2021 and December 2021.	F 711	Deficiency: F711 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Physicians were immediately notified and either came in to sign or signed Physician Order Sheets electronically. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Physician order sheet audit will be conducted tp prevent the same deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator and Medical records reached out to all physicians and educated them on policy and how to sign medical records electronically. 4. HOW THE FACILITY WILL	

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F 711	Continued From page 13 In addition, the monthly physician's orders for January 2022 and February 2022 were not in the chart and there were no electronic signatures. 2. Resident #59's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2021 and December 202. In addition, the January 2022 and February 2022 monthly physician's orders were not in the chart and there were no electronic signatures. 3. Resident #76's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician orders for November 2021 and December 2021. In addition, the January 2022 and February 2022 monthly physician's orders were not in the chart and there were no electronic signatures. 4. Resident #34's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2021 and December 2021. In addition, the January 2022 and February 2022 monthly physician's orders were not in the chart and there were no electronic signatures. On 2/4/22 at 11:45 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Managers (LPN/UM #1 and #2) from the [redacted] floor and [redacted] floor. Both LPN/UM#1 and #2 confirmed January Order Summary Reports were not on the chart and further stated 11-7 nurse was responsible for putting the monthly orders in residents chart.	F 711	MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Medical records to conduct audit monthly to ensure Physician Order Sheets is signed by all physicians x 3 months. All findings to be discussed at monthly QAPI.	

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5 . Resident #32's hybrid medical record revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for November 2021, December 2021 and January 2022 monthly physician's orders was not in the chart and there was no electronic signature.

6 . Resident #41's hybrid medical record revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for November 2021, December 2021 and January 2022 monthly physician's orders was not in the chart and there was no electronic signature.

7 . Resident #51's hybrid medical record revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for November 2021, December 2021 and January 2022 monthly physician's orders was not in the chart and there was no electronic signature.

8. Resident #71's hybrid medical record revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for November 2021, December 2021 and January 2022 monthly physician's orders was not in the chart and there was no electronic signature.

9. Resident #86's hybrid medical record revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for November 2021, December 2021 and January 2022 monthly physician's orders was not in the chart and there was no electronic signature.

10. Resident #99's hybrid medical record

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revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for December 2021 and January 2022 monthly physician's orders was not in the chart and there was no electronic signature.

11. Resident #100's hybrid medical record revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for December 2021 and January 2022 monthly physician's orders was not in the chart and there was no electronic signature.

12. Resident #144's hybrid medical record revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for November 2021 and December 2021 monthly physician's orders was not in the chart and there was no electronic signature.

13. Resident #78's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2021. In addition, the January 2022 and February 2022 monthly physician's orders were not in the chart and there were no electronic signatures.

14. Resident # 128's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for October 2021, November 2021, or December 2021. In addition, the January 2022 and February 2022 monthly physician's orders were not in the chart and there were no electronic signatures.

15. Resident # 137's hybrid medical records revealed the resident's physician had not hand

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signed or electronically signed the monthly physician's orders for October 2021, November 2021, or December 2021. In addition, the January 2022 and February 2022 monthly physician's orders were not in the chart and there were no electronic signatures.

16. Resident # 149's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021. In addition, the January 2022 and February 2022 monthly physician's orders were not in the chart and there were no electronic signatures.

17. Resident #55's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for September 2021, October 2021, November 2021, and December 2021. In addition, the January 2022 and February 2022 monthly physician's orders were not in the chart and there were no electronic signatures.

18. Resident #60's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021. In addition, the January 2022 and February 2022 monthly physician's orders were not in the chart and there were no electronic signatures.

On 2/4/22 at 12:38 PM, the surveyors discussed the above findings with the Director of Nursing and Administrator.

On 2/7/22 at 10:00 AM the surveyor interviewed the LPN/UM #3 on the [redacted] floor. The LPN/UM #3 confirmed the January and February

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F 711	Continued From page 17 Order Summary Reports were not in the chart. He stated the 11-7 staff person is responsible for putting the orders in the chart. On 2/7/22 the Director of Nursing provided the surveyors with the facility policy titled Physician Orders, reviewed 10/2021. The policy indicated all orders must be signed by an authorized, credentialed physician or other authorized practitioner in accordance with state regulations regarding prescriptive privileges. NJAC 8:39-23.2	F 711		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		2/22/22

