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	315393	A. BUILDING _____ B. WING _____	01/11/2023

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NEW COMMUNITY EXTENDED CARE FACILITY	**266 S ORANGE AVE NEWARK, NJ 07103**

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F 000	INITIAL COMMENTS Standard Survey: 1/11/23 Census: 99 Sample Size: 22 A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		2/3/23

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

Electronically Signed | 02/03/2023

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

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to initiate a comprehensive care plan for 2 of 20 residents reviewed for care planning, Residents #58 and #209. The deficient practice is evidenced by the following. 1. Resident #58 was observed by the surveyor on 1/4/23 at 9:39 AM awake in bed watching television. The resident was conversant with encouragement by the surveyor. A review of the hybrid medical record (electronic and paper) revealed the following information: The resident's Record of Admission included admission diagnoses of Ex Order 26. 4B1	F 656	F656 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE 1. Resident #58: Administrator, Director of Nursing, members of Interdisciplinary Team met and reviewed the resident□s plan of care and concurred with the surveyor□s finding that resident #58 plan of care did not address the Ex Order 26. 4B1 diagnosis or the [redacted] medication used in the management of this diagnosis and possible side effects. 2. Resident # 209: Administrator, Director of Nursing, members of Interdisciplinary Team met and reviewed the resident□s plan of care and agreed with the surveyor□s finding that resident #209 plan of care did not address the	

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F 656	Continued From page 2 Ex Order 26. 4B1 . The Ex Order 26. 4B1 Physician Orders included an order for the Ex Order 26. 4B1 medication, Ex Order 26. 4B1 . administered twice daily for Ex Order 26. 4B1 . The Ex Order 26. 4B1 quarterly Minimum Data Set (MDS) assessment tool, Section C, indicated the resident had Ex Order 26. 4B1 as evidenced by a Brief Interview for Mental Status (BIMS) score of . Section N indicated the resident received Ex Order 26. 4B1 medication daily during the assessment period. The Ex Order 26. 4B1 Ex Order 26. 4B1 Follow Up Note included documentation reflecting the resident had a history of and ongoing episodes of and Ex Order 26. 4B1 related to Ex Order 26. 4B1 . The practitioner noted the resident's condition may be improved with medication, support, redirection, and environmental factors. A photocopy of the Plan of Care - Current was provided to the surveyor by the Social Services Director. The care plan did not include a comprehensive care plan addressing the resident's Ex Order 26. 4B1 or the use of Ex Order 26. 4B1 . The surveyor interviewed the Director of Nursing (DON) on 1/10/23 at 1:14 PM to discuss the care plan omission. The DON stated the resident should have been care planned for Ex Order 26. 4B1 and the use of Ex Order 26. 4B1 2. Resident #209 was observed by the surveyor	F 656	Diabetic diagnosis, pain management nor did it address the possible complications that could arise from the use of insulin. CAUSE OF PROBLEM IDENTIFICATION: The Administrator, Director of Nursing, Interdisciplinary Team and unit charge nurses met and reviewed the identified residents medical records and confirmed the deficient practice as identified by the surveyor. This deficient practice occurred because the Director of Nursing, Interdisciplinary Team members, failed to review the residents plan of care during care plan meetings to ensure it covers all triggered areas reflecting individual person-centered care. What corrective action will be accomplished for those residents found to have been affected by deficient practice? The Director of Nursing, Interdisciplinary Team immediately revised the plan of care for residents #58 and #209 to address the deficient practice. The staff on the units taking care of the residents involved and the residents were in serviced on the updated plan of care by the Director of Nursing. ACTION TAKEN: The Director of Nursing , Charge Nurses, Administrator, and Interdisciplinary Team, reviewed and revised the facility policy on resident assessment and Care planning. The Director of Nursing in serviced professional nurses on the revised policy and stressed the need for ensuring that proper care planning and relevance to person centered care must be adhered to base on assessment. The Team	

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F 656	Continued From page 3 on 1/3/23 at 11:31 AM, in bed and conversant. The resident informed the surveyor that she/he had requested for [Ex Order 2] medication. The surveyor asked the resident to describe his/her [Ex Order 2] in a scale from zero to ten being the highest. Resident #209 described the [Ex Order 2] as [Ex Order]. On 1/3/23 at 12:20 AM, Resident #209 confirmed with the surveyor that she/he had received his/her [Ex Order 26.] medication and no longer experienced *Ex Order 26. 4B1*. On 1/4/23 at 10:46 AM, the surveyor observed Resident #209 asleep on his/her [Ex Order 2] side On 1/5/23 at 11:54 AM, the surveyor observed Resident #209 asleep on his/her [Ex Orde] side. On 1/6/23 at 10:19 AM, the surveyor observed Resident #209 asleep on his/her [redacted] side. On 1/9/23 at 1:08 PM, the surveyor observed Resident #209 in his/her room in bed and conversant. The resident informed the surveyor that the medication had been working from when they first met. The resident stated the medication caused her/him to [redacted] *Ex Order 26. 4B1* [redacted]. A review of the hybrid medical record (electronic and paper) revealed the following information: The resident's Record of Admission included diagnoses of [redacted] The *Ex Order 26. 4B1* Physician Order included the following medications:	F 656	developed a QA Tool for F656 to be used by nursing department to monitor compliance and Director of Nursing will present report to Administrator, Interdisciplinary Team, Chief Operations Officer and Chief Executive Officer monthly for review. Completed 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICES: The Director of Nursing, Interdisciplinary Team, Unit charge Nurses, used the QA Tool for F656 to review the individual plan of care for all 99 inhouse residents to ensure compliance and no other residents were identified as not in compliance. No other resident was affected by the deficient practice. 3. MEASURE OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The revised facility policy and the developed QA Tool was used to in-service all Interdisciplinary Team, Unit charge nurses and Nursing Supervisors stressing need to follow facility reversed policy when addressing individual resident□s care needs upon admission, readmission, change in health status and annual MDS evaluations and care plannings to ensure compliance with F656 deficiency by the Director of Nursing. Nursing Department and Interdisciplinary Team will utilize the QA Tool for F656 compliance to conduct audit and Director of Nursing will present report to Administrator, Chief Operation Officer and Chief Executive Officer monthly and to	

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F 656	Continued From page 4 *Ex Order 26. 4B1* ordered on 8/16/22. -*Ex Order 26. 4B1*, ordered on *Ex Order 26. 4B1*. -*Ex Order 26. 4B1* ordered on *Ex Order 26. 4B1*. *Ex Order 26. 4B1* at bedtime ... for *Ex Order 26. 4B1* without complications ordered on *Ex Order 26. 4B1*. *Ex Order 26. 4B1* with meals *Ex Order 26. 4B1* hold for *Ex Order 26. 4B1* less or equal *Ex Order 26. 4B1* before meals ... *Ex Order 26. 4B1*, ordered on *Ex Order 26. 4B1*. The *Ex Order 26. 4B1* quarterly MDS assessment tool, Section C, indicated the resident had *Ex Order 26. 4B1* as evidenced by a BIMS score of *Ex Order*. Section J, J0100 indicated the resident had not received scheduled *Ex Order 2* or PRN *Ex Order 26. 4B1* Section N, N0350 was blank and did not indicate the resident received *Ex Order 26. 4B1*. A photocopy of the Plan of Care - Current was provided to the surveyor by the Social Services Director. The care plan did not include a comprehensive care plan addressing the resident's *Ex Order 2* and the potential for *Ex Order 26. 4B1* episodes with the use of *Ex Order 26. 4B1*. The surveyor interviewed the Director of Nursing	F 656	QAPI Team quarterly x 1 year for their review. Completed: Ongoing. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Administrator, Chief Operations Officer, Chief Executive Director will continue to review and monitor the report on F656 presented by Director of Nursing monthly and to QAPI Team quarterly to ensure consistent compliance 1 year. Findings will be utilized for future training of nursing staff/Interdisciplinary team members. Completed: Ongoing.	

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F 656	Continued From page 5 (DON) on 1/10/23 at 1:14 PM to discuss the care plan omissions. On 1/11/23 at 10:15 AM, in the presence of the survey team and the Licensed Nursing Home Administrator, the DON stated the resident should have been care planned for the as needed [redacted] medication and the potential for [redacted] with the use of [redacted]. The DON also stated Resident #209's care plan was updated on [redacted] after surveyor inquiry. A review of the facility provided "Interdisciplinary Care Plan (IDCP)" policy revised 11/20/22 included but was not limited to the following: Purpose: Promote continuity of care communication among [redacted] staff Increase patient safety Safeguard against adverse events that are most likely to occur right after admission ... Focuses on the resident as the center of control and support each resident and/ or representative in making his or her own choices by making an effort to understand: -What each resident is communicating verbally and nonverbally; identifying what is important to each resident with regard to daily routines and preferred activities; having an understanding of the resident's life before coming to reside in the nursing facility. Procedure: 4. In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental or psychosocial functioning which was otherwise not identified in the baseline care plan, those changes will be incorporated into an updated summary provided to resident and his	F 656		

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F 656	Continued From page 6 or her representative, if applicable. Comprehensive Care Plan: 3. The care plan will address all services furnished to attain, maintain highest practicable well-being; ... 6. The care plan will be reviewed and revised after each quarterly, annual or significant change in status assessment; meet professional standards of quality; be provided by qualified persons; and be culturally competent and trauma informed. 9. Care plan meetings are scheduled weekly or on as needed basis and will include, in addition to the IDT [interdiciplinary team]members, participation from resident, family/representative, CNA [Certified Nursing Aide] who provides care and Dietary staff. NJAC 8:39-11.2 (d); (i); 27.1 (a)	F 656		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain current equipment for the purposes of immediate response to potential life-threatening, cardiac emergencies. This deficient practice was identified in 2 of 2	F 678	F678 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE No resident was affected by this deficient practice since a review of the facility record by the Administrator, Director of Nursing , Unit charge nurses and Admissions Director showed no resident requiring cardio pulmonary	2/24/23

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F 678	Continued From page 7 Automated External Defibrillator (AED) kits reviewed during the medication labeling and storage task and was evidenced by the following: On 1/5/23 at 10:16 AM, the surveyor observed an AED emergency response kit, mounted on the wall of the Third-floor nurse's station, in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM). The surveyor, with the assistance of the LPN/UM, removed the AED kit from the wall mounting, opened it, and observed two defibrillator pads enclosed in a package. LPN/UM stated she had ordered replacements two weeks ago from the Central Supply Manager (CSM) and received the two incorrect defibrillator pads observed. She further explained that she had informed the CSM and had not received the correct defibrillator pads since receiving the incorrect defibrillator pads. On 1/5/23 at 10:25 AM, LPN/UM stated the AED device would not turn on and confirmed that the battery for the AED was not working. At that time, the LPN/UM acknowledged that the AED device should have had the correct pads on-hand and the battery to power the device should have been functional. On 1/5/23 at 10:33 AM, the surveyor entered the Second-floor nurse's station and observed the Director of Nursing (DON) and the Registered Nurse (RN) testing the second AED device. The surveyor asked the RN to identify the expiration date on the defibrillator pad on the AED device and the RN stated the expiration date was 9/3/22 and that the pad identified was expired. At that time, during an interview with the surveyor, the DON stated that the CSM ordered the	F 678	resuscitation prior to the citation by surveyor . CAUSE OF PROBLEM IDENTIFICATION: The Administrator and Director of Nursing reviewed the facility process for monitoring Defibrillators was not detailed enough to address actual checking of the different components and accessories. Also identified during this review was the failure of the Director of Nursing, Unit charge nurses and supervisors following up to ensure that the process in place was being followed by professional nurses. Date of Completion: 02/03/23 What corrective action will be accomplished for those residents found to have been affected by this deficient practice? A review of the facility records by the Administrator, Director of Nursing , Unit charge nurses and Admissions Director showed no resident requiring cardio pulmonary resuscitation prior to the citation by surveyor. No residents were impacted by this deficient practice. Action Taken: Immediately both AED was removed from 2ND and 3rd floor units by Director of Nursing. The Director of Nursing instructed all nursing units to keep monitoring all residents and should any need for cardio pulmonary resuscitation arise while waiting for arrival of replacement pad and battery, manual CPR to be initiated and EMS to be activated. The Administrator and the Director of Nursing placed a call to facility	

