

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

PRINTED: 09/27/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315343</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/22/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>		
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F 000	INITIAL COMMENTS  Survey Date: 12/22/22  Census: 63  Sample: 16 plus 2 closed records  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 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)  §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.  §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		1/24/23	

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

TITLE

(X6) DATE

Electronically Signed

01/12/2023

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 640	<p>Continued From page 1</p> <p>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:</p> <ul style="list-style-type: none"> <li>(i) Admission assessment.</li> <li>(ii) Annual assessment.</li> <li>(iii) Significant change in status assessment.</li> <li>(iv) Significant correction of prior full assessment.</li> <li>(v) Significant correction of prior quarterly assessment.</li> <li>(vi) Quarterly review.</li> <li>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.</li> <li>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.</li> </ul> <p>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined that the facility failed to timely transmit a resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care in accordance with federal guidelines. This deficient practice was identified for one of 18 residents, (Resident #22) reviewed for the timely transmission of MDS's and was evidenced by the following:</p> <p>On 12/20/22 at 11:36 AM, the surveyor interviewed the MDS/Coordinator (MDS/C) who stated that she completed Resident #22's</p>	F 640	<p>F-640 SS=D - Encoding/Transmitting Resident Assessments CFR(s): 483.20(f) (1)-(4)</p> <p>I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>¿ The Quarterly MDS Assessment of Resident #22 with a Target Date of 09/02/22 was transmitted to the CMS System by the MDS Coordinator on December 19, 2022. Validation Report was generated from the CASPER</p>		

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F 640	<p>Continued From page 2</p> <p>quarterly MDS dated 09/03/22, but she forgot to submit it to the Center for Medicare &amp; Medicaid Services (CMS). The MDS/C stated that the facility had 14 days to submit an assessment after it was completed</p> <p>The surveyor reviewed the medical record for Resident #22.</p> <p>A review of the resident's Face Sheet (An Admission Summary) reflected that the resident had resided at the facility since [REDACTED] and had diagnoses which included but were not limited to [REDACTED].</p> <p>A review of the facility's CMS Submission Report for Resident #22 indicated that the target date for the resident's quarterly MDS was 09/02/22 and the quarterly MDS was submitted to CMS late on 12/19/22.</p> <p>The MDS is a comprehensive federal mandated process for clinical assessment of all residents that must be completed and submitted to the Quality Measure System. The facility must electronically transmit the MDS up to 14 days of the assessment being completed. After transmitting of the MDS, it will generate a quality measure to enable a facility to monitor the residents decline and progress.</p> <p>On 12/20/22 at 1:46 PM, the surveyor informed the facility's Administrative staff of the MDS transmission error.</p> <p>NJAC 8:39-11.1</p>	F 640	<p>(Certification and Survey Provider Enhanced Reports) system to confirm successful submission and acceptance of the Quarterly MDS Assessment by CMS.</p> <p>i MDS Coordinator was counselled and re-in serviced on the importance of complying with the regulations related to Encoding/Transmitting Resident Assessments. Emphasis was made in making sure that completed MDS assessments are successfully transmitted to the CMS System on a timely basis, e.g., OBRA assessments must be transmitted within 14 days after the MDS completion.</p> <p>Resident #22 was NOT adversely affected by the deficient practice.</p> <p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <p>i All residents have the potential to be affected by the same deficient practice. MDS Coordinator generated the CASPER Report for Missing MDS Assessments from the CMS National Repository to identify if any other residents were affected by the same deficient practice. Completed MDS assessments in the past 6 months were cross-referenced with the Validation Reports to make sure that the MDS Assessments were successfully submitted and accepted in the CMS System.</p> <p>No other residents were adversely affected by the deficient practice.</p> <p>III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE</p>		

