STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315194	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

(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 000	INITIAL COMMENTS Complaint #s: NJ 163099, 164140, 164735, 164747, 167673, 168219, 165875 STANDARD SURVEY: 1/25/24 CENSUS: 111 SAMPLE SIZE: 31 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure that there was an order for the administration of [NJ Exec Order 2] being provided to Resident # 189 and b.) failed to accurately document a medication being administered per Physicians order for Resident # 35. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered	F 658	The [NJ Exec Order 26.4b1] medication on the [NJ Exec Order 26.4b1] consult sheet order was immediately clarified with the [NJ Exec Order 26.4b1] consultant for resident # 35. Order for [NJ Exec Order 2] for resident #189 was obtained from the physician. All residents on psychotropic medications have the potential to be affected. All residents On O2 therapy have the	2/5/24

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

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F 658	Continued From page 1 professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: 1. The surveyor reviewed the electronic medical record (EMR) of Resident # 189 which revealed the following: According to the Resident Face Sheet, Resident #63 was admitted with diagnoses that included NJ Exec Order 26.4b1 [redacted] A review of the resident's progress notes revealed the following: On [redacted] a progress noted revealed [redacted], on [redacted] on [redacted] a [redacted], on [redacted] on [redacted]. A review of the NJ Exec Order 26.4b1 summary in the the vitals section of the EMR, revealed that there were documented methods of [redacted] via [redacted] on the following dates: [redacted]	F 658	potential to be affected. All Nursing staff were in-serviced on reviewing the consistency of Psychiatry consultant medication lists and actual orders. All Nursing staff were in-serviced on the O2 administration policy. Weekly audits of all psychiatric consults will be done by director of nursing or her designee to ensure Psychiatric consultant orders/recommendations and med lists are consistent with current orders for 1 month. Monthly audits of 5 psychiatric consults will be done by director of nursing or her designee to ensure Psychiatric consultant orders/recommendations and med lists are consistent with current orders for 3 months Weekly audits of all resident rooms will be done by director of nursing or designee to ensure all residents that have oxygen have a physicians order x 4 weeks. Monthly audits of all resident rooms will be done by director of nursing or designee to ensure all residents that have oxygen have a physicians order for 2 months Results of the audits will be presented to the administrator or his designee at the QAPI meeting which is held quarterly.	

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F 658		F 658		

Continued From page 2

NJ Exec Order 2 and NJ Exec Order 2

On 1/23/24 at 1:25 PM, the surveyor discussed the above concerns with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)).

A review of the facility's Oxygen Administration policy and procedure updated 1/2024, revealed "Verify that there is a physician's order for this procedure. review the physician's orders for oxygen administration."

2. The Surveyor reviewed the electronic medical record (EMR) of resident #35 which revealed the following:

According to the Resident Face Sheet, the resident was admitted with a diagnosis of NJ Exec Order 26.4b1 . (a condition characterized by NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1, especially with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and often with NJ Exec Order 26.4b1 , resulting from NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 are NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 that cause NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 your general NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 is NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 with your circumstances and NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 an NJ Exec Order 26.4b1 characterized by NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1

A review of the resident's electronic medication record revealed the following:

An order dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 twice a day (NJ Exec Order 26.4b1).

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F 658	Continued From page 3 An order dated [NJ Exec Order] to discontinue [NJ Exec Order 26.4b1] as needed every 4 hours for [NJ Exec Order 26.4b1] A review of the resident's paper medical record and electronic medical record revealed the following: A [NJ Exec Order 26.4b1] Consult dated [NJ Exec Order 26.4] that reflected a recommendation to maintain [NJ Exec Orde] A [NJ Exec Order 26] of New Jersey Plan of Care dated [NJ Exec Orde] with a medication list that included [NJ Exec Orde] PRN every 4 hours as needed for [NJ Exec Order 26.4b1] On 1/24/24 at 12:10 PM the surveyor interviewed the [NJ Exec Order 26] [U.S. FO] who stated that she has personal clinical notes that reflected the change in medication orders, but they were not in the resident's medical record as they are no longer putting hard copies in the resident's chart. On 1/24/24 at 12:41 PM the [U.S. FOIA] provided to the surveyor a copy of an email from the [NJ Exec Order 26.4b1] [U.S. FOIA (b) (6)] stating the [NJ Exec Order 26.4] consultation report omitting [NJ Exec Order 26.4b1] and documenting [NJ Exec Order 26.4b1] was an error in transcription. 2. The Surveyor reviewed the electronic medical record (EMR) of resident #35 which revealed the following: According to the Resident Face Sheet, the resident was admitted with a diagnosis of	F 658		

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F 658	Continued From page 4	F 658		

NJ Exec Order 26.4b1 [redacted]. (a condition characterized by NJ Exec Order 26.4b1 [redacted] especially with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, and often with NJ Exec Order 26.4b1, resulting from NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 are NJ Exec Order 26.4b1 that cause NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 your general NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 is NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 with your circumstances and NJ Exec Order 26.4b1 with your NJ Exec Order 26.4b1. an NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1)

A review of the resident's electronic medication record revealed the following:

An order dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 twice a day (aNJ Exec Order 26.4b1).