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F 678	Continued From page 8 defibrillator pads two weeks ago and received the incorrect pad. The DON confirmed that the AED device should have been equipped with an unexpired pad in the event of an emergency for cardiac arrest. The DON stated that at that time, the facility did not have an unexpired defibrillator pad in stock for use but the CSM was on his way to bring new defibrillator pads that day. The DON also stated she had no prior knowledge and was not informed about the expired defibrillator pads by her staff. On 1/5/23 at 10:45 AM, the surveyor and RN/UM reviewed the audit check list "Code Cart Check/Defibrilator" [Defibrillator] for the Second floor dated January 2023 and the December 2023 was not found. The RN/UM explained that the signatures on the check list meant that the AED device was checked and "was ready to go with no problem". On 1/5/23 at 10:53 AM, the surveyor and LPN/UM reviewed the audit check list "Code Cart Check/Defibrilator" [Defibrillator] for the Third floor dated January 2023 and December 2023. At that time, during a follow up interview with the surveyor, LPN/UM explained that the signatures meant it was checked and that there was not a documentation that the pads were expired. On 1/5/23 at 01:32 PM, during a subsequent interview with the surveyor, the DON confirmed there were only two AED device present in the building. On 1/6/23 at 1:05 PM, during an interview with the survey team, the DON stated that the facility did not have a policy and procedure relating to	F 678	contracted medical device supply company for same day delivery of correct pad and battery for one of the machines while an order was placed for replacement of the other defibrillator. Completed 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICES: The Administrator, Director of Nursing and unit charge nurses reviewed the deficient practice for F678 and concurred that it has potential to affect all 99 in house residents had there been need for Cardio Pulmonary Resuscitation for any resident prior to this citation. However, review of the inhouse residents' records showed no resident requiring such level of emergency care, hence no resident was affected by this deficient practice. 3. MEASURE OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Nursing, Administrator and unit charge nurses reviewed the facility Defibrillator monitoring process and wrote a policy and procedure for defibrillator use and monitoring detailing need for each component to be monitored for functioning and expiration. A monitoring form with nurse signatures was also reviewed and revised. QA Audit Tool for F678 was developed by Director of Nursing and unit charge nurse to be used to monitor compliance. Director of Nursing in serviced all professional nurses on the new policy and	

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F 678	Continued From page 9 the AED device and that they followed the manufacturer's directions. The Licensed Nursing Home Administrator (LNHA) stated they had a process for ensuring the AED device was operational and the defibrillator pads were in-date however the process failed because of the lack of communication from the staff to the DON and LNHA. NJAC 8:39-23.3(a) (b)1	F 678	procedure and the monitoring sheet to be completed by nurses. The Director of Nursing or designee will utilize the QA Audit Tool for F678 to audit weekly the unit nurses compliant with defibrillator functionality. Director of Nursing will present report of the Audit finding to Administrator, Chief Operations Officer, Chief Executive Officer monthly for their review and approval to ensure consistency. On quarterly basis during team meetings, the Director of Nursing will present same finding report to QAPI team for their review and approval. Any new professional nurse hired will be educated to this policy and monitoring tool by Director of Nursing or designee. Completed: 2/3/2023 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Administrator, Chief Operations Officer, Chief Executive Officer and QAPI Team will continue to review and monitor the report of the audit presented by the Director of Nursing on monthly and quarterly basis x 1 year to ensure maintained compliance for F678 deficiency. Findings will also be used for future training for consistency.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		2/24/23

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F 755	Continued From page 10 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to administer a medication to the manufacturer's cautionary specifications. This deficient practice was identified for 1 of 3 nurses administering medications to 1 of 5 residents (Unsampled Resident) during the medication administration observation and was	F 755	F755 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE Unsampled Resident was determined by Administrator and Director of Nursing through record review and interview of the LPN charge nurse to be the identified resident for this deficient practice. CAUSE OF PROBLEM IDENTIFICATION: The Administrator, Director of Nursing	

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F 755	Continued From page 11 evidenced by the following. A review of the manufacturer's specifications for *Ex Order 26. 4B1* under section 2.3 Reconstitution and Administration. In general, other oral medications should be administered at least 2 hours before or 2 hours after *Ex Order 26. 4B1* [see Drug Interactions (7)] ... On 1/6/23 at 9:20 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN) preparing to administer medications to Unsampled Resident. The LPN prepared eight medications which included one packet that contained *Ex Order 26. 4B1* . The surveyor observed the LPN pour the packet into a separate drinking cup, add water into the same cup and mixed its contents until dissolved. The LPN proceeded to the Unsampled Resident's room who was encouraged to a seated position on the bed. The LPN administered the medications and was immediately followed by the administration of the *Ex Order 26. 4B1* . Review of the Physician Order for *Ex Order 26. 4B1* included the following active physician orders: *Ex Order 26. 4B1* for *Ex Order 26. 4B1* at 9:00 for 3 days for *Ex Order 26. 4B1*" with an order date of *Ex Order 26. 4B1*. On 1/6/23 at 10:01 AM, the surveyor with the LPN reviewed the electronic Medical Administration Record (eMAR) which reflected an order dated *Ex Order 26. 4B1* for '*Ex Order 26. 4B1* for	F 755	reviewed the facility policy on medication administration and determined it did not include reading Unsampled Resident's label for medication cautionary. This omission could be the reason why the nurse who wrote the order originally failed to include cautionary and resulted in the medication administering nurse not reading and following the cautionary. What corrective action will be accomplished for those residents found to have been affected by deficient practice? Unit nurse was directed by Director of Nursing to immediately call and notify the primary physician for the Unsampled Resident who was directly involved with this deficient practice. He was notified by nurse in charge, order was received to monitor Unsampled Resident hourly x 48 hours and to notify the physician if any changes in health status. However, no adverse effect noted. Action Taken: The Medication time was corrected and cautionary precautions were included in the special instruction for medication administration. Director of Nursing, Administrator and Unit Charge Nurses reviewed and revised the facility policy and procedure for medication administration to include putting cautionary and reading cautionary on all medications requiring cautionaries as indicated by manufacture and or Pharmacy. Director of Nursing and Administrator in serviced all professional nurses on this revised policy. Completed 02/03/23	

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F 755	Continued From page 12 Ex Order 26. 4B1 at 9:00 for 3 days for Ex Order 26. 4B1. The LPN confirmed there were no additional instructions on the eMAR for the Ex Order 26. 4B1. At that time, the surveyor with the LPN reviewed the resident's medication label for Ex Order 26. 4B1 which had a cautionary "Mix w/ [with] water. Take at least 2 hrs [hours] before or after meds [medications]". The LPN at that time, acknowledged that Ex Order 26. 4B1 should have been separated by Ex Order 26. 4B1 apart from the other medications. The LPN also stated she would reschedule Unsampled Resident's Ex Order 26. 4B1 two hours apart from the other medications. On 1/9/23 at 10:25 AM, during an interview with the survey team the Director of Nursing (DON) stated she was not aware of how Ex Order 26. 4B1 was to be administered. On 1/9/23 at 10:28 AM, during an interview with the survey team the Licensed Nursing Home Administrator (LNHA) stated we will check if the LPN moved the medication and inform the prescriber. A review of the facility provided "Administration of Medications" policy revised 11/10/22 did not include reading the resident's label for medication cautionary. NJAC 8:39-11.2(b), 29.2(d)	F 755	2. IDENTIFYING OTHER RESIDENTS WHO COULD HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICES: The Director of Nursing, Administrator and the unit charge nurses developed a QA Audit Tool for F755 to be used to monitor and ensure compliance for this deficient practice. Nurses were in serviced by the Director of Nursing and instructed to use this Audit tool to review all in house 99 residents' E-mar for medication administration accuracy and cautionaries as all have potential to be affected by this deficient practice . No other residents were affected. 3. MEASURE OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Nursing and Administrator in-serviced all professional nurses on the reviewed and revised policy and procedure for medication administration, stressing need to pay attention to medication order accuracy and cautionary adherence. A QA Audit Tool for F755 focusing on medication order accuracy, cautionary adherence and side effect monitoring was also developed. Director of Nursing and Nursing Supervisors will use this audit tool to monitor compliance for F755. The Director of Nursing or designee will utilize the QA Audit Tool for F755 to audit the medication administration records and physically observe professional nurses performing medication pass monthly to	

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F 755	Continued From page 13	F 755	ensure consistency and compliance. Director of Nursing will present the report of the QA Audit report finding to the Administrator, Chief Operations Officer, and Chief Executive Officer monthly and also quarterly to QAPI Team during their meetings for their review and approval to maintain compliance. Upon hire of any professional nurse, Director of Nursing or designee will educate the nurse on this policy and audit tool. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Administrator, Chief Operations Officer, and Chief Executive Officer and QAPI Team will continue to review and monitor report of QA Audit tool for F755 presented by Director of Nursing or designee monthly and quarterly x 1 year to ensure steady compliance. Findings will also be utilized for future training of nursing staff.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		2/24/23

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F 812	Continued From page 14 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) failed to sanitize and air dry steam table pans in a manner to prevent microbial growth and b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 1/4/22 at 9:55 AM, in the presence of the Food Service Director (FSD) the surveyor observed the following: 1. In the food preparation area, the surveyor observed a Food Service Worker (FSW), wearing gloves which were soiled in a red colored substance, holding a dish rag which was also soiled with a red colored substance. The FSW walked to the hand washing sink and with his gloved hands and turned on the faucet, the FSW took the soiled dish rag and put it in the sink basin and then took it out and squeezed the water off of the dish rag. The FSW took the dish rag and turned off the faucet with his gloved hands, walked to the food preparation area and began wiping multiple surfaces of the food preparation	F 812	F812 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE No resident was affected by this deficient practice. CAUSE OF PROBLEM IDENTIFICATION: Food Service Director , Assistant Food Service Director, Food Service Manager and the Administrator reviewed the facilities policy on Food preparation and sanitization and confirmed the surveyor's findings of deficient practice for F812. This deficient practice occurred because the Food Service Director, Asst. Food Service Director and Food Service Manager failed to ensure that all kitchen staff followed established facility policy regarding food preparation and sanitation. What corrective action will be accomplished for those residents found to have been affected by deficient practice? No residents were affected by this deficient practice. ACTION TAKEN: The Administrator, Food Service Director and Food Service Manager reviewed and revised facility policy on food preparation and sanitation.	