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F 761	Continued From page 18 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to store insulin vials consistent with manufacturer specifications and failed to properly label a vial of insulin. This was found with 2 of 5 medication carts inspected. The deficient practice was evidenced as follows: On 2/1/22 at 12:34 PM, the surveyor inspected the third floor medication cart for the C Side in the presence of the Registered Nurse who was assigned to the cart. There was a vial of Lispro insulin that was unopened in the cart. The bag that contained the vial of insulin had a sticker on it that read "Refrigerate until opened." There was also a vial of Lantus insulin that was in the cart unopened. There was a sticker on the box that held the vial that said "Refrigerate until opened" and on the bag that held the box and the vial that read "Refrigerate until opened." On 2/1/22 at 12:45 PM, the surveyor inspected the third floor medication cart for the A Side in the presence of the Licensed Practical Nurse that was assigned to the cart. There was a vial of Humalog insulin that was unopened in the cart. The bag that held the insulin had a sticker on it that read "Refrigerate until opened." There was also an opened insulin vial. The vial or the box that held the vial had no pharmacy label	F 761	Deficiency: F761 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Medications removed, replacements ordered and placed in refrigerator until use. Medication cart audit completed to ensure medication is labeled properly. Pharmacy notified for proper labeling with resident name on all medications. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this deficient practice. Upon receiving medication from pharmacy DON/Designee will ensure all meds are properly labeled and stored accordingly. Medication cart audit will be conducted to ensure same deficient practice will not occur. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON/ Designee conducted facility wide in-service for labeling and storage.	

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F 761	Continued From page 19 with a resident's name. The bag that held the box and vial had a pharmacy label on it with a resident's name. On 2/3/22 at 1:34 PM, the surveyor spoke to the Director of Nursing (DON) and the Administrator. The surveyor shared the concern with the unopened insulin being stored in the medication cart instead of the refrigerator and the insulin with no pharmacy label with a resident's name that matched the pharmacy label on the bag that held it. The DON confirmed that the insulin vials that were unopened should have been in the refrigerator and the vial of insulin should have had a pharmacy label on it with a resident's name that matched the label on the bag. On 2/9/22 at 12:00 PM, the surveyor reviewed the facility's undated policy and procedure titled "7.0 Insulin Pen Labeling & Packaging." The regional nurse that provided it stated "This is from the pharmacy for pens and vials. They have nothing specific for vials." Under "Policy" it read "Insulin pens are to be individually labeled and placed in a reclosable plastic bag to control the spread of infection." The surveyor then reviewed the facility policy and procedure with a review date of 11/2021 and titled "Medication Storage." Number 6 read "Medication will be stored at the appropriate temperature in accordance with manufacturer and pharmacy labeling." NJAC 8:39-29.4 (a), (h)	F 761	4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Don/Designee will conduct weekly cart audits to ensure proper labeling and storage is done x 1 month, then biweekly x 1 month, then monthly. All findings will be reported during monthly QAPI	
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State	F 836		5/12/22

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F 836	Continued From page 20 and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to have sufficient nursing staff to meet the needs of residents. The facility did not schedule enough staff to ensure residents' activities of daily living (ADL) needs were met for 2 residents, #137 and	F 836	Deficiency: F836 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Administrator and staffing coordinator	

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F 836	Continued From page 21 #23, who were dependent on staff for ADLs. The deficient practice is evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth	F 836	went to local CNA school for recruitment. TNA's were hired and are in school for CNA license. There is an recruitment advertisement for LPNS, CNAS and RNS. Management is conducting weekly analysis on CNA needs. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The supervisor and staffing coordinator will audit the staffing par for each unit every shift. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The staffing coordinator will audit the staffing par daily and staff each unit accordingly to the unit census. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Director of Nursing /Assistant Director of Nursing along with staffing coordinator will conduct staffing/scheduling audits 2 times per week x 4 weeks to discuss staffing needs according to par levels with census. All findings will be reported during QAPI monthly.	

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place.

(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.

(3) All computations shall be based on the midnight census for the day in which the shift begins.

d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...

A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks beginning 1/16/22 and 1/23/22 revealed the following:

The facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs during the 7:00 AM - 3:00 PM shift for 14 days beginning 1/16/22 and ending 1/29/22 as evidenced by the following:

- 01/16/22 had 10 CNAs for 156 residents on the day shift, required 20 CNAs.
- 01/17/22 had 10 CNAs for 156 residents on the day shift, required 20 CNAs.
- 01/18/22 had 12 CNAs for 156 residents on the day shift, required 20 CNAs.

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- 01/19/22 had 10 CNAs for 156 residents on the day shift, required 20 CNAs.
- 01/20/22 had 9 CNAs for 156 residents on the day shift, required 20 CNAs.
- 01/21/22 had 12 CNAs for 158 residents on the day shift, required 20 CNAs.
- 01/22/22 had 10 CNAs for 158 residents on the day shift, required 20 CNAs.
- 01/23/22 had 10 CNAs for 158 residents on the day shift, required 20 CNAs.
- 01/24/22 had 11 CNAs for 159 residents on the day shift, required 20 CNAs.
- 01/25/22 had 11 CNAs for 159 residents on the day shift, required 20 CNAs.
- 01/26/22 had 11 CNAs for 159 residents on the day shift, required 20 CNAs.
- 01/27/22 had 11 CNAs for 159 residents on the day shift, required 20 CNAs.
- 01/28/22 had 9 CNAs for 167 residents on the day shift, required 21 CNAs.
- 01/29/22 had 10 CNAs for 167 residents on the day shift, required 21 CNAs.