An order dated NJ Exec Order 26.4b1 to discontinue NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 as needed every 4 hours for NJ Exec Order 26.4b1 [redacted]

A review of the resident's paper medical record and electronic medical record revealed the following.

A NJ Exec Order 26.4b1 Consult dated NJ Exec Order 26.4b1 that reflected a recommendation to maintain NJ Exec Order 26.4b1 [redacted]

A NJ Exec Order 26.4b1 of New Jersey Plan of Care dated NJ Exec Order 26.4b1 with a medication list that included NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 PRN every 4 hours as needed for NJ Exec Order 26.4b1.

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F 658	Continued From page 5 On 1/24/24 at 12:10 PM, the surveyor interviewed the [NJ Exec Order 26] [U.S. FO] who stated that she has personal clinical notes that reflected the change in medication orders, but they were not in the resident's medical record as they are no longer putting hard copies in the resident's chart. On 1/24/24 at 12:41 PM, the [U.S. FOIA] provided to the surveyor a copy of an email from the [NJ Exec Order 26.4b1] U.S. FOIA (b) (6) stating the [NJ Exec Order 26.4b] consultation report omitting [NJ Exec Order 26.4b1] and documenting [NJ Exec Order 26.4b1] was an error in transcription. NJAC 8:39-27.1 (a)	F 658		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		2/5/24

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F 761	Continued From page 6 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were stored and labeled appropriately. This deficient practice was identified in three (3) of four (4) medication carts inspected on four (4) of four (4) units. This deficient practice was evidenced by the following: On 1/18/23 at 11:37 AM, the surveyor inspected 1st floor South Cart High in the presence of LPN#1 and an additional surveyor and observed one (1) foil package of Budesonide (Pulmicort) nebulizer solution (a steroid inhalant liquid used with a mechanical nebulizer to treat asthma) with no date documented on the foil package when opened. The surveyor also observed one (1) box of Ipratropium/Albuterol (DuoNeb) nebulizer solution (an inhalant liquid used with a mechanical nebulizer to treat asthma), which contained one (1) open foil packet. There was no indication of when the foil pouch or box was opened. On 1/18/23 at 11:47 AM, the surveyor interviewed LPN#1 who stated that she could not find any dates when opened on the Budesonide package or the Ipratropium/Albuterol package. The surveyor with LPN#1 reviewed the Budesonide and Ipratropium/Albuterol manufacturer label and packaging which specified for Budesonide, once the foil pouch was opened, use ampules within	F 761	All resident have the ability to be affected by the deficient practice. All affected medication was immediately removed from medication cart. All medication carts have the potential to be affected. All nurses were in-serviced on the policy on medication storage of nebulizer vials, PPD vials, unopened Insulin pens and twice a day temperature checks of Flu vaccines. Director of nursing or designee will audit all medication carts daily for 2 weeks to ensure proper storage of all medication, Director of nursing or designee will audit all medication carts weekly for 2 months to ensure proper storage of all medication. results of the audits will be presented to the administrator or her designee at the QAPI meeting which is held every 3 months.	

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F 761	Continued From page 7	F 761		

(two) 2 weeks, and specified for the Ipratropium/Albuterol to be used within one (1) week of removal from foil package. The LPN#1 acknowledged the lack of dates, and the undated items were removed from the medication cart.

On 1/18/24 at 11:55 AM, the surveyor inspected 1st floor South Cart Low in the presence of RN#1 and an additional surveyor and observed one (1) vial of PPD Tubersol (Tuberculin Purified Protein Derivative-Mantoux, an injectable solution used to aid diagnosis of tuberculosis infection in persons at increased risk of developing active disease). The surveyor observed a date of 1/10/24 written on the box and vial.

On 1/18/24 at 11:56 AM, the surveyor interviewed RN#1 who stated the vial of PPD Tubersol should have been stored in the refrigerator.

Review of the PPD Tubersol labeling and package information reflected:
"Store at 2° to 8°C (35° to 46°F). Do not freeze. Discard product if exposed to freezing. Protect from light. Tuberculin PPD solutions can be adversely affected by exposure to light. The product should be stored in the dark except when doses are actually being withdrawn from the vial. A vial of TUBERSOL which has been entered and in use for 30 days should be discarded."

On 1/18/24 at 12:07 PM, the surveyor inspected the 1st floor South Cart Subacute in the presence of RN#2 and an additional surveyor and observed one (1) vial of Insulin Aspart (an injectable medication used to treat diabetes) that was unopened. The surveyor also observed one (1) box of Ipratropium/Albuterol nebulizer solution,

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F 761	Continued From page 8	F 761		

which contained one (1) open foil packet and two (2) loose vials. There was no indication of when the foil pouch or box was opened.

On 1/18/24 at 12:09 PM, the surveyor interviewed RN#2 who stated the Insulin Aspart should be stored in the refrigerator. The surveyor with RN#2 reviewed the Ipratropium/Albuterol manufacturer label and packaging which indicated for the Ipratropium/Albuterol to use within one (1) week of removal from foil package. The medication nurse acknowledged the lack of dates on the Ipratropium/Albuterol.