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F 640	Continued From page 3	F 640	<p>THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <ul style="list-style-type: none"> <li>¿ MDS Coordinator, IDCP (Interdisciplinary Care Plan) Team and Unit Managers were educated on the regulations governing F640: Encoding/Transmitting Resident Assessments. Focus was made on the Transmittal Requirements, i.e., that the facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, within 14 days after completion of a resident's MDS assessment.</li> <li>¿ The MDS Coordinator will develop an MDS Completion and Submission Reconciliation Tracking Form that will be completed on a weekly basis. This will be utilized to ensure that all completed MDS assessments are transmitted to the CMS system on a timely basis.</li> </ul> <p>IV. MONITORING OF CORRECTIVE ACTIONS:</p> <ul style="list-style-type: none"> <li>¿ The MDS Coordinator or designee will conduct audits on 5 residents monthly x 6 months to verify that the most recent MDS assessments were transmitted to the CMS system on a timely basis. Goal is to ensure that the facility is compliant with Transmittal Requirements, i.e., that the facility electronically transmitted encoded, accurate, and complete MDS data to the CMS System, within 14 days after completion of a resident's MDS assessment.</li> </ul>		

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F 640	Continued From page 4	F 640	Findings will be reported to the Director of Quality Assurance and Performance Improvement on a monthly basis and will be presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans. COMPLETION DATE: January 24, 2023		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) follow interventions in the resident's care plan for smoking, b.) thoroughly complete two out of last three facility required safe smoking evaluations for a resident and c.) accurately code the resident's annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care as a smoker. This deficient practice was identified for one of one resident's, (Resident #19) reviewed for smoking and was evidenced by the following:  On 12/15/22 at 10:24 AM, the surveyor observed Resident #19 seated in a wheelchair in front of	F 689	F689: SS=E - Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The IDCP Team reviewed and updated the Care Plan of Resident #19 to ensure that it accurately reflects resident's current smoking status and plan of care. Updated Care Plan was discussed with Resident #19, including the need for him/her to wear a smoking apron when smoking to ensure optimal	1/24/23	

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F 689	<p>Continued From page 5</p> <p>the nurse's station. The resident stated that he/she lived at the facility before the Pandemic and that he/she liked to go outside and smoke cigarettes. The resident further told the surveyor that the facility had designated smoking times in which the resident was required to follow. The resident explained that he/she had to follow the rules if he/she wanted to keep smoking at the facility and was only allowed to go outside if staff was present in the area during the designated smoking times. The resident further told the surveyor that he/she was not allowed to hold onto his/her cigarettes or lighter and that the staff handed out these items when he/she wanted to smoke.</p> <p>On 12/19/22 at 11:38 AM, the surveyor walked outside the main entrance of the facility and observed Resident #19 outside actively smoking a cigarette in the front patio area. The surveyor observed that the resident could hold the cigarette on his/her own. At the time of the observation, it was cold outside. The resident was wearing gloves without fingers, a heavy winter coat, and baggy, thick, long pants. The surveyor further observed a staff member present in the area. The surveyor observed the resident safely extinguish his/her cigarette and self-propel himself/herself by way of wheelchair back into the building. The surveyor did not observe that the resident was wearing a smoking apron at the time of the observation.</p> <p>On 12/20/22 at 11:48 AM, the surveyor observed the resident sitting in his/her wheelchair in front of the nurse's station. The resident stated that he/she had not gone outside to smoke yet today because it was too cold out.</p>	F 689	<p>safety. All staff involved in the care of Resident #19 (including Activities Staff, Nursing Staff, Security Guards, and Receptionists) were in-serviced on resident's care plan, with focus on following the interventions, specifically the need for resident to wear a smoking apron when smoking.</p> <p>¿ The Activities Director or designee will complete a thorough Safe Smoking Evaluation for Resident #19 to ensure that all areas are assessed to determine resident's ability to smoke safely.</p> <p>¿ MDS Coordinator modified the Annual MDS Assessment of Resident #19 with ARD (Assessment Reference Date) of 10/22/2022 to ensure accurate coding of MDS Item J1300 (Tobacco Use) and to reflect that Resident #19 is a smoker. Resident #19 has not been adversely affected by the deficient practice.</p> <p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <p>¿ All residents who smoke have the potential to be affected by the same deficient practice. The Activities Director generated a list of all residents who smoke. IDCP Team reviewed the records of these residents to ensure that:</p> <p>(a) An Individualized Smoking Care Plan is in place and interventions are followed by staff,</p> <p>(b) The most recent Safe Smoking Evaluation is thoroughly completed by Activities Director or Designee to ensure</p>		