Additionally, the facility was deficient in total staff for residents on 1 of 14 evening shifts as follows:

-01/29/22 had 15 total staff for 167 residents on the evening shift, required 17 total staff.

On 2/1/22 at 10:10 AM, the surveyor interviewed Resident #137. The resident stated they were waiting to get washed. The resident stated the previous day they got washed in the afternoon even though they told staff they preferred to get washed at 9:00 AM. CNA #1 stated they are working short of staff and it is impossible for three CNAs (the amount of CNAs scheduled for the unit on 2/1/22) to honor everyone's preferences.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315178	A. BUILDING _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE EAST ORANGE, NJ 07017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 24 On 2/1/22 at 10:45 AM, the surveyor interviewed CNA #2 who was assigned to Resident #23. The CNA stated she had 15 residents on her assignment that day. The CNA further stated she tried her best (to take care of residents in a timely manner) but she had a lot of residents and could only move so fast. On 2/8/22 at 1:50 PM, the surveyor interviewed CNA #3 regarding residents' nail care. She stated she doesn't have time to cut residents' nails because there is not enough staff. She stated she had not finished washing her residents (at 1:50 PM) and had not taken a lunch break. On 2/9/22 at 12:30 PM, the surveyor discussed the staffing ratio concerns with the Director of Nursing (DON) and the Staffing Coordinator (SC). The SC stated she was aware of the current required staffing ratios and aware that the facility has been short on staff. The DON and the SC discussed the various ways the facility is recruiting new staff. The SC stated 2 new CNAs were hired the previous day. The facility policy titled Staffing, updated 10/21, indicated the facility provides enough staff with the skills and competency necessary for all residents in accordance with resident care plans and the facility assessment.	F 836		
F 880 SS=D	NJAC 8:39- 25.2 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		5/9/22

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	315178	A. BUILDING _____ B. WING _____	C 02/09/2022

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COMPLETE CARE AT ORANGE PARK	140 PARK AVE EAST ORANGE, NJ 07017

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F 880	Continued From page 25	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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COMPLETE CARE AT ORANGE PARK	140 PARK AVE EAST ORANGE, NJ 07017

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F 880	Continued From page 26 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to follow effective infection control practices to reduce the spread of infection during the 2/3/22 medication pass. The deficient practice was identified for 2 nurses, Licensed Practical Nurse (LPN) #1 and #2, of 6 nurses observed during the Medication Administration Task and is evidenced as follows: On 2/3/22 at 8:40 AM, the surveyor observed LPN #1 prepare to administer medications to a resident. LPN #1 determined the blood pressure machine battery needed to be charged. LPN #1 obtained a blood pressure machine from LPN #2,	F 880	Deficiency: F880 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: 1:1 in-service given to Nurse # 1 and 2 on proper sanitation of equipment in between residents before and after use. 1:1 in-service given to nurse #2 on proper infection control practices such as hand hygiene, donning , PPE, and not returning to med cart with items that were brought into patients room. Nurse # 1 and #2 failed to follow facilities	

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F 880	Continued From page 27 who was administering medications on an adjacent hallway on the same unit. LPN #1 did not sanitize the blood pressure machine before or after measuring the resident's blood pressure. When questioned by the surveyor, LPN #1 stated she would sanitize the machine before using it on the next resident. The surveyor completed the medication pass observation of LPN #1 at 9:00 AM and immediately approached LPN #2 to begin the next medication pass observation. LPN #2 stated he needed to retrieve the blood pressure machine from LPN #1. LPN #2 returned to the medication cart with the blood pressure machine. LPN #2 donned gloves, did not sanitize the blood pressure machine, entered the resident's room and used the machine on the resident. LPN #2 removed the gloves, and without performing hand hygiene, began to pour medications for administration to the resident. LPN #2 removed medications from inside the medication cart, including a bottle of eye drops in a plastic zip lock bag and a box of tissues. After pouring the medications, LPN #2 donned gloves and touched multiple drawer pulls on the medication cart and locked the cart with gloved hands. The nurse placed the eye drop container in the zip lock bag and the box of tissues on the resident's over bed table. There were numerous personal items of the resident's on the over bed table. LPN #2 administered oral medications and eye drops to right and left eyes with the soiled gloves. LPN #2 removed his gloves and washed his hands in the resident's bathroom. He lathered his hands outside of running water for 15 seconds. LPN #2 confirmed facility policy required at least	F 880	infection control protocols ongoing 1:1 in-services to be conducted to nurses involved in deficient practices with competencies to ensure deficient practice does not reoccur. All nurses were in-serviced on infection control, handwashing, and not to return personal items that were used in resident room to the medication cart ie: tissue boxes. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All resident can be affected by this deficient practice. Director of Nursing /designee will conduct infection control audits. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Director of nursing /designee conducted facility wide in-service on infection control practices including hand hygiene and cleaning/disinfection of non-critical resident care items. LTC assessment completed. The following videos were viewed by infection preventionist and all staff and in the facility Clean hand, Keep Covid out, sparkling surfaces, and proper donning and doffing of PPE. CDC train was also completed CDC train module 6a Principles of standard precautions, CDC train Module 6b Principles of transmission- based precaution, CDC train Module 11 b Environmental	