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F 812	Continued From page 15 area with the same dish rag. The surveyor asked the FSD if this was how the food preparation areas should be Cleaned, if the FSW should have gloved hands which were soiled, and if the FSW should have been using the hand washing sink for cleaning the dishrag. The FSD stated that this is not how the food preparation area should be cleaned. 2. In the food preparation area, on metal dishware drying shelving unit, the surveyor observed four half sized steam table pans and seven full sized pans which were stacked with water between them. 3. The surveyor observed the 3-compartment sink and the 3rd compartment sanitizing sink was full of water. There was a greasy brown substance floating on top of the water of the 3rd compartment sanitizing sink. The FSD drained the 3rd sanitizing compartment sink and observed a grease-like substance staining the inside of the metal compartment of the 3rd compartment sanitizing sink, the FSD stated that this sink should have been cleaned properly before adding hot water and sanitizer to it as it is the last step before the dishware is air dried, request policies for the concerned areas. On 1/04/23 at 1:30 PM, the surveyor discussed the kitchen concerns with the facility Administrator and Director of Nurses. The surveyor reviewed the Dietary Services Generalized Cleaning and Sanitization p/p with a revised date of 1/4/2023, which revealed that all food contact surfaces will be cleaned with three steps: "Step one all debris will be removed, step	F 812	All dietary staff were immediately re-educated on hand hygiene, infection control and facility's revised policy on food preparation and sanitation by Food Service Director. A QA Tool was developed by Food Service Director and Administrator to use in monitoring compliance. Food Service manager and Assistant Food Service Director were educated on the use of the F812 QA Tool. Completed 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICES: The Food Service Director, Assistant Food Service Director, Foodservice Manager and the Administrator met and reviewed the deficient practice and agreed that all 99 in house residents have potential to be affected by this deficient practice if not corrected, however, no resident was affected by the deficient practice. 3. MEASURE OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All foodservice staff were re-in serviced on the newly revised Policy on Food preparation and sanitization and the new tool for monitoring F812 deficiency. The contract Infection Preventionist used existing QA Tool for hand hygiene to performed a new competency evaluation on all kitchen staff to ensure understanding of in-services given. Upon hire of any new Foodservice Worker the policies regarding Food preparation	

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F 812	Continued From page 16 two a solution of soap and water will be used to cleanse area then area will be rinsed of soap solution, step three sanitizing solution (chemical # 8) will be used to sanitize area being cleaned, area will be allowed to dry before use and all towels used to clean will be discarded when soiled." And the surveyor received and reviewed the Dietary Services Small Equipment Sanitization with a revised date of 1/4/23, which revealed all items are to be completely air dried before they are stacked and items that are stacked wet can breed bacteria. NJAC 8:39-17.2(g)	F 812	and sanitation will be reviewed with the employee by Food Service Director or designee. The Director of Food Services and Infection Preventionist will present report of competency evaluation to Administrator and morning care team monthly and to QAPI team quarterly x 1 year. Annual competencies requiring all Foodservice workers to exhibit proper hand hygiene and proper food preparation and sanitization protocol will be continued. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Food Service Director will continue to present monthly reports to Administrator and the morning care team every monthly and quarterly to the QAPI team for their review and monitoring to ensure consistent compliance at 100% x 1 year. Findings will be utilized for future training of food service staff. 2. Food Procurement, Store/Prepare/Serve-Sanitary. F812 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE No resident was affected by this deficient practice. CAUSE OF PROBLEM IDENTIFICATION: The Administrator, Food Service Director , Assistant Food Service Director, Food Service Manager reviewed and revised the facility policy on Small Equipment Sanitization and confirmed the surveyor's	

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F 812	Continued From page 17	F 812	findings of deficient practice for F812. This deficient practice occurred because the Food Service Director, Assistant Food Service Director and Food Service Manager failed to ensure that there were enough drying racks and that all kitchen staff follow established facility policy regarding Small Equipment Sanitization. What corrective action will be accomplished for those residents found to have been affected by this deficient practice? No residents were impacted by this deficient practice. Action Taken: The Food Service Director immediately had the food service staff to rewash all Four half sized steam table pans and the seven full sized pans and air dried them separately. Also, all the food preparation areas were sanitized to avoid contamination. Two additional Drying racks were added to existing one rack to allow additional space for drying small equipment properly. All dietary staff were immediately re-educated on the revised Policy including use of QA Audit Tool for F812 and F880 to ensure compliance. Completed 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICES: Food Service Director, Assistant Food Service Director, Food Service Manager and the Administrator met and reviewed the deficient practice and agreed that all 99 residents in house have potential to be	

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F 812	Continued From page 18	F 812	affected by this deficient practice if not corrected, no residents were affected by this deficient practice. 3. MEASURE OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Administrator and Food Services Director developed QA tool to address F812 deficiency. All Food Service staff were in-service on the revised policy and QA Audit Tool for F812 and F880 by Food Services Director. The Director of Food Services or designee will utilize the QA Audit Tool for F812 & F880 to audit weekly sanitation practices in the kitchen to ensure maintained compliance. Upon hire of any new Food Service Worker the policies regarding Food preparation and sanitation will be reviewed with the employee by Food Service Director or designee. The Director of Food Services will present the QA Audit Tool for F812 F880 report findings to the Administrator, Chief Operations Officer, and Chief Executive Officer monthly for their review and approval to ensure a sustained compliance. The same report will also be presented to the QAPI Team quarterly for their review and approval. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Food Service Director will continue to present monthly reports to Administrator,	

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F 812	Continued From page 19	F 812	Chief Operations Officer, and Chief Executive Officer and report quarterly to the QAPI team for their review and monitoring to ensure consistent compliance at 100% x 1 year. Findings will also be utilized for future training of food service staff. 3. Food Procurement, Store/Prepare/Serve-Sanitary. F812 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE No resident was affected by this deficient practice. CAUSE OF PROBLEM IDENTIFICATION: The Food Service Director, Assistant Food Service Director, Food Service Manager and the Administrator reviewed the facility policy on Food preparation and sanitization and confirmed the surveyor's findings of deficient practice for F812. This deficient practice occurred because The Food Service Director, Assistant Food Service Director and Food Service Manager failed to ensure that all kitchen staff follow established facility policy regarding General Cleaning and Sanitation. What corrective action will be accomplished for those residents found to have been affected by deficient practice? No residents were affected by this deficient practice. Action Taken: Administrator and Director of Food Services reviewed and revised facility policy on Kitchen General Cleaning and Sanitation.	

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F 812	Continued From page 20	F 812	All Dietary staff were immediately re-educated on revised Policy on General Cleaning and Sanitization The Director of Food Services immediately directed one of the food service workers to wipe and sanitize the food preparation area involved in this deficient practice. The 3 bay sink was immediately emptied and cleaned by food service employee as directed by the Food Service Director. The Administrator and Food Service Director placed a call to facility contracted Chemical vendor (CL) who installed new Sanitizer dispenser at 3 bay sink area on 1/31/2023. In-services given to all Food Service staff on the proper use of this dispenser by the contracted vendor with staff signatures as acknowledgement of understanding. Completed 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICES: The Food Service Director, Assistant Food Service Director, Food Service Manager and the Administrator met and reviewed the deficient practice and agreed that all 99 residents in house have potential to be affected by this deficient practice if not corrected, however, no residents were affected by the deficient practice. 3. MEASURE OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All Food Service staff were in-service on the revised policy on Generalized	

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F 812	Continued From page 21	F 812	Cleaning and Sanitization, as well as use of the dispenser at 3 bay sink by Food Service Director and Chemical Contract Vendor. QA Tool to track compliance with F812 was developed by Food Service Director and Administrator to be used to track compliance. Food Service Director will present report to morning care team and Administrator monthly and to QAPI Team quarterly x 1 year. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Food Service Director will continue to present monthly reports to Administrator, Chief Operations Officer, and Chief Executive Officer and report quarterly to the QAPI team for their review and monitoring to ensure consistent compliance at 100% x 1 year. Findings will be utilized for future training of food service staff.	
F 880 SS=D	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 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	F 880		2/3/23

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F 880	Continued From page 22 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 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315393	A. BUILDING _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	**266 S ORANGE AVE NEWARK, NJ 07103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 §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: a) provide [redacted] care in a manner to decrease the spread of infection for 1 resident, #59, reviewed for *Ex Order 26. 4B1* [redacted], and b) develop a facility plan with measures to monitor for and prevent the growth of *Ex Order 26. 4B1* [redacted]. The deficient practices are evidenced by the following. 1. The surveyor observed Resident #59 on 1/03/23 11:59 AM. The resident was awake and alert in bed with *Ex Order 26. 4B1* [redacted] in place to [redacted] and [redacted]. Earlier that day, the Registered Nurse (RN) stated the resident had a *Ex Order 26. 4B1* [redacted] on the *Ex Order 26. 4B1*. The *Ex Order 26. 4B1* Treatment Record contained a *Ex Order 26. 4B1* treatment order to *Ex Order 26. 4B1* [redacted]. On 1/6/23 at 9:20 AM the surveyor observed the Licensed Practical Nurse (LPN) perform the	F 880	F880 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE Resident # 59 has potential to be impacted by this deficient practice had the [redacted] not been [redacted] prior to placing the [redacted] to secure the [redacted] No adverse effect was noted. CAUSE OF PROBLEM IDENTIFICATION: The Administrator, Director of Nursing, Infection Preventionist met and reviewed the [redacted] dressing and interviewed the [redacted] care nurse who confirmed the surveyor□s deficient practice findings. This deficient practice occurred because the Director of Nursing, Infection Preventionist and Administrator failed to ensure that [redacted] care procedure is detailed to cover every step of infection prevention. What corrective action will be accomplished for those residents found to have been affected by deficient practice? The [redacted] care nurse was immediately	

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F 880	Continued From page 24 [redacted] treatment to the resident's [redacted]. The LPN obtained the over bed table from the resident's bedside and brought it out to the treatment cart in the hallway. Without first sanitizing the table, the LPN placed the clean drape over the table. The treatment supplies were assembled on the over bed table and brought back into the resident's room and placed at the bedside. The LPN removed the soiled dressing from the [redacted] and discarded it in the room trash can near the resident's bed. When the LPN completed the treatment, she removed a pen from her uniform pocket and wrote the date on the tape which secured the top dressing over the resident's [redacted]. The LPN discarded the remainder of the items left on the supply field into the room trash can. The LPN did not remove the trash from the room before she moved to the next resident. The surveyor discussed the treatment with the LPN after it was completed. The LPN confirmed she should have sanitized the over bed table before placing the drape; should have sanitized the pen after removing it from her uniform pocket; and should have removed the trash from the resident's room when the treatment was completed. A review of the [redacted] Care Procedure, revised [redacted], revealed the over bed table should be "checked for cleanliness" prior to placing a drape. Additionally, the procedure indicated that all items needed for the treatment were to be placed on	F 880	instructed by the Director of nursing to remove the contaminated dressing and redress the [redacted] after re-in servicing her on proper [redacted] care procedure. She was observed by the Administrator to ensure competency. Action Taken: The facility policy on [redacted] care procedure was reviewed and revised to detail step by step process and need to avoid deficient practice by Administrator, Director of Nursing and Infection Preventionist. The [redacted] care nurse and other nurses were in serviced on the revised [redacted] care procedure. Completed 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICES: Administrator, Director OF Nursing, Infection Preventionist, Chief Operations Officer and Chief Executive Officer reviewed the deficiency and determined it has potential to affect all 8 inhouse residents who receive [redacted] care. . A QA Tool was developed by Administrator, Director of Nursing and Infection Preventionist, nurses used it to monitor all 8 inhouse residents with wounds to ensure no other residents impacted. Based on the report, no other residents were affected by this deficient practice. 3. MEASURE OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The facility policy on [redacted] care procedure	