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F 689	<p>Continued From page 6</p> <p>The surveyor reviewed the medical record for Resident #19.</p> <p>A review of the resident's annual MDS dated 10/22/22, reflected that the resident had a Brief Interview for Mental Status Score (BIMS) score of [REDACTED] which indicated the resident's cognition [REDACTED] reflected that the resident had diagnoses which included but were not limited to [REDACTED]. A further review of the resident's annual MDS, Section J1300 - Current Tobacco Use indicated that the resident was not a smoker.</p> <p>A review of the residents Safe Smoking Evaluation (SSE) dated 04/23/22, completed by the activities department indicated that the resident smoked, did not wear oxygen, the resident's cognitive short term, long term, and decision-making skills were intact and consistent. The SSE further reflected that the resident had the functional capacity, balance, range of motion, and fine motor skills to hold a cigarette. The observation/education section of the form was filled out in its entirety indicating that the resident was safe to smoke independently. The summary of the SSE indicated, "smokes safety in the designated smoking areas and also understands the smoking policy." The SSE did not indicate that the resident had to wear an apron while smoking.</p> <p>A review of the resident's SSE dated 07/24/22,</p>	F 689	<p>that all areas are assessed to determine resident's ability to smoke safely, (c) (c) The most recent MDS Assessment was accurately coded for Tobacco Use in J1300, in order to facilitate the management of the resident's care as a smoker.</p> <p>No residents were adversely affected by the deficient practice.</p> <p>III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>¿ All Staff were re-educated on the the facility's "Resident Smoking Policy." Reiterated facility's policy regarding the importance of residents to follow the facility's smoking rules. These include but are not limited to the following:</p> <p>(a) A Safe Smoking Evaluation is thoroughly completed by the Activities Director or Designee to assess or re-assess resident's ability to smoke safely upon admission/readmission, quarterly, when experiencing a significant change in status, or when a resident's smoking restriction are lifted.</p> <p>(b) An Individualized Smoking Care Plan is in place and interventions are followed by staff</p> <p>(c) The MDS assessment is accurately coded in MDS Item J1300 (Tobacco Use), in order to facilitate the management of the resident's care as a smoker.</p> <p>Goal is to ensure that residents who smoke are free from potential accidents and hazards because of smoking.</p>		

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F 689	<p>Continued From page 7</p> <p>completed by the activities department indicated that the resident smoked, did not wear oxygen, the resident's cognitive short term, long term, and decision-making skills were intact and consistent. The SSE further reflected that the resident had the functional capacity, balance, range of motion, and fine motor skills to hold a cigarette. The observation/education section on the SSE was not completed and was left blank indicating the resident was not observed smoking a cigarette or educated by staff the day of the assessment. The summary of the SSE indicated, "Resident does not have cigarettes at the moment. Upon purchasing or receiving observations will be completed." The SSE did not indicate that the resident had to wear an apron while smoking.</p> <p>A review of the resident's SSE dated 10/22/22, indicated that the resident was a smoker. The medical section, cognitive patterns, functional capacity, and observation/education section of the SSE was not filled out and left blank. The summary of the SSE reflected that the resident does smoke but did not have cigarettes at the time of the SSE and upon purchasing or receiving cigarettes an evaluation would be completed for the resident. The SSE did not indicate that the resident had to wear an apron while smoking.</p> <p>A review of the resident's Care Plan updated 8/22/22, reflected a focus area that the resident was a smoker. The resident's Care Plan indicated that the resident had committed multiple infractions, such as buying and selling cigarettes to other residents and violated the facility's smoking policy. As a result of the resident not adhering to the smoking policy, the</p>	F 689	<p>IV. MONITORING OF CORRECTIVE ACTIONS:</p> <p>¿ The Unit Manager or designee will conduct audits on 5 residents who smoke on a monthly basis x 6 months. Audit will focus on determining facility compliance with the following:</p> <p>(a) Completion of a thorough Safe Smoking Evaluation to assess or re-assess resident's ability to smoke safely upon admission/readmission, quarterly, when experiencing a significant change in status, or when a resident's smoking restriction are lifted.</p> <p>(b) An Individualized Smoking Care Plan is in place and interventions are followed by staff</p> <p>(c) The MDS assessment is accurately coded in MDS Item J1300 (Tobacco Use). Audit Findings will be reported to the Director of Quality Assurance and Performance Improvement on a monthly basis and will be incorporated in the facility's QAPI (Quality Assurance and Performance Improvement) Program for on-going compliance monitoring x 6 months.</p> <p>COMPLETION DATE: January 24, 2023</p>		