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F 880	Continued From page 28 20 seconds of lathering outside of running water. LPN #2 removed the eye drop bottle, plastic zip lock bag, and tissue box from the resident's over bed table and returned them to the inside of the medication cart without first sanitizing the surfaces. The surveyor interviewed LPN #2 after the medication pass observation and reviewed the breaks in infection control practices with the nurse. He expressed understanding of the omissions concerning hand hygiene, sanitizing medical equipment after use, and sanitizing items before returning them to the medication cart. On 2/3/22 at 9:20 AM, the surveyor returned to interview LPN #1 who stated it would have been best practice to sanitize the blood pressure machine immediately after use. On 2/3/22 at 9:30 AM, the surveyor discussed the infection control concerns with the LPN Unit Manager. He expressed understanding and stated he would educate LPN #1 and #2. On 2/3/22 at 1:30 PM, the surveyor reported the concerns to the Administrator, Director of Nursing (DON), and regional staff persons. On 2/7/22 at 9:45 AM the DON provided the surveyor with the following facility policies: 1. Handwashing/Hand Hygiene, updated 1/2022, included directives to perform hand hygiene after removing gloves. The policy indicated that hands are to be vigorously lathered with soap for a minimum of 20 seconds. The policy further directed that hand hygiene is the final step after removing and disposing of personal protective equipment.	F 880	disinfection, CDC train module 7 Hand Hygiene. All topline staff and infection preventionist completed CDC train Module 1 Infection Preventionist, Module 4 infection surveillance, and Module 11a reprocessing reusable care equipment. Weekly infection control in-services ongoing for all staff in the facility. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Director of nursing / designee will conduct weekly audits for infection practices, hand hygiene competencies and sanitation of non-critical care items weekly x 1 month, then bi weekly x 1 month then monthly. All finding will be reported during QAPI monthly.	

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F 880	Continued From page 29 2. Cleaning and Disinfecting Non-Critical Resident Care items, revised/reviewed 10/2021, indicated reusable items (i.e. stethoscopes, durable medical equipment) are cleaned and disinfected between residents. NJAC 8:39-19.1(b)	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, conducted from 2/01/22 to 2/03/22 in the presence of the Maintenance Director, it was determined that the facility failed to maintain their Packaged Terminal Air Conditioner (PTAC) units in safe and optimal condition. This deficient practice was evidenced for 102 of 102 PTAC units observed by the following: While touring the facility from 9:00 AM to 1:00 PM, the surveyor observed that PTAC units had clogged and dirty filters in the following resident rooms: [redacted]	F 908	F908 Essential Equipment, Safe Operating Condition HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE All PTAC units in the Facility were inspected and filters changed on February 3, 2022. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents have the potential of being affected by this deficient practice. No negative findings were currently noted to any Resident or Staff. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Facility Protocol was put in place to	4/8/22

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COMPLETE CARE AT ORANGE PARK	140 PARK AVE EAST ORANGE, NJ 07017

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F 908	Continued From page 30 [redacted] When interviewed at the time of the observations, the Maintenance Director agreed that the PTAC filters should not be like that in the facility. A log indicated that PTAC filters was not provided and no policy and procedure on the maintenance of PTAC units were provided at that time. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 2/03/22. NJAC 8:39 - 31.2(e)	F 908	ensure all Facility PTAC units are inspected monthly for functioning and cleanliness. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance director and/or designee will conduct monthly rounding to all Facility PTAC units and document findings in the maintenance log. All findings will be reviewed at the Facility QAPI MONTHLY meeting through the next 12 months.	
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview from 2/01/22 to 2/03/22, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that wooden handrails were installed, secured and splinter free in all required locations. This deficient practice was evidenced by the following: From 2/01/22 to 2/03/22, while touring the facility from 9:45 AM to 12:15 PM, the surveyor observed wooden handrails that were not	F 924	F924 Corridors have Firmly Secured Handrails 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: This deficient practice has the potential to affect all Residents and Staff. No Residents or Staff were injured due to these findings.	4/18/22

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COMPLETE CARE AT ORANGE PARK	140 PARK AVE EAST ORANGE, NJ 07017

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F 924	Continued From page 31 secured and splinter free on Floors #3, #2, #1 and ground floor in all areas of the facility. At that same time, an interview was conducted during the observations with the Maintenance Director, who had agreed and confirmed that the areas observed did have wooden handrails that needed to be sanded, finished, installed and secured. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e)	F 924	2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: This deficient practice has the potential to affect all Residents and Staff. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All facility handrails on #3, #2, #1 were fixed, installed and secured by to ensure a safe environment for all Residents and Staff. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director and/or designee will conduct monthly rounding to ensure compliance with all handrails and document findings in the maintenance log. All findings will be reviewed at the Facility QAPI MONTHLY meeting through the next 12 months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315178 Y1	A. Building B. Wing Y2	5/20/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE EAST ORANGE, NJ 07017