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NEW COMMUNITY EXTENDED CARE FACILITY	**266 S ORANGE AVE NEWARK, NJ 07103**

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F 880	Continued From page 25 the treatment field using aseptic technique. Step 23 of the procedure instructed staff to leave the trash from the treatment in the room trash can. 2. The surveyor interviewed the Licensed Nursing Home Administrator (LNHA) on 1/05/23 at 11:04 AM regarding the facility water management program. The LNHA stated she did not have information on the program and would have to investigate it. She stated the previous building services person had resigned and she would "look in his human resources paperwork." The surveyor spoke with the LNHA on 1/06/23 at 12:19 PM and again asked for documentation outlining the facility water management program. She replied that she was still looking. On 1/11/23 at 1:00 PM, the surveyor confirmed to the LNHA that a water management plan had not been provided to the surveyor. No further information was given to the survey team from the LNHA. NJAC 8:39-19.1; 8:39-19.4; 8:39-27.1(a);	F 880	was reviewed and revised to detail step by step process and need to avoid deficient practice by the Administrator, Director of Nursing and Infection Preventionist. The Infection Preventionist commenced retraining of all nurses on the revised [redacted] care procedure. A competency evaluation for [redacted] care procedure was commenced by Infection Preventionist and Nursing Supervisors for all nurses who perform [redacted] care. Director of Nursing will present report to Administrator, Chief Operation Officer and Chief Executive Officer monthly and to QAPI Group Quarterly x1 year. Upon hire of any new professional nurse, Director of nursing or designee will educate the nurse and perform competency on [redacted] care procedure. Completed: Ongoing. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Administrator, Director of Operations and Chief Executive Officer will continue to review and monitor the report presented by Director of Nursing Monthly and QAPI Group quarterly x1 year to ensure consistent compliance at 100 %. Completed: Ongoing.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060731	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	266 S ORANGE AVE NEWARK, NJ 07103

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S 560	S560 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Director of Nursing, Administrator, Human Resource Director, and Chief Operating Officer reviewed new community extended care staffing ratio and confirmed it did not meet the State of New Jersey required daily staffing ratio for the 14 days as identified by the surveyors . It was also identified that our current plan	2/16/23

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

Electronically Signed | 02/03/23

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S 560	Continued From page 1 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 place.	S 560	of recruitment requires more effort in order to meet current standard. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? This deficient practice did not affect any residents. Action taken: A meeting was held by the Administrator including Director of Nursing, Director of Human Resources, Chief Operating Officer and Chief Executive Officer and a review and revision of facility position control as well as a new recruitment method took place. The use of temporarily agency staffing while intensifying effort to recruit our own staff. Completed 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: Utilization of the Quality Assurance Daily Morning Meeting attendance log/Nursing Home Resident Care Staffing Report tools was used by Director of Nursing and Unit Charge Nurses to monitor and track as well as review the plan for Nursing Department Daily Staffing needs and the impact it has on the residents on each unit. This report was presented to Administrator, Human Resources Director, Chief Operations Officer and Chief Executive Officer who reviewed and concurred all 99 in-house residents have potential to be affected by this deficiency if not corrected. However, no resident is directly affected.	

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S 560	Continued From page 2 (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 of 12/18/22 and 12/31/22 revealed the following: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/18/22 had 7 CNAs for 104 residents on the day shift, required 13 CNAs. -12/19/22 had 9 CNAs for 104 residents on the day shift, required 13 CNAs. -12/20/22 had 11 CNAs for 104 residents on the day shift, required 13 CNAs. -12/21/22 had 9 CNAs for 104 residents on the day shift, required 13 CNAs. -12/22/22 had 9 CNAs for 103 residents on the day shift, required 13 CNAs.	S 560	3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: 1. The facility policy on staffing was revised by the Administrator, Director of Human Resources, Chief Operation Officer and Chief Executive Officer to expand current recruitment methods to include Essex County CNA Apprenticeship program, Indeed both sponsored /Non sponsored, Zip recruiter, Glassdoor, Peerless.com, Residents and family newsletter, Staffing need email Request to Local Department of Health, Health care consultant Company(New Era group), NCC Clarion as well as local poster posting around surrounding areas, and word of mouth to staff and other communities members. 2. Administrator, Director of Human Resources in collaboration with upper management and Board of Directors of New Community Corporation raised CNA's salary to $18.00 and $19.00, also included $75.00 incentives for extra shift weekend coverage, and a sign on bonus of $1000.00. 3. The Director of Nursing will continue to review her daily staffing needs utilizing attendance log and the Nursing Home Resident Care Staffing Report tools to monitor her CNA staffing ratio and submit findings monthly to Administrator and Executive Branch for their review. This report will also be presented during quarterly QAPI meeting x 1 year. Completed: Ongoing. 4. MONITORING THE CONTINUED	

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S 560	Continued From page 3 -12/23/22 had 10 CNAs for 102 residents on the day shift, required 13 CNAs. -12/24/22 had 7 CNAs for 101 residents on the day shift, required 13 CNAs. -12/25/22 had 7 CNAs for 101 residents on the day shift, required 13 CNAs. -12/26/22 had 9 CNAs for 101 residents on the day shift, required 13 CNAs. -12/27/22 had 10 CNAs for 101 residents on the day shift, required 13 CNAs. -12/28/22 had 9 CNAs for 101 residents on the day shift, required 13 CNAs. -12/29/22 had 8 CNAs for 101 residents on the day shift, required 13 CNAs. -12/30/22 had 10 CNAs for 101 residents on the day shift, required 13 CNAs. -12/31/22 had 7 CNAs for 101 residents on the day shift, required 13 CNAs. On 1/11/23 at 12:25 p.m., the survey team informed the Director of Nursing and the Licensed Nursing Home Administrator of the staffing ratio concerns.	S 560	EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Administrator and New Community Corporation Executive Branch and QAPI team will continue to review and monitor the report of the staffing ratio presented by the Director of Nursing monthly and quarterly x 1 year until sustained compliance is achieved. Completed: Ongoing	

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
315393 Y1	A. Building B. Wing Y2	3/6/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	266 S ORANGE AVE NEWARK, NJ 07103

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 F0656	Correction	ID Prefix F0678	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.24(a)(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	02/03/2023	LSC	02/24/2023	LSC	02/24/2023
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	02/24/2023	LSC	02/03/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	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?
1/11/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315393	A. BUILDING **01** B. WING _____	**01/11/2023**

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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 on 01/11/2023 and New Community Extended Care was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. New Community Extended Care is a four-story Type II Protected building that was built in 1986.	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story	K 161		2/25/23

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

Electronically Signed | 02/03/2023

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

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K 161	Continued From page 1 non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to maintain the fire resistive construction of the building capable of resisting the passage of smoke and fire into other compartments in accordance with National Fire Protection Association (NFPA) 101, 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 and 19.1.6.4, 19.1.6.5. This had the potential to affect 99 residents. Findings included:	K 161	K161 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification During a tour of the building with the state surveyor, Director of Maintenance and New Community Extended care maintenance crew confirmed that there was a 3-inch penetration where metal pipe penetrated the ceiling tile in the kitchen dish room without fire-stopping material.	

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NEW COMMUNITY EXTENDED CARE FACILITY	**266 S ORANGE AVE** **NEWARK, NJ 07103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 2 On 01/11/2023 at 11:21 AM, an observation of the dish room in the kitchen contained two 3-inch penetrations where metal pipe penetrated the ceiling tile and contained no fire-stopping material. During an interview on 01/11/2023 at 1:28 PM, the Director of Environmental Services (DES) acknowledged the findings and stated he was not aware of the penetrations in the ceiling in the kitchen. He indicated he and the maintenance team made weekly rounds but missed the holes and would get the penetrations sealed. He stated he expected the life safety code requirements to be followed. During an interview on 01/11/2023 at 2:23 PM, the Administrator acknowledged the findings and stated she was not aware of the penetrations in the ceiling. She stated she expected all life safety code requirements to be followed. On 01/11/2023 at 2:30 PM, the Administrator indicated she would have to look for a policy on the building construction type and send it via email if she had one. A policy was not provided prior to exit. NJAC 8:39-31.1(c), 31.2(e)	K 161	This deficient practice occurred because the Director of Environmental Services and maintenance crew failed to ensure that the penetration site had fire stopping material to prevent the spread of fire or smoke upwards in an event of fire in the kitchen. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. Action taken: The deficient practices were stopped immediately by the environmental services director and inhouse maintenance crew who covered the space with a fire stopping material. Facility Policy and procedure on preventing uncovered open penetrations was reviewed and revised by Director of Environmental Services, Administrator, Chief Operations Officer and a QA Audit Tool for K161 was developed to be used by maintenance crew to look for penetrating holes without fire stopping materials covering. The Director of Environmental Services in-serviced the maintenance crew on the safety hazards that may occur with such deficient practices and how to use the QA Audit tool for K161 to conduct physical observation of the building. They all signed the Inservice attendance/agenda sheet indicating complete understanding and full knowledge of pipe penetrations with importance of fire stopping materials and the safety issues involved. Completed: 02/03/23	

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K 161	Continued From page 3	K 161	2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICES: The Director of environmental services, Chief Operation Officer, Administrator and Chief Executive Officer met and reviewed the deficient practice and agreed that all 99 in-house residents have the potential to be affected by this deficient practice had a fire occurred prior to closure of the openings with fire stopping material. Since there was no fire or smoke incidence, no residents were affected by this deficient practice. Completed: 02/03/23 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: 1. The Director of Environmental Services, in-serviced all-in house maintenance crew on the revised policy and procedure for open penetrations and use of QA Audit Tool for K161 compliance stressing the importance of maintaining life safety compliance throughout the building. 2. Inhouse maintenance crew during monthly rounds, will utilize the QA Audit Tool for K161 to conduct physical observation of entire facility to look for any holes and other life safety fire code issues. 3. Director of Environmental Services will present the report of monthly QA Audit Tool for K161 findings to the Administrator, Chief Operations Officer and Chief Executive Officers for their review and approval to ensure	

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K 161	Continued From page 4	K 161	compliance. Same report will be presented to QAPI Team quarterly during meetings for their review and approval to ensure maintained compliance. Upon hire of any new maintenance personnel, Director of Environmental Services or designee will in service the new hire on facility policy for open penetrations and use of QA Audit Tool for K161 compliance 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Administrator, Chief Operation Officer, Chief Executive Officer will continue to monitor and review report of QA Audit Tool for K161 compliance findings presented by Director of maintenance monthly to ensure consistent compliance, and QAPI team will monitor same reports quarterly to guarantee maintained compliance at 100 percent x 1 year. Findings will be used for future training of maintenance staff.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		2/23/23

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K 222	Continued From page 5 only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