On 1/18/24 at 12:15 PM, the surveyor inspected the 2nd floor North Cart Low in the presence of RN#3 and an additional surveyor observed twenty-three (23) various unidentified loose tablets on the bottom of the 2nd drawer of the medication cart.
The surveyor interviewed RN#3 who stated she could not identify the loose tablets.

On 1/18/24 at 12:25 PM, the surveyor inspected the 2nd floor South medication room in the presence of RN#3 and an additional surveyor. The surveyor observed a temperature log for the medication refrigerator located in the medication room. The refrigerator was observed to contain vials of influenza vaccine. The temperature log reflected monitoring of the refrigerator once a day.

On 1/18/24 at 1:15 PM, the U.S. FOIA (b) (6) provided a copy of the facility policy on medication storage. The facility policy reflected "The facility shall store all medications and biologicals in a safe, secure, and orderly manner." In addition, the facility policy reflects at

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F 761	Continued From page 9 line 1 "Medications and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received." A review of CDC guidelines for vaccine storage reflected for "Monitoring Vaccine Temperatures, To ensure the safety of vaccines, the storage unit minimum and maximum temperatures should be checked and recorded at the start of each workday. If using a TMD that does not display minimum and maximum temperatures, then the current temperature should be checked and recorded a minimum of two times (at the start and end of the workday)." NJAC 8:39-29.4(d)(g)	F 761		

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	060737	A. BUILDING: _____ B. WING _____	C 01/25/2024

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COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

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S 000	Initial Comments Complaint NJ00163099 Survey Date 1/25/23 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ00163099 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. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S 560	Inadequate number of Certified Nursing Assistants All the residents may be affected by the short staff as required by NJ DOH. The Administrator will in-service the Staffing Coordinator in reference to the state guideline S560. • The Director of Human Resources will continue to post the vacancies on all 3 shifts. • The Director of Human Resources will post flyers to promote a successful Open House/Job fair.	2/5/24

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

Electronically Signed | 02/04/24

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COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

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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	• • The staffing agency will block a schedule for the open position to cover the vacancies. • The Staffing Coordinator or designee will audit the staffing weekly for 2 weeks then monthly for 2 months. The Staffing Coordinator will submit the audit report to the administrator or designee at the Quality Assurance Improvement Committee which meets every 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 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 4 weeks of staffing in 2 segments for the 01/25/2024 Standard Survey with Complaints at St. Josephs Cedar Grove (aka Complete Care at St. Vincents) revealed the following. For the 2 weeks of Complaint staffing from 08/27/2023 to 09/09/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -08/27/23 had 12 CNAs for 143 residents on the day shift, required at least 18 CNAs. -08/28/23 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -08/29/23 had 15 CNAs for 143 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060737	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 day shift, required at least 18 CNAs. -08/30/23 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -08/31/23 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/01/23 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/02/23 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/03/23 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/05/23 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/06/23 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/07/23 had 15 CNAs for 140 residents on the day shift, required at least 17 CNAs. -09/08/23 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -09/09/23 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. For the 2 weeks of staffing prior to the Standard Survey from 12/24/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -12/24/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/29/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/30/23 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. -12/31/23 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. -01/01/24 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -01/02/24 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -01/03/24 had 14 CNAs for 133 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060737	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 day shift, required at least 17 CNAs. -01/04/24 had 16 CNAs for 166 residents on the day shift, required at least 17 CNAs. -01/05/24 had 16 CNAs for 133 residents on the day shift, required at least 17 CNAs. -01/06/24 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. The surveyor observed daily staffing reports for nursing on each day of the survey. On 1/25/24, the surveyor received the facility Staffing Policy and Procedure (updated 1/2023) from the Licensed Nursing Home Administrator (LNHA). The Policy Statement indicated the "facility provides sufficient numbers of staff with the skills and competency (sic) necessary to provde care and services for all residents in accordance with resident care plans and the facility assessment." The policy and procedure did not address State minimum staffing requirements. On 1/25/24 at 12:00 PM, the survey team informed the LNHA and Administrative team that staffing fell below the minimum standard on 23 of 28 day shifts reviewed.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315194 Y1	A. Building B. Wing Y2	2/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

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 F0658	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/05/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
1/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315194 Y1	A. Building B. Wing Y2	2/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658	Correction	ID Prefix F0761	Correction	ID Prefix	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. #	Completed
LSC	02/05/2024	LSC	02/05/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060737 Y1	A. Building B. Wing Y2	2/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/05/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
1/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060737 Y1	A. Building B. Wing Y2	2/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/05/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
1/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315194	A. BUILDING **01** B. WING _____	**01/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ST VINCENTS LLC	**315 EAST LINDSLEY ROAD** **CEDAR GROVE, NJ 07009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
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 01/19/2024 and St. Joseph's Healthcare and Rehab Center was found to be in compliance 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. St. Joseph's Healthcare and Rehab Center is a two-story Type II Protected building that was built in 2001. The facility is divided into 18 smoke zones.	K 000		

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

Electronically Signed | 02/01/2024

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