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 F0552	Correction	ID Prefix F0584	Correction	ID Prefix F0677	Correction
Reg. # 483.10(c)(1)(4)(5)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	04/13/2022	LSC	04/18/2022	LSC	04/08/2022
ID Prefix F0711	Correction	ID Prefix F0761	Correction	ID Prefix F0836	Correction
Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.70(a)-(c)	Completed
LSC	04/08/2022	LSC	02/22/2022	LSC	05/12/2022
ID Prefix F0880	Correction	ID Prefix F0908	Correction	ID Prefix F0924	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(d)(2)	Completed	Reg. # 483.90(i)(3)	Completed
LSC	05/09/2022	LSC	04/08/2022	LSC	04/18/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/9/2022	☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315178	A. BUILDING **01** B. WING _____	C **02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 2/01/22 to 2/03/22,was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 3- building that was built in 80's, It is composed of Type II unprotected construction. The facility is divided into 14- smoke zones. The generator does 100% of the building. The building has a ground floor and a partial basement. The facility utilized 1135 waivers allowing for regulatory flexibility during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibility did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 215 certified beds. At the time of	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/22/2022

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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COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

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K 000	Continued From page 1 the survey the census was 166.	K 000		
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/01/22, in the presence of the Maintenance Director, it was determined that the facility failed to provide two acceptable exits from each floor as evidenced by the following: At 10:00 AM, the surveyor and the facility's Maintenance Director, observed that the basement area was provided with only one exit. The exit was a stairway to the first floor. The basement level was used only for mechanical space, maintenance office and laundry. No residents were allowed into the basement and residents do not have access to this level. At the time, the surveyor interviewed the Maintenance Director who acknowledged there were not two exits in the basement area. At the time of observation there were three laundry staff and one assistant maintenance staff member working in the area.	K 252	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: This deficiency has the potential to affect any employee who works in the maintenance and laundry area in the basement; no residents have the potential of being affected by this deficient practice. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All remainder of the Facility areas meet the requirements of this regulation. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC	5/12/22

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	315178	A. BUILDING **01** B. WING _____	C **02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 252	Continued From page 2 An interview was conducted with the Administrator and Maintenance Director and they confirmed that the project for the basement exit was to be completed by Windsor Gardens and at this time the project was not started. The facility was given a time-limited waiver that expired on 10/31/2021, but did not complete the work. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e)	K 252	CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Visitors do not have access to this area additional exit signs are in place to guide staff to appropriate additional exit signs. Maintenance Director or Supervisor will monitor the area for safety daily. The facility respectfully requests a time limited waiver to fix the issue. A waiver request form was completed on 5/12/2022 to complete the work that is required in the basement to correct this issue. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR.I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Facility respectfully requested a time limited waiver dated 11/23/23 to allow time to correct the deficient practice by way of installing an exit. Project Plan to be reviewed at monthly QAPI x12.	
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual	K 281		4/13/22

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K 281	Continued From page 3 intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 2/01/22 to 2/03/22, the facility failed to provide automatic emergency illumination, that would operate automatically along the means of egress, and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.8, 7.8.1.1, 7.8.1.2, 7.8.1.4. The deficient practice was evidenced by the following: At 10:38 AM, the surveyor and Maintenance Director observed in the smoking courtyard at the egress/discharge gate with a keypad and keyed-lockset, that there was no emergency lighting at the lock or beyond the gate to the public way. The findings were verified by the Maintenance Director at the times of the observation. The Administrator was informed of the findings at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e)	K 281	K281: ILLUMINATION OF MEANS OF EGGRESS 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO This deficient practice has the potential to affect any Resident or Staff in the area. This deficiency can affect all residents who smoke. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All other Facility areas currently meet this requirement. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Facility installed emergency lighting to the smoking courtyard completed on February 22, 2022. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance will audit lighting function weekly x 4 weeks, then monthly x 2	

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K 281	Continued From page 4	K 281	months and lastly quarterly x3 quarters. Findings will be reported to the Administrator and/or designee at the facility's QAPI meeting monthly.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 2/01/22 to 2/03/22, it was determined that the facility failed to provide an operational battery backup emergency light above the emergency generator's transfer switches, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was observed for 2 of 2 transfer switches and was evidenced by the following: At 10:04 AM, the surveyor and Maintenance Director, observed in the ground floor physical therapy room, where the generator transfer switch's were located, that no emergency lighting was provided at each of the 2-ATS switches. This finding was verified by the Maintenance Director, at the time of the observation's. The Administrator was notified of the above findings at the Life Safety Code exit conference on 2/03/22.	K 291	K291: EMERGENCY LIGHTING 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: This deficient practice has the potential to affect any Resident or Staff in the area. This deficiency can affect all residents in the event of power outage. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents or staff members have been affected by this deficiency. 3 WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEM CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIEN PRCTICE WILL NOT RECUR: On 2/17/22 Maintenance director installed 2 emergency lights on the generator transfer switch closet .	4/8/22