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K 222	Continued From page 6 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to ensure the means of egress through 2 of 7 exits were readily accessible in accordance with National Fire Protection Association (NFPA) 101: 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. Finding included: On 01/11/2023 at 11:14 AM, an observation of the first floor revealed two exits to the patio were locked with a padlock. The doors were marked as exits and could not be opened readily by staff at all times. The key to the doors were located at the lobby. No residents resided on the first floor. During an interview on 01/11/2023 at 1:29 PM, the Director of Environmental Services (DES) acknowledged the findings and revealed the doors had padlocks to keep unwanted people from the street out of the facility. He indicated a key was placed at the lobby in the event it needed to be unlocked. He revealed there were other exits on the floor in the event of emergency. He indicated they put the locks on the doors during the start of the COVID-19 pandemic. He indicated he expected all life safety code requirements to	K 222	K222 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Director of Environmental Services, Administrator, in-house maintenance crew while touring the building with surveyor concurred with the observation of deficient practice involving two exit doors to the patio being padlocked. This deficient practice occurred because the Director of Environmental Services and in-house maintenance crew failure to repair or replace the two malfunctioned access-controlled Egress door assemblies leading to the patio installed in accordance with 7.2.1.6.2 permission. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by these deficient practices as there was no emergencies requiring existing through the patio doors prior to repair of this deficient practices. Action taken:	

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K 222	Continued From page 7 be followed. During an interview on 01/11/2023 at 1:41 PM, the Administrator acknowledged the findings and stated the doors were padlocked to keep unwanted people out of the facility. She indicated a key was kept at the lobby in the event the doors needed to be unlocked. She stated she expected the life safety code to be followed. On 01/11/2023 at 2:30 PM, the Administrator indicated she would have to look for a policy on inspecting and maintaining egress doors and would send it via email if the facility had established one. A policy was not provided prior to exit. NJAC 8:39-31.1(c), 31.2(e)	K 222	The Director of Environmental Services and Administrator instructed the maintenance crew to immediately remove the locks on the two exit doors leading to the patio. The Director of Environmental services, the Administrator, the Chief Operations Officer and the Chief Executive Officer met and approval was given for repair of the patio doors. Facility policy on inspecting and maintaining of exit doors was reviewed and revised by the Environmental Services Director and Administrator. In-service given to all maintenance and all staff present on the new policy prohibiting locking of any exit doors with padlocks and safety hazards that may occur during such deficient practices. All Staff acknowledged understanding of the revised policy and signed the in-service sheet. [redacted]: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: The Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer met and determined that all 99 in-house residents have potential to be affected by this deficient practice. However, since there was no incident requiring emergency use of the two exit doors to the patio, no residents were affected by the deficient practice. 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: 1.Upon completion of the access-controlled Egress Door	

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K 222	Continued From page 8	K 222	assemblies repaired by facility contracted electronic vendor Centrum. The Administrator, the Chief Operations Officer and the Chief Executive Officer, developed a QA Tool for K222 monitoring. The Environmental Service Director in-serviced in-house maintenance team on how to conduct Inspections on monthly bases using QA tool developed for K222 to ensure proper functioning and record will be maintained by the Environmental Service Director or designee and report presented to Administrator, the Chief Operations Officer and the Chief Executive Officer on monthly bases and to QAPI team on quarterly bases by the environmental service director x 1 year. 2. Upon new hire of any maintenance staff Director of Environmental Services or designee will orient the person on how to use the tool for K222 and its importance to life safety. Completed: 02/03/23 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Director of Environmental Services will continue to present monthly report of K222 findings to Administrator, the Chief Operations Officer and the Chief Executive Officer monthly and quarterly by QAPI team to ensure consistent compliance at 100 percent x 1 year. Findings will be used for future training of maintenance staff.	
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101	K 271		2/23/23

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K 271	Continued From page 9 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to maintain the exit discharge free of obstructions in accordance with National Fire Protection Association (NFPA) 101, 19.2.7. Findings included: On 01/11/2023 at 11:17 AM, observation revealed the first-floor egress exited into a courtyard that had a gate. The gate was locked with a padlock and required a key to open the gate. During an interview on 01/11/2023 at 1:29 PM, the Director of Environmental Services (DES) acknowledged the findings and revealed the gate was locked to keep people out of the back side of the facility and keep the residents safe. He indicated the maintenance team had a lock to the gate but knew the exit discharge should not be locked. He expected all life safety code requirements to be followed. During an interview on 01/11/2023 at 1:40 PM, the Administrator acknowledged the findings and stated she did not know the gate was locked. She indicated the gate should not be locked. She indicated she found out the Maintenance	K 271	K271 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Administrator, Director of Environmental services, and in house maintenance crew in the presence of the surveyor confirmed the surveyors finding, confirming the exit gate into the courtyard locked with a padlock. The deficient practice occurred because the Director of Environmental services failed to train the new maintenance supervisor on facility life safety code and Administrator failed to ensure that the in-house maintenance crew are aware of facility life safety policies. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? After reviewing the surveyors' findings, the Administrator, Director of Environmental Services and Chief Operations Officer determined that other residents could have been affected had fire incident occurred. However, since there was no	

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K 271	Continued From page 10 Supervisor had locked it to keep people out. During an interview on 01/11/2023 at 2:25 PM, the Maintenance Supervisor (MS) stated he locked the gate to keep people out and to better protect the residents. He indicated he did not know the exit discharge could not be locked. He stated he had no life safety code training from the facility but expected all life safety code requirements to be followed. On 01/11/2023 at 2:30 PM, the Administrator indicated she would have to look for a policy on inspecting and maintaining exits and would send it via email if the facility had established one. The policy was not provided prior to exit. NJAC 8:39-31.1(c), 31.2(e)	K 271	fire incident, no residents were affected. Action taken: The Administrator and Director of Environmental Services immediately instructed the facility maintenance supervisor to remove the padlock from the exit gate in the courtyard. The Administrator, The Director of Environmental Services and the Chief Operations Officer had a meeting and reviewed and revised the facility policy on exit inspections and maintenance. Director of Environmental Services and Administrator in serviced all maintenance in-house crew and all other staff with signed signatures as an acknowledgment of understanding. Completed: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: A review of the deficient practice was conducted by Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer and noted that all 99 in house residents have potential to be affected by this deficient practice had there been an emergency requiring exiting through this courtyard while the gate was padlocked. However, since no such emergency existed, no residents were affected by this deficient practice. 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: 1. All in house maintenance crew and all staff present were in serviced on the	

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K 271	Continued From page 11	K 271	revised facility exit inspection and maintenance policy by Administrator and Director of Environmental Services to ensure awareness of NFPA 101, 19.2.7 risks. 2. Director of Environmental Services, Administrator, Chief Operation Officer and maintenance crew developed a QAPI Audit tool which maintenance crew used to check to ensure all exists remain free of obstructions and maintained. This tool will be utilized by maintenance crew to check all exits weekly to ensure free of obstructions and compliance. and report will be maintained by the Director of Environmental Services after presentation to Administrator, Chief Operations Officer and Chief Executive Office during monthly meetings for their review and approval to confirm compliance. Same report will be presented to QAPI Team during their quarterly meetings for their review to ensure compliance. Completed: 2/03/23 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: All reports related to K271 will continue to be reviewed and monitored by the Administrator, Chief Operation Officer, Chief Executive Officer monthly and quarterly by QAPI team during meetings to ensure consistent compliance at 100 percent x 1 year. Findings will be used for future training of maintenance staff.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		2/23/23

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K 321	Continued From page 12 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) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure 1 of 1 activity storage room greater than 50 square feet was in accordance with 19.3.2.1.3. Life Safety Code (LSC) 101, 19.3.2.1.3, which requires doors to be self-closing or automatic closing. This deficient practice had the potential to affect 17 residents who resided on the third floor.	K 321	K321 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Director of Environmental Services, The Administrator, the in-house maintenance crew all confirmed that	

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K 321	Continued From page 13 Findings included: On 01/11/2023 at 10:37 AM, observation of the activity room on the third floor revealed the room was being used as storage. The room contained holiday decorations, cardboard boxes, plastics, furniture in cardboard boxes wrapped in plastic, and other combustible items. During an interview on 01/11/2023 at 1:28 PM, Director of Environmental Services (DES) acknowledged the findings and stated he was not aware the room required a door closer. He indicated the room was over 50 square feet in size. He indicated they would get a self-closing device installed on the door. He stated he expected the life safety code requirements to be followed. During an interview on 01/11/2023 at 2:21 PM, the Administrator stated she was not aware the activity storage room required a self-closing device. She stated the items stored in the room were from the holidays and contained new furniture for the facility. She stated they would get a self-closing device installed on the door or clean the room out. She stated she would order the metal containers with self-closing devices and expected all life safety code requirements to be followed. During an interview on 01/11/2023 at 2:23 PM, the Maintenance Supervisor (MS) stated he had only worked at the facility for three months. He stated he was not aware of the requirements for the activity storage room door to contain a self-closing devices and expected all life safety code requirements to be followed.	K 321	observation of the deficient practice found by the State surveyor Activity Room on the 3rd floor unit had stored items without a door closer. This deficient practice occurred because the Administrator, Director of Environmental Services, in house maintenance supervisor and Director of Activity failed to conduct environmental rounds to ensure Activity room was not used as storage room by Activity staff and maintenance crew. Since the room was not equipped with a door closer and could pose a risk if fire occurred. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice since fire did not occur prior to finding of the deficient practice. Action taken: The Administrator, Director of Environmental Services instructed the Activity Director and in house maintenance to immediately remove all stored items in that room, while maintenance supervisor obtained and installed a door closer on this door. A QA tool for K321 was developed by Administrator, Chief Operation Officer, Director of Environmental and given to in house maintenance crew to use to check all facility room doors to ensure all storage rooms have door closers. Administrator, Director of Environmental Services, and Chief Operations Officer reviewed and revised facility policy on inspection doors that required door	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 14 On 01/11/2023 at 2:30 PM, the Administrator indicated she would have to look for a policy on inspecting doors that require self-closing devices and send it via email if she had one. The policy was not provided prior to exit. NJAC 8:39-31.2(e)	K 321	closers and all maintenance, activity and nursing staff were in serviced on this revised policy by Administrator, Director of Environmental and Activity Director and all signed to acknowledge understanding of the reversed policy including risks involved if violated. Completed: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: Since there were no fire incidents, the Administrator, Director of Environmental Services, Chief Operations Officer and Activity Director reviewed the deficiency and concurred that all 17 in house 3rd Floor unit residents have potential to be affected had fire occurred prior to observation of this deficient practice. No residents were therefore affected by this deficient practice. 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: Administrator, Director of Environmental, Chief Operations Officer, reviewed and revised facility policy on inspecting door closers and developed a QAPI Audit tool for maintenance staff to use during monthly rounds to identify storage rooms without door closers. Director of Environmental, Administrator, and Activity Director in serviced all staff on this new policy and tool. In house maintenance crew will continue to utilize this QA tool and Director of Environmental Services or designee will present report to the Administrator, Director of Environmental, Chief Operations Officer, Chief Executive	

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	315393	A. BUILDING **01** B. WING _____	**01/11/2023**

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K 321	Continued From page 15	K 321	Officer monthly and Quarterly to QAPI group x 1 year. All new hires will be in serviced on this revised policy by the Department Director or Designee. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Administrator, Director of Environmental Services, Chief Operations Officer, Chief Executive Officer monthly and quarterly by QAPI team during meetings to ensure consistent compliance at 100 percent x 1 year. Findings will be used for future training of maintenance staff.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, document review, and facility policy review, it was determined that the facility failed to inspect, test, and maintain the fire alarm system in accordance with National Fire Protection Association (NFPA) 70, National Electrical Code and NFPA 72, National Fire Alarm and Signaling Code. This deficient practice had the potential to affect 99	K 345	K345 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification While touring the building with the State surveyor, the Director of Environmental Services, in house maintenance crew and	2/23/23