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F 689	<p>Continued From page 8</p> <p>resident was restricted from smoking for 30 days. The resident's Care Plan further indicated that Resident #19 complied with the facility's agreement of not smoking and was given back smoking privileges at the facility upon completion of his/her restriction. The Care Plan further reflected a focus area dated 2/19/21 that the resident continues to utilize/wear smoke apron for safety. The interventions in the resident's Care Plan included to provide resident with smoke apron to be left near security desk, re-educated resident on smoking policy, and resident will receive his/her cigarettes during the following break times from the Activities staff: 10 AM, 12:30 PM, 2:00 PM, and 4:00 PM.</p> <p>On 12/19/22 at 11:30 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was alert, oriented, and very capable of making his/her needs known. The CNA told the surveyor that the resident smoked and had behaviors at times. The CNA gave the example that when the resident wanted something, he/she wanted it immediately, and if the resident did not get what he he/she wanted, the resident would get loud and curse. The CNA further stated that the resident didn't have behavioral outburst often and stated, "hasn't had an episode in a minute."</p> <p>On 12/20/22 at 9:59 AM, the surveyor interviewed the receptionist. The receptionist desk was large, directly in front of the main doors to the facility, and to the right of the receptionist desk when walking into the building, the surveyor observed a box with smoking aprons in it. The receptionist stated that the activities department were the staff responsible for giving the resident's</p>	F 689			

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F 689	<p>Continued From page 9</p> <p>their cigarettes. The receptionist explained that there were three residents that lived at the facility who smoked that were required to wear an apron. The receptionist mentioned Resident #19 by name and stated that the residents knew that they had to put on the smoking apron. The receptionist pointed at the box with the aprons in them when she explained the process to the surveyor. The receptionist further stated that she and the security guard were the staff responsible for making sure the residents wore their aprons while smoking. The surveyor inquired if the resident was non-compliant with wearing his/her smoking apron. The receptionist told the surveyor that we wouldn't let the resident go outside without wearing the apron then stated, "They try and get around wearing it." The receptionist then gave the example that the resident would say that he/she just wanted to go outside to get fresh air.</p> <p>On 12/20/22 at 11:31 AM, the surveyor interviewed the MDS/Coordinator who stated that section J1300 was filled out incorrectly on the resident's annual MDS dated 10/22/22, and the resident was a smoker.</p> <p>On 12/20/22 at 12:01 PM, the surveyor interviewed the security guard who was sitting at the front door watching the outside of the building. The security guard told the surveyor that it was her job to watch the resident's when they smoked. The security guard was able to tell the surveyor that Resident #19 was required to wear a smoking apron upon inquiry. The security guard stated that if she was to observe that the resident was not wearing the apron, she would go get it and bring it to the resident. The surveyor</p>	F 689			

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NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 689	<p>Continued From page 10</p> <p>told the security guard the observation and time of the observation from the day prior in which the resident was observed smoking without wearing his/her apron. The security guard stated that she was out to lunch at the time of the surveyor's observation and normally Resident #19 would wear his/her apron when outside smoking</p> <p>On 12/20/22 at 12:54 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident was alert and oriented to person, place, and time and the resident smoked cigarettes. The LPN further stated that activities came today to ask the resident if he/she wanted to smoke, and the resident declined. The LPN further stated that she worked agency and she was unsure of the facility's protocol for smoking assessments.</p> <p>On 12/20/22 at 1:01 PM, the surveyor interviewed the