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K 291	Continued From page 5 NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	These emergency lights has been added to facility weekly emergency lights switch maintenance log. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Emergency light will be tested on a weekly by the maintenance department or designee schedule, and will be brought to the QA meeting monthly x 12 months	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		4/13/22

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K 321	Continued From page 6 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 and interview from 2/02/22 to 2/03/22, in the presence of the Maintenance Director, it was determined that the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous area 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 practice was observed in 1 of 10 hazardous storage areas in the facility and was evidenced by the following: On 2/02/22 at 11:28 AM, the surveyor observed on the ground floor Team Member Services/HR room, that 50 plus combustible cardboard boxes were being stored, and the door did not have a self-closing device installed. The room was greater than 50 square feet in size. An interview was conducted with the Maintenance Director during the observation, who stated that hazardous storage areas must have a door with a self-closing device. The Administrator was informed of the finding, at the Life Safety Code exit conference on 2/03/21. NJAC 8:39-31.2(e)	K 321	K321 HAZARDOUS AREAS-ENCLOSURE 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: This deficient practice has the potential to affect all Residents and employees. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No Residents or employees were affected but the potential to be affected is there. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Self-closing closers were installed on the identified door to the Human Resources office on February 22, 2022. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:	

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K 321	Continued From page 7	K 321	Maintenance and/or designee will conduct audits daily to ensure self-closing function to all fire barrier doors are properly working. Audits will be reviewed by the Maintenance Director and/or designees and reviewed at the facility's QAPI monthly meeting through the next 12 months.	
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/03/22, the facility failed to provide and maintain supervised smoke/heat detection in operating condition at all times in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.4.1, 9.6, 4.6.12.1 and NFPA 72. This deficient practice was evidenced in 1 of 30 smoke detectors observed in the following area. On 2/03/22 at approximately 12:48 PM, the surveyor and the Maintenance Director observed in the first floor shower room that 1 of 1 fire alarm smoke/heat detectors, was taped from activation by black electrical tape. An interview was conducted with the Maintenance	K 345	K345 Fire Alarm System- Testing and Maintenance 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Identified fire alarm smoke/heat detector located in the first-floor shower room and removed the black electrical tape which had been inadvertently placed over the device. The alarm was tested and was found to be functioning properly. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE	4/14/22

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K 345	Continued From page 8 Director during the observation and he stated that he was unsure why the detector was blocked with tape to prevent an activation. The Administrator was notified of the finding at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e) NFPA 70,72	K 345	POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents and staff have the potential of being affected by this deficient practice. No Residents were affected by this deficient practice. Maintenance Director conducted a full building audit to ensure all smoke detectors were functioning properly and within proper code. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Maintenance Department and/or designee will conduct weekly rounds to ensure compliance is maintained. 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: 5 The Maintenance Department and/or designee will conduct weekly rounds to ensure compliance is maintained. All findings will be documented on the Maintenance log book and reviewed at the Facility QAPI monthly meeting through the next 12 months.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353		5/11/22

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K 353	Continued From page 9 inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/25/22, it was determined that the facility failed to maintain the sprinkler system,1.) by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, 2.) it was determined that the facility failed to inspect the automatic fire sprinkler system quarterly for 3 of 4 inspections in accordance with NFPA 25. Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. 1. From 2/02/22 to 2/03/22, during a building tour from 9:30 AM, to 1:25 PM, the surveyor, and Maintenance Director, observed drop ceiling tiles missing and/or holes in the ceiling tiles (sheetrock) and bad cuts around the fire sprinkler heads in the following areas of the facility: Between resident room [redacted] and [redacted] open ceiling	K 353	K353 Sprinkler System- Maintenance and Testing 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: All Residents and Staff have the potential of being affected by this deficient practice. All identified drop ceiling tiles noted by the Life Safety Inspector were replaced and corrected within compliance. All quarterly fire inspection reports were for the year 2021 were received and filed in the Life Safety Facility Book. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents have the potential of being	