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K 345	Continued From page 16 residents. Findings included: During an observation on 01/11/2023 at 11:10 AM, the fire alarm panel located in the lobby detailed seven trouble signals Review of the facility's policy titled, "Inspection of Fire Alarm System," revised 11/16/2022, specified, "It shall be the policy of New Community Extended Care facility to ensure the safety and welfare of all residents, staff and visitors during any emergency involving, or related to fire or smoke. Inspection of Fire Alarm System to be done every 6 months by [vendor name] and copy placed in the maintenance book. Policy on daily visual observation of Fire alarm panel showing looking for trouble signals by Maintenance Personnel. Any identified trouble signal will immediately be called into [vendor name] for service by the maintenance personnel using number written on the Fire Alarm Panel." Review of the facility's policy titled, "Inspection of Fire Alarm and Sprinkler System," revised 11/16/2022, specified, "It shall be the policy of New Community Extended Care facility to ensure the safety and welfare of all residents, staff and visitors. Procedure: 1. Extended Care fire Alarm System will be inspected for proficient function by our contracted agency [vendor name] on semi-annual bases [sic]. Report of finding will be placed in the maintenance log book by Environmental Director or designee. 2. Any issues or concerns identified in the inspection report will be reviewed and addressed by Director of Environmental services or designee." The policy further specified, "4. Report will be	K 345	Administrator confirmed the deficient practice identified by the surveyor showing no record of semi-annual visual inspection of the fire alarm in 12 months and absence of wire at Second, Third and Fourth floor tamper switch devices indicated in the inspection report conducted by facility contracted vendor done 6/9/2022. The deficient practice occurred because Director of Environmental Services and in house maintenance crew failed to follow facility Policy on Fire Alarm and Sprinkler system inspection and follow up of inspection reports. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No other residents were affected by this deficient practice as there was no fire prior to this deficiency. Action taken: The Director of Environmental Services immediately initiated a call with facility contracted Fire Alarm/Sprinkler System Vendor Metro Fire & Safety who came and repaired as well as conducted the required semi-annual inspection of the Fire Alarm System. Facility policy on fire alarm/sprinkler system was reviewed and revised by the Administrator, Director of Environmental, Chief Operations Officer, Chief Executive Officer and all maintenance staff in-serviced on the revised policy with signed signature acknowledging understanding of facility policy related to semi-annual inspection and need to	

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K 345	Continued From page 17 reviewed and placed in maintenance log book for Environmental Service Director or designee. 5. All issues identified will be reviewed and addressed by Director of Environmental Services or designee. 6. Maintenance Department with the lead Director or Designee will initiate service call for random system issues." A review of the "Report of Inspection / Test," dated 06/09/2022, revealed the fire alarm was inspected by the licensed vendor on 06/09/2022. There was no documentation of a semi-annual visual inspection of the fire alarm system within the past 12 months. Further review of the report revealed, the second, third, and fourth floor central stairwell and the second and fourth floor tamper switch had no wire at the device. . During an interview on 01/11/2023 at 1:06 PM, the Director of Environmental Services (DES) acknowledged the findings and stated he was not aware of the semi-annual inspection requirements; however, he was responsible for the life safety requirements in the facility. The DES indicated he was aware of the 06/09/2022 inspection findings but the devices had additional wires. Per the DES, he was not aware of the trouble signals on the fire alarm panel. According to the DES, he was responsible for reviewing the life safety code inspection reports and having any concerns fixed. The DES stated he was going to reach out to the vendor to get the fire alarm system inspected, tested, and maintained per the code. Per the DES, he expected the life safety code requirements to be followed. During an interview on 01/11/2023 at 1:39 PM, the Administrator acknowledged the findings and stated the facility had no other documentation the	K 345	review and respond to findings in the report. Completed: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: The Chief Operations Officer, The Administrator, the Director of Environmental Services and Chief Executive Officer reviewed the deficiency and concurred with the surveyor that all 99 residents were potentially at risk had fire incident occurred prior to the findings. However, no residents were affected related to K345 deficiency. 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: The Administrator, Chief Operations Officer, Chief Executive Officer and Director of Environmental Services developed a QA Audit Tool for K345 to track fire alarm/sprinkler system inspections and follow ups. The Director of Environmental Services and in house maintenance crew were in serviced on the use of this QA Audit tool by Administrator. The in-house maintenance crew and environmental service director will be utilized the AQ Audit Tool to monitor weekly the Fire Alarm Panel and will ensure that the bi-annual inspections of Fire Alarm Panel and required repairs by facility contracted vendor Metro Fire & Safety is done timely. The Director of Environmental Services or designee will be presenting the report of QA Audit tool for K345 compliance	

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K 345	Continued From page 18 fire alarm system was inspected other than the report dated 06/09/2022. The Administrator indicated she was not aware the fire panel contained trouble signals. According to the Administrator, she relied on the DES to get the inspection concerns resolved since some of life safety code requirements were not her specialty. Per the Administrator, she expected all life safety code requirements to be followed. During an interview on 01/11/2023 at 2:29 PM, the Maintenance Supervisor (MS) stated he had only worked at the facility for three months and was not trained in the life safety requirements. The MS stated he expected all life safety code requirements to be followed. NJAC 8:39-31/1(c), 31.2(e) NFPA 70, 72	K 345	findings monthly to the Administrator, Chief Operations Officer, Chief Executive Officer for their review and approval to ensure compliance and same report will be presented to QAPI Team during their quarterly meetings for their review and approval to ensure consistent compliance. Upon new hire of any in house maintenance staff, the Director of Environmental Services or designee will in service him or her on the facility policy and QAPI Audit Tool for K345. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Administrator, Chief Operations Officer, and Chief Executive Officer will continue to review and monitor reports of findings from QA Audit tool regarding K345 every month as presented by Director of Environmental Services or designee to ensure sustained compliance. Same report will continue to be presented to QAPI Team quarterly during meetings for their review and approvals to maintained consistent compliance practice x 1 year. Findings will be used for future training of maintenance staff.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		2/23/23

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K 353	Continued From page 19 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, interviews, document review, and facility policy review, it was determined that the facility failed to inspect, test, and maintain the automatic sprinkler system in accordance with National Fire Protection Association (NFPA) 25, Standard for the Inspection, Testing, and Maintaining of Water-Based Fire Protection Systems. This deficient practice had the potential to affect 99 residents. Findings included: During an observation on 01/11/2023 at 11:31 AM, the sprinkler riser contained a sticker that denoted a five-year internal inspection was completed on 08/2007. Review of a facility's policy titled, "Inspection of Fire Alarm and Sprinkler System," revised 11/16/2022, specified, "It shall be the policy of New Community Extended Care facility to ensure the safety and welfare of all residents, staff and visitors. Procedure: 1. Extended Care fire Alarm	K 353	K353 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Director of Environmental Services and in house maintenance crew concurred with the findings of deficient practice identified by the surveyor regarding facility's failure to inspect, test and maintain automatic sprinkler system in accordance with NFPA 25 standard for the Inspection, Testing and maintaining of Water-based Fire Protection Systems. The Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer reviewed records and determined the deficient practice occurred because the Director of Environmental Services and in house maintenance crew failed to follow facility policy on inspection scheduling, testing and addressing issues on inspection reports and sprinkler system	

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K 353	Continued From page 20 System will be inspected for proficient function by our contracted agency [vendor name] on semi-annual bases [sic]. Report of finding will be placed in the maintenance log book by Environmental Director or designee. 2. Any issues or concerns identified in the inspection report will be reviewed and addressed by Director of Environmental services or designee. 3. Facility Sprinkler System will be maintained and inspected quarterly and as needed by our contracted agency [vendor name]. 4. Report will be reviewed and placed in maintenance log book for Environmental Service Director or designee. 5. All issues identified will be reviewed and addressed by Director of Environmental Services or designee. 6. Maintenance Department with the lead Director or Designee will initiate service call for random system issues." A review of the "Report of Inspection / Test," dated 03/31/2022, revealed no five-year internal obstruction inspection was completed. The report revealed deficiencies in the middle stairwell two on the second through fourth floors where the butterfly value was not wired to the alarm panel and the tamper switch was broken. The report also revealed the waterflow switch in the middle stairwell was not wired on the second through fourth floors. A review of the "Report of Inspection / Test," dated 12/01/2022, revealed no five-year internal obstruction inspection was completed. The report revealed deficiencies of a broken tamper off valve at fire pump, middle stairwell two on second through fourth floors where the butterfly value was not wired to the alarm panel, tamper on system side of fire pump did not come into panel, waterflow switch in the middle stairwell was not	K 353	maintenance as well as failed to consistently conduct weekly Fire Pump Test Run. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All 99 in house residents have potential to be affected by K353 deficient practice had fire occurred prior to identification of this deficient practice. However, no resident was affected as fire did not occur. Action taken: The Director of Environmental Service immediately reached out to facility Fire/Sprinkler contract vendor Metro Fire & Safety and scheduled inspection of the 5(five) year Internal Obstruction Inspection and repair of the previous 12/1/2022 inspection findings. Five-year inspection of the Internal Obstruction inspection completed by vendor Metro Fire & Safety. All in house maintenance staff and Director of Environmental Services were re-in serviced on facility policy on scheduling, inspecting and addressing issues related to sprinkler system and Fire Pump Test run for K353. A QA Audit Tool was developed by Director of Environmental Services, Administrator, Chief Operations Officer and Chief Executive Officer. Director of Environmental Services in serviced maintenance crew on how to utilize the tool to conduct audit of all sprinkler inspections and follow up on inspection reports including weekly Fire Pump Test run. They signed the in-service sheet acknowledging understanding of the use	

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K 353	Continued From page 21 wired on second through fourth floors, waterflow in pump room was not wired, flowed inspectors test on fourth floor by Room [redacted] for over five minutes and no waterflow came in at the panel. A review of the "Fire Engine Test Run - Weekly" for the past 12 months revealed the fire pump was not inspected weekly on 01/10/2022, 01/24/2022, 02/14/2022, 02/28/2022, 03/14/2022, 03/28/2022, 04/11/2022, 04/25/2022, 05/09/2022, 05/23/2022, 06/13/2022, 06/27/2022, 07/11/2022, 07/25/2022, 08/08/2022, 08/22/2022, 09/05/2022, 09/19/2022, 10/03/2022, 10/17/2022, 10/31/2022, 11/14/2022, 11/28/2022, 12/12/2022, and 12/26/2022. During an interview on 01/11/2023 at 1:06 PM, the Director of Environmental Services (DES) acknowledged the findings and indicated he was not aware of the five-year internal inspection requirements. The DES acknowledged the fire pump was not exercised weekly and indicated he did not know why the fire pump was not inspected weekly. The DES indicated the weekly inspection was delegated to the maintenance team, and he had not looked at the documentation since November 2022. According to the DES, the Maintenance Supervisor (MS) was responsible for the weekly exercising of the fire pump. Per the DES, he was waiting on a proposal regarding the issues noted from the vendor sprinkler contractor in the March 2022 inspection report, but did not get the report, and that was why the issues were still not fixed as denoted on the 12/01/2022 inspection report. The DES indicated he was responsible for obtaining and reviewing the inspection reports and having any noted concerns fixed. The DES stated he was going to reach out to the vendor sprinkler contractor to ask for the	K 353	of the tool and policy. Completed: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: The Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer met and reviewed K353 deficiency and agreed it has potential to affect all 99 in house residents had fire occurred. No residents were affected by this deficient practice. 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: Re-in service of Director of Environmental services and in house maintenance crew on facility policy regarding scheduling, testing, inspecting and repair of inspection finds related to sprinkler system and weekly Fire Pump Test run was done by facility Administrator and Chief Operation Officer. The in-house maintenance crew resumed weekly fire pump testing and Metro Fire & Safety conducted five-year Sprinkler testing. All findings in compliance. Completed: 2/03/23 The Director of Environmental Services will present the report of the QA Audit Tool for K353 findings to Administrator, Chief Operations Officer and Chief Executive Officer on monthly basis and to QAPI Team quarterly during their meetings for their review and approval to ensure consistent compliance. Any new maintenance hire will be in serviced on the facility policy regarding Sprinkler System Inspection, Testing and	

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K 353	Continued From page 22 current findings to get the concerns addressed. According to the DES, he was responsible for the life safety code requirements and expected the life safety code requirements to be followed. During an interview on 01/11/2023 at 1:39 PM, the Administrator acknowledged the findings and stated the five-year internal inspection was completed in the past but did not remember how many years ago and had no documentation it was completed in the last five years. Per the Administrator, she and DES got the inspection reports, but she relied on the DES to get the inspection concerns resolved since some of life safety code requirements were not her specialty. According to the Administrator, she would now involve the Chief Operating Officer to ensure the inspections were completed as required. The Administrator stated she expected all life safety code requirements to be followed. During an interview on 01/11/2023 at 2:29 PM, the MS stated he had only worked at the facility for three months and was not trained on the life safety requirements. The MS stated he expected all life safety code requirements to be followed. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	follow up on inspection reports. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Director of Environmental services or designee will continue to present reports of findings from the audit tool for K353 to Administrator, Chief Operations Officer and Chief Executive Officer monthly for their continued review and monitoring to ensure a sustained compliance. QAPI team will continue to same reports on quarterly basis during their meetings for their monitoring and review to maintained sustained compliance at 100 percent x 1 year. Findings will be used for future training of maintenance staff.	
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	K 363		2/23/23

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K 363	Continued From page 23 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, 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 observations and interviews, it was determined that the facility failed to ensure 1 of 3 fire doors on the third floor was not impeded from closing and latched into the frame. This deficient practice had the potential to affect 17 residents who resided on the third floor.	K 363	K363 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Administrator, Director of	

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K 363	Continued From page 24 Findings included: On 01/11/2023 at 10:31 AM, an observation revealed the left side of the double set fire doors, located on the third floor East wing, dragged on the floor, and failed to latch. During an interview on 01/11/2023 at 1:15 PM, the Director of Environmental Services (DES) acknowledged the findings and indicated the fire door was now fixed. The DES stated he expected the life safety code requirements to be followed. During an interview on 01/11/2023 at 1:39 PM, the Administrator stated she did not know why the fire door failed to latch, but the maintenance team had worked to fix the door. According to the Administrator, a vendor contractor performed fire drills monthly and checked the fire doors to ensure the doors closed properly. The Administrator stated she expected the life safety code requirements to be followed. During an interview on 01/11/2023 at 2:37 PM, the Maintenance Supervisor (MS) stated he was not aware the fire door failed to latch. The MS stated he expected all life safety code requirements to be followed. On 01/11/2023 at 2:30 PM, the facility's policy related to the maintenance of the emergency exits was requested from the Administrator; however, the Administrator did not provide a policy prior to the surveyor's exit. NJAC 8:39-31.1(c), 31.2(e)	K 363	Environmental Services and facility maintenance crew confirmed the deficient practice related to in proper closure and latching of the emergency fire door on the 3rd Floor East corridor found by the surveyor during rounds violating NFPA 101 7;2.1.9. This deficient practice occurred because Director of Environmental Services and maintenance crew failed to routinely inspect all exist fire doors as per facility policy and make necessary repairs as required. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer met and reviewed the deficiency for [redacted] and concurred that all 17 residents on the [redacted] floor unit had potential to be affected by this deficiency practice had fire or smoke emergency occurred prior to the finding. Since there was no fire or smoke incidences, no resident was affected. Action taken: The Director of Environmental Services and Administrator immediately instructed the in-house maintenance supervisor to further inspect and repair the deficient door. A call was placed to facility fire door specialist vendor Bildisco Doors for inspection and repair by Director of Environmental Services. Emergency fire door on the 3rd Floor East corridor was replaced. Facility policy on Fire doors/Exit door inspections and maintenance was	

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K 363	Continued From page 25	K 363	reviewed with the Director of Environmental Service and in house maintenance crew by the Administrator. The in-house maintenance crew and Director of Environmental Services checked the entire building Fire/Exit doors to ensure proper closures and latching. Completed: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: The Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer met and reviewed the deficiency for K363 and concurred that all 17 on 3rd floor unit residents had potential to be affected by this deficiency practice had fire or smoke emergency occurred prior to the finding. Since there was no fire or smoke incidence, no resident was affected. 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: The Administrator, Chief Operations Officer and Chief Executive Officer reviewed and revised facility policy on fire door/exit doors inspections and maintenance. Administrator in serviced the Director of Environmental Services and all in house maintenance crew on this policy and its importance in life safety . A QA Audit tool was developed by Director of Environmental Services, Administrator, Chief Operations Officer and Chief Executive Officer for maintenance to use in observing compliance to K363	

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K 363	Continued From page 26	K 363	deficiency. The Administrator in serviced the maintenance crew on how to use this tool. The Director of Environmental Services or designee will monitor the findings of the QA Audit Tool for K363 conducted monthly by maintenance crew and will present report to Administrator, Chief Operations Officer and Chief Executive Officer monthly and to QAPI Team during their quarterly meetings for their review and approval to ensure compliance. Upon new hire of any maintenance staff, the Director of Environmental Services or designee will orient the staff on this policy and the QA Audit Tool for K363. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: The Administrator, Chief Operations Officer and Chief Executive Officer will monitor and review all K363 deficiency compliance report monthly and QAPI Team quarterly to ensure maintained compliance at 100 percent x 1 year. Findings will be used for future training of maintenance staff.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO	K 741		2/23/23

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K 741	Continued From page 27 SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, document review, and facility policy review, it was determined that the facility failed to ensure 1 of 1 smoking areas was maintained with metal containers with self-closing cover devices into which ashtrays could be emptied, that were readily available to all areas where smoking was permitted in accordance with National Fire Protection Association (NFPA) 101, 19.7.4. This deficient practice had the potential to affect 16 of the 99 residents of the facility who smoked. Findings included: On 01/11/2023 at 11:14 AM, the smoking area on the first floor was observed to not have a metal container with self-closing devices into which ashtrays could be emptied. The smoking area	K 741	K741 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Administrator, Director of Environmental Services and maintenance crew during the tour with the surveyor confirmed the surveyor deficient finding of violation of NFPA 101, 19.7.4 no metal containers with self-closing device in the facility designated smoking area. This deficient practice occurred because the Administrator and Director of Environmental Services failed to ensure there was metal containers with self-closing devices in the facility designated smoking area that would	

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K 741	Continued From page 28 contained four smoking poles. Review of a facility's policy titled, "Smoking Guidelines," revised on 11/22/2022, specified, "It is the facility's policy to maintain a safe environment for those residents, resident representative, their families, visitors and staff who smoke." The policy further specified, "C. Designated Smoking Area. 1. The patio is the only designated smoking area where ash tray receptacles are provided for smoking." A review of a document titled, "List of Smokers," updated 01/01//2023, indicated there were 16 residents identified by the facility as residents who smoked. During an interview on 01/11/2023 at 1:10 PM, the Director of Environmental Services (DES) acknowledged the findings and stated he was not aware the smoking area must contain metal containers with self-closing devices into which ashtrays could be emptied. The DES indicated he and the Administrator were responsible for the life safety code requirements. Per the DES, he expected the life safety code requirements to be followed. During an interview on 01/11/2023 at 1:37 PM, the Administrator stated she was not aware the smoking area must contain metal containers with self-closing devices into which ashtrays could be emptied. Per the Administrator, she thought just the smoker pole receptacles were acceptable. The Administrator stated she would order the metal containers with self-closing devices and expected all life safety code requirements to be followed.	K 741	prevent fire from cigarette butts. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? There were no residents affected by this deficient practice. Action taken: The Administrator and Director of Environmental Services purchased metal containers with self-closing devices. The in-house maintenance supervisor installed all the new metal containers with self-closing devices in the designated smoking area. The housekeeping staff who are responsible for maintaining the cleanliness of this designated smoking area were given the keys and in serviced on how to empty and close the containers. Completed: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: After reviewing the surveyors finding of deficient practice for NFA 101 19.7.4, the Administrator and Director of Environmental services agreed with the finding that all 16 residents who smoke in this designated area were at risk had fire occurred prior to identifying this deficient practice. None of the residents was affected by this deficient practice. 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: The Administrator, Director of Environmental Services and Maintenance Supervisor in serviced housekeeping staff who are responsible for emptying and	

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K 741	Continued From page 29 During an interview on 01/11/2023 at 2:21 PM, the Maintenance Supervisor (MS) stated he was not aware of the requirements for metal containers with self-closing devices into which ashtrays could be emptied. The MS stated he expected all life safety code requirements to be followed. NJAC 8:39-31.2(e)	K 741	locking the metal containers with self-closing devices on how to carry out this duty. All other staff who monitor smoking and residents who smoke were also educated on the importance of placing cigarette butts inside this metal container to avoid fire. A QAPI Tool for K741 was developed by the Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer to be used by Housekeeping Department to monitor the use and emptying of the metal container daily for compliance. The Housekeeping Supervisor will be responsible for monitoring the daily report of the QA Audit Tool for K741 and will present report of the findings to Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer monthly for their review and monitoring. Same report will be presented to QAPI Team during their quarterly meeting for their review to ensure compliance. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: To maintain a sustained compliance at 100 percent, the Administrator, Chief Operations Officer and Chief Executive Officer and QAPI Team will continue to monitor all reports on NFPA 101, 19.7.4 quarterly x 1 year. Findings will be used for future training of housekeeping staff.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		2/23/23

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K 761	Continued From page 30 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined that the facility failed to inspect all fire-rated doors required by the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) sections 7.2.1.15.2 and 7.2.1.15.4 and the NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives. This deficient practice had the potential to affect 99 residents. Findings included: During a concurrent record review and interview on 01/11/2023 at 9:00 AM, with the Director of Environmental Services (DES), a review of the life safety code inspection documentation revealed there were no annual fire-rated door inspections conducted. The DES stated he had never heard of the code requirement to inspect the fire-rated doors, and the inspection was not completed. Per the DES, the facility would have to implement that inspection of the fire-rated	K 761	K761 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Director of Environmental Services, The Administrator and Chief Operations Officer reviewed the facility maintenance log book and confirmed the surveyors finding of deficient practice for NFPA 101, 7.2.1.1.15.2 and 7.2.1.15.4 and NFPA 80(2010 edition) annual Fire-rated door inspections not performed. The Director of Environmental Services and in house maintenance crew failed to schedule annual fire-rated doors inspections resulting in this violation. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? There were no residents affected by this	

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K 761	Continued From page 31 doors. The DES indicated he had worked as the DES for approximately five years and was responsible for the life safety code requirements. During an interview on 01/11/2023 at 1:45 PM, the Administrator stated that when the vendor contractor conducted fire drills, they looked at the doors to ensure the doors closed properly. The Administrator stated she had no documentation that all the fire door components were inspected annually. Per the Administrator, she expected all life safety code requirements to be followed. During an interview on 01/11/2023 at 2:23 PM, the Maintenance Supervisor (MS) stated he was not aware of the annual inspection requirements of all fire-rated doors. Per the MS, he expected all life safety code requirements to be followed. On 01/11/2023 at 2:30 PM, the facility's policy related to the maintenance of the emergency exits was requested from the Administrator; however, the Administrator did not provide a policy prior to the surveyor's exit. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	deficient practice. Action taken: The Director of Environmental Services and in house maintenance crew inspected all fire rated doors in the facility. The facility policy on inspection and maintenance of all fire rated doors was reviewed and revised by Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer. All in house maintenance crew were in serviced on the reversed policy by the Administrator and Director of Environmental Services. Completed: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: The Chief Executive Officer, Chief Operations Officer, Director of Environmental Services and Administrator after reviewing the deficient practice cited by the surveyor, agreed that it has potential to affect all 99 in house residents had fire occurred prior to the finding. However, no resident was affected. 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: The Administrator , Chief Operations Officer and Chief Executive Officer developed a QA Audit Tool for K761 to be used by maintenance crew to review and track all fire door inspections and findings. The Director of environmental Services and Chief Operations Officer in serviced maintenance crew on the use of this new	

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K 761	Continued From page 32	K 761	QA Audit tool for K761 The Director of Environmental Services or designee will utilize the new QA Audit Tool for K761 to monitor compliance and present report to Administrator, Chief Operations Officer, Chief Executive Officer monthly for their review and approval and present same report quarterly to QAPI team during their meetings for their review to ensure consistent compliance. If any new maintenance personnel are hired, Director of Environmental Services or designee will in service the staff on the revised policy and QA Audit Tool for K761. Completed: 02/03/23 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: All report related to K761 presented by the Director of Environmental Services or designee will continue to be monitored and reviewed by the Administrator, Chief Operations Officer, Chief Executive Officer monthly and quarterly by QAPI team to make sure ensure consistent compliance are maintained at 100 percent x 1 year. Findings will be used for future training of maintenance staff.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		2/23/23

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K 918	Continued From page 33 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and document review, it was determined the facility failed to: 1. exercise the emergency generator 12 times each year for at least 30 minutes in 20 to 40-day intervals, 2. document the time needed by the generator to transfer power to the building was within the 10-second time frame, 3. annually perform a diesel fuel quality analysis test, and 4. ensure an annual load bank test was performed	K 918	K918 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Administrator, Director of Environmental Services, Chief Operations Officer, Chief Executive Officer reviewed the facility policy on emergency generator	

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K 918	Continued From page 34 in accordance with National Fire Protection Association (NFPA) 99. These deficient practices had the potential to affect 99 residents who resided in the facility. Findings included: A review of the "Emergency Generator Record Keeping" for the previous 12 months revealed there was no load test conducted for 12 of 12 months, to indicate the generator would start and transfer power to the building within 10 seconds; the facility's emergency generator was not tested under load 12 times for 30 minutes in the last 12 months; and there were no documented exercises of the transfer switches monthly for the last 12 months. A review of the "Generator Inspection Report," for the dates of 01/20/2022, 03/21/2022, and 06/28/2022, revealed no load bank test, no automatic transfer switch (ATS) exercise, and no diesel fuel quality analysis tests were performed. During an interview on 01/11/2023 at 9:08 AM, Service Department Manager (SDM) of the contracting agency revealed the facility had never asked the agency to conduct a diesel fuel quality analysis. The SDM indicated the agency had never performed a load bank test and the transfer test was completed several years ago. During an interview on 01/11/2023 at 1:18 PM, the Director of Environmental Services (DES) acknowledged the findings and indicated he was only aware of the monthly load test requirements for 30 minutes 12 times a year. The DES indicated he did not know why the generator was not exercised under load for 30 minutes.	K 918	maintenance including maintenance log book and agreed with surveyors finding of NFPA 110 and NFPA 111 violation. It was determined that the Director of Environmental Services and in house maintenance crew failed to carry out the weekly and monthly testing requirements and also failed to schedule inspections for the emergency generator annual diesel fuel quality analysis test with our contracted fire/electrical vendor R & J Controls Inc. as required by NFPA 110 and NFPA 111 manufacturers resulting in this deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Since there were no fire emergencies prior to the finding of this deficient practice, no resident was affected. Action taken: Facility policy on maintaining and testing emergency generator was reviewed and revised by Director of Environmental Services, Administrator and Chief Operations Officer and also a QA tool was developed to address K918 deficiencies. All in house maintenance crew were in serviced on the importance of following this policy and how to use the tool by Administrator. Director of Environmental Services scheduled emergency generator testing and all related required inspections and testing covering all found deficient practice for NFPA 99, NFPA 110 and NFPA 111 with our contracted vendor(R&J Control)	

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K 918	Continued From page 35 According to the DES, the vendor contractor had never indicated to perform the other tests, inspections, and preventative maintenance. Per the DES, he was responsible for the life safety code requirements and would schedule the inspections to comply. The DES stated he expected the life safety code requirements to be followed. During an interview on 01/11/2023 at 1:37 PM, the Administrator stated she was not aware of the inspection, testing, and maintenance requirements for the generator except to exercise the generator under load for 30 minutes 12 times a year. Per the Administrator, the DES was responsible for documentation related to the generator. According to the Administrator, the previous maintenance supervisor (MS) left last year, and she had an issue getting the life safety code binder together but expected all life safety code requirements to be followed. The Administrator did not provide a policy related to the maintenance of the emergency generator prior to the surveyor's exit. During an interview on 01/11/2023 at 2:49 PM, the MS stated he had only worked at the facility for three months and was not aware of the generator requirements. Also, the MS indicated he did not know if he was even responsible for the inspection, testing, and maintenance of the generator at the facility, as his responsibilities were not detailed on hire. Per the MS, he expected all life safety code requirements to be followed. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	Completed: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: Upon reviewing this deficient practice, the Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer concurred that all 99 in house residents had potential to be affected by this deficient practice had fire occurred prior to these findings, however no resident was affected since there was no fire incident. 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: All in house maintenance crew and Director of Environmental Services were in serviced on the revised policy and the new QA Audit Tool for K918 by Administrator with emphasis on ensuring compliance to avoid risks resulting from fire emergencies. All signed signatures acknowledging understanding. On monthly basis, the Director of Environmental Services or designee will utilize the QA Audit tool for K918 to audit all inspections and testings' carried out relating to emergency generator to ensure compliance and will present findings to Administrator, Chief Operations Officer and Chief Executive Officer monthly for their review and approval and to QAPI Team Quarterly during meetings to ensure compliance. 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315393	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	**266 S ORANGE AVE** **NEWARK, NJ 07103**

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K 918	Continued From page 36	K 918	CHANGE: The Administrator, Director of Environmental Services, Chief Operations Officer, Chief Executive Officer and QAPI Team will continue to monitor and review reports presented by Director of Environmental Services or designee monthly and quarterly by QAPI team to ensure consistent compliance at 100 percent x 1 year. Findings will be used for future training of maintenance staff.	
K 926 SS=D	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on interviews and document review, it was determined that the facility failed to ensure that staff concerned with the application, maintenance, and handling of medical gases and cylinders were trained on the risk in accordance with the National Fire Protection Association (NFPA) 99, 11.5.2.1. This deficient practice had the potential to affect 99 residents who resided in the facility. Findings included:	K 926	K926 1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice. Cause of problem identification The Administrator and Director of Environmental Services upon reviewing the facility life safety code binder, confirmed the surveyors finding related to NFPA 99, 11.5.2.1 violation. The Administrator and Environment Director agreed that this deficient practice	2/23/23

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	315393	A. BUILDING **01** B. WING _____	**01/11/2023**

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K 926	Continued From page 37 A review of the life safety code binder revealed no staff training on the risk associated with the handling and use of medical gases and cylinders. During an interview on 01/11/2023 at 8:35 AM, the Administrator acknowledged the findings and indicated staff had not received training on the risk associated with the handling and use of medical gases and cylinders. Per the Administrator, she was unaware of the staff training requirements on the risks associated with the handling and use of medical gases and cylinders. The Administrator did not provide the surveyor with a copy of the facility's policy related to the training requirements for the staff who maintained and handled medical gases and cylinders prior the surveyor's exit. During an interview on 01/11/2023 at 1:27 PM, the Director of Environmental Services (DES) acknowledged the findings and stated he was not aware of the training requirement for staff on the risk associated with the handling and use of medical gases and cylinders. The DES indicated staff were not trained on the risk of handling and use of oxygen. According to the DES, he was responsible for the life safety code requirements and expected all life safety code requirements to be followed. During an interview on 01/11/2023 at 2:26 PM, the Maintenance Supervisor (MS) stated he had only worked at the facility for three months and had not received training on the risk associated with handling and use of medical gases and cylinders. The MS stated he expected all life safety code requirements to be followed. NJAC 8:39-31.2(e)	K 926	occurred because both the Administrator and Director of Environmental Services failed to ensure maintenance and nursing staff who handle medical gases and oxygen cylinders about risks involved. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were involved in this deficient practice. Action taken: The Administrator and Director of Environmental Services, Chief Operations Officer, and Chief Executive Officer met and reviewed and revised facility policy on safe handling of medical gases and oxygen cylinders. Administrator in-serviced all-in house facility maintenance crew and the nursing staff who handle oxygen cylinders on the revised policies stressing importance of understanding the risks if not properly handled and stored. Completed: 02/03/23 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE: The Administrator and Director of Environmental Services, Chief Operations Officer, and Chief Executive Officer determined that all in house 99 residents were potentially at risk had staff mishandled either the medical gases or oxygen cylinder prior to being in serviced, no residents were affected by this deficient practice. Completed: _____	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315393	A. BUILDING **01** B. WING _____	**01/11/2023**

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K 926	Continued From page 38	K 926	3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENCIES WILL NOT OCCUR: Upon reviewing and revising facility policy on safe handling of medical gases and oxygen cylinders, Administrator educated all maintenance Staff and Nursing Staff to ensure understanding of risks associated with mishandling medical gases and oxygen cylinders. Any new hire in nursing or maintenance department will be in-serviced on this revised policy. Bi-annual retraining of nursing and maintenance staff and records will be maintained in the maintenance log book by the Director of Maintenance or designee. QAPI Tool for K926 developed by Administrator, Director of Environmental Services, Chief Operations Officer and used by maintenance director to monitor compliance and present report to Administrator, Chief Operations Officer and Chief Executive Officer monthly and quarterly to QAPI Team during their meetings for their review and approval to maintain consistent compliance. Completed: 02/03/23 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE: Director of Environmental Services will continue to present monthly report of K926 findings and compliance to Administrator, Director of Environmental Services, Chief Operations Officer and Chief Executive Officer, and quarterly to QAPI team for their review to ensure maintained compliance at 100 percent x 1	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 926	Continued From page 39	K 926	year. Findings will be used for future training of maintenance staff.	

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
315393 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/6/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	266 S ORANGE AVE NEWARK, NJ 07103

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 K0161	02/25/2023	LSC K0222	02/23/2023	LSC K0271	02/23/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	02/23/2023	LSC K0345	02/23/2023	LSC K0353	02/23/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	02/23/2023	LSC K0741	02/23/2023	LSC K0761	02/23/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	02/23/2023	LSC K0926	02/23/2023	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? ☐ YES ☐ NO
1/11/2023	