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K 353	Continued From page 10 tiles third floor lounge bathroom open ceiling tile Resident room [redacted] escutcheon plate not in place Resident room [redacted] ceiling tiles missing Ceiling tiles missing North Stairwell first floor Resident room [redacted] ceiling tiles missing Resident room [redacted] ceiling tiles missing Second floor day room conduit into ceiling (bad cuts) Resident room [redacted] missing ceiling tiles West Stair second floor escutcheon plate missing Rehab exit ceiling tile on floor from ceiling approximately 4' x 2' Resident room [redacted] ceiling tile missing Resident room [redacted] ceiling tiles missing Storage access by room [redacted] missing ceiling tile Resident room [redacted] ceiling tile (bad cut) Resident room [redacted] ceiling tile in the bathroom missing 2. From 2/02/22 to 2/03/22 record review indicated that fire sprinkler inspections for each quarter of 2021, were not provided from the Maintenance Director. He stated that due to the previous ownership and the new facility management company and payment issues, the fire sprinkler inspections were done, but the fire sprinkler vendor will not release the inspection documents. The new management company did provide an inspection dated 2/02/22 and there were not current issues with the system. The Maintenance Director stated and confirmed the above findings during the building tour and record review interview from 2/02/22 to 2/03/22. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 2/03/22.	K 353	affected by this deficient practice. Maintenance Director conducted a full building audit with the Administrator to ensure all ceiling tiles are intact and within compliance. A fire sprinkler inspection was conducted on February 2, 2022, with no identified issue with the Facility system. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Maintenance will conduct weekly audits throughout the center to ensure all ceiling tiles are within compliance. Education was also provided to all staff on the importance of documenting any concerns with ceiling tiles in the Maintenance logbook for Maintenance to review. Quarterly sprinkler inspections are pre-scheduled for the remainder of the year. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: facility has a designated contractor to maintain quarterly inspection on the sprinkler system. All audit findings will be reviewed at the Facility QAPI MONTHLY meeting through the next 6 months.	

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K 353	Continued From page 11 NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363		5/11/22

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COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

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K 363	Continued From page 12 and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview from 2/01/22 to 2/03/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 4 of 40 resident room door's and storage areas and was evidenced by the following: From 2/02/22 to 2/03/22, during the building tour from 9:00 AM to 1:00 PM, the surveyor and Maintenance Director, observed that the doors to resident rooms, did not latch into the door frame in the following room numbers: #[redacted] door sticks into frame #[redacted] door does not latch, paper towel folded and stuffed into latch frame #[redacted] door will not latch, hardware malfunction Storage room door across from resident room #[redacted] will not latch, hardware malfunction. An interview was conducted with the Maintenance Director, who stated and confirmed that the above resident room doors and storage room, had hardware issues that prevented the doors from latching into there frame's properly.	K 363	K363-Corridors -Doors 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The four rooms identified as not properly latching (#[redacted], #[redacted], #[redacted], Storage room across from RM #[redacted]) immediately were corrected to ensure compliance. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents and staff have the potential of being affected by this deficient practice. No Residents were affected by this deficient practice. Maintenance Director conducted a full building audit to ensure all further Facility room doors were securely latching and closing. No further findings currently noted. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: the facility will ensure that all corridor doors can resist the passage of smoke in accordance with the requirements of	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315178	A. BUILDING **01** B. WING _____	C **02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

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K 363	Continued From page 13 The Administrator was informed of the finding at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.1(c), 31.2(e)	K 363	NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. by performing daily rounds conducted by Maintenance director or designee. This practice will Ensure that all room doors will close, and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance Department and/or designee will conduct daily rounds to ensure compliance is maintained. All findings will be documented on the Maintenance logbook and reviewed at the Facility QAPI Monthly meeting through the next 12 months.	
K 374 SS=D	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	K 374		4/18/22

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	315178	A. BUILDING **01** B. WING _____	C **02/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

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K 374	Continued From page 14 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 2/03/22 in the presence of the Maintenance Director, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 9 smoke barrier door sets observed and was evidenced by the following: At 1:14 PM, the surveyor observed that 1 of 2 smoke barrier doors by resident room 234 were blocked from fully closing by a stored linen cart. The linen cart was directly in front of the right-side door by resident room 234, when released from the electro-magnetic hold open device 1 of 2 doors released and closed and one door remained open due to the linen cart blocking the door. The Maintenance Director, confirmed the findings above during the observation. The facility Administrator was informed of the findings during the Life Safety Code survey exit conference on 2/03/22. NJAC 8:39-31.1(c), 31.2(e)	K 374	K374 Subdivision of Building Spaces-Smoke Barrier 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The linen cart was immediately removed from blocking the smoke barrier door. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents, Staff and Visitors have the potential of being affected by this deficient practice. No other areas were found to be blocked or improperly latching. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: In-services were conducted by the Maintenance Director and Nursing supervisor on February 3, 2022, and February 17, 2022, to all employees on	

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COMPLETE CARE AT ORANGE PARK	**140 PARK AVE** **EAST ORANGE, NJ 07017**

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K 374	Continued From page 15	K 374	the 3 shifts. The Maintenance Director and/or designee will conduct daily rounds to ensure that doors are properly latching and not blocked by Facility carts. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance Department will conduct weekly audits x 4 weeks, then monthly x 2 months and lastly quarterly x3 quarters. All findings will be documented in the Maintenance logbook and reviewed at the facilitys QAPI MONTHLY meeting.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 2/02/22 to 2/03/22, in the presence of the facility Maintenance Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 2 of 90 units were adequately maintained, in accordance with the	K 521	K521 HVAC 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE:	4/14/22

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K 521	Continued From page 16 National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: While touring the building from 2/02/22 to 2/03/22, from approximately 10:30 AM to 1:30 PM, the surveyor, in the presence of the Maintenance Director, observed that the ventilation in the following resident room bathrooms did not function: # 201, #136 The surveyor requested that the Maintenance Director, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Maintenance Director who confirmed that the exhaust vents in the above resident room bathrooms, were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference on 2/03/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	Residents bathroom ventilation system for rooms [redacted] and [redacted] were replaced and corrected on February 22, 2022. No further concerns noted to these rooms. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents have the potential of being affected by this deficient practice. No further findings noted in any other Resident room/area. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Maintenance Director and/or designee will conduct weekly room inspection to ensure all room ventilation systems are being maintained and properly functioning. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance Director and/or designee will conduct weekly room rounds and document any negative findings in the Maintenance logbook. All findings will be reviewed at the Facility QAPI meeting	

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K 521	Continued From page 17	K 521	monthly x12 months	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/03/21, in the presence of the Maintenance Director, it was determined that the facility failed to maintain elevator emergency communication for 3 of 3 passenger elevator telephones tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: At 11:56 AM, the surveyor had the Maintenance Director conduct a test of the emergency	K 531	K531- Elevators 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Facility immediately contracted a new vendor on 2/4/2022. They serviced Facility Elevators and swapped out the phone lines in order to ensure proper communication between the center and the vendor is in place.	4/18/22

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K 531	Continued From page 18 communication telephone system in the (3) facility passenger elevators. The emergency telephone did function properly, but the vendor that answered the phone indicated that the contract was expired and they would no longer answer any further communication issues and asked the Maintenance Director to remove them from the emergency telephone directory immediately. The Administrator was informed of this finding at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents and staff have the potential of being affected by this deficient practice. No Residents or staff were affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly Elevator emergency phone line inspection will be conducted by our maintenance Director or designee or outside vendor company which included Monthly Phase 2 inspections. 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance Department and/or designee will provide all findings from the monthly inspections to the Facility QAPI monthly meeting through the next 12 months.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101	K 911		4/13/22

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K 911	Continued From page 19 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 2/03/22, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that electrical panels were up to code as per NFPA 99. This deficient practice was evidenced for 1 of 10 electrical panels observed by the following: On 2/03/22 at 10:48 AM, the surveyor and Maintenance Director observed the utility room on the third floor by resident room 313, that the right-side electrical panel's face plate, was not in the proper position exposing the main breaker bar and live electrical wires. The door to the electrical room was locked at the time of the observation. The Maintenance Director confirmed the finding during the observation. The Administrator was informed of the finding at the Life Safety Code exit conference on 2/03/22. NFPA 99 NJAC 8:39-31.2(e)	K 911	K911- Electrical Systems 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: All Residents and staff have the potential of being affected by this deficient practice. The electrical door panel to the identified utility room on the third floor was secured with no further exposed wires. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No Residents or staff were affected by this deficient practice. No further findings were noted throughout the Facility. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Maintenance Director and/or designee will conduct monthly audits to ensure compliance is maintained.	

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K 911	Continued From page 20	K 911	4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: All findings will be documented on the Maintenance logbook and reviewed at the Facility QAPI MONTHLY meeting through the next 6 months.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920		4/13/22

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K 920	Continued From page 21 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/02/22, the facility did not prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was evidenced by the following: At 9:40 AM, the Surveyor and Maintenance Director, observed in resident room 324 (windowside bed), that electronics were plugged into a white household grade extension cord. The extension cord was then plugged into the duplex wall outlet. The finding was verified by the Maintenance Director at the time of the observation. The Administrator was notified of the findings at the Life Safety Code exit conference on 2/03/22. NJAC 8:39-31.2(e)	K 920	K920 Electrical Equipment- Power Cords and Extension 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: This deficient practice has the potential to affect Residents, Staff, and the Facility. There was no notable injury or negative findings currently due to this practice. The electrical cord was immediately removed on 2/3/2022 from the Residents room with education to the Resident and family. Alternate resources were provided to meet the Residents electronic needs. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The Maintenance Director conducted a full building audit to ensure no further findings were noted. No residents, Staff or Facility was affected. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All employees have been educated on this deficient practice. Residents have been educated during Resident Council as well	

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K 920	Continued From page 22	K 920	on the importance of speaking with Maintenance for any electrical needs in their rooms. Maintenance will round all rooms monthly to ensure compliance. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance director and/or designee will conduct monthly rounds to all center areas and log findings in the maintenance log. All findings will be reviewed at the Facility QAPI MONTHLY meeting through the next 12 months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315178 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/22/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE EAST ORANGE, NJ 07017

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0252	05/12/2022	LSC K0281	04/13/2022	LSC K0291	04/08/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	04/13/2022	LSC K0345	04/14/2022	LSC K0353	05/11/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	05/11/2022	LSC K0374	04/18/2022	LSC K0521	04/14/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	04/18/2022	LSC K0911	04/13/2022	LSC K0920	04/13/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/9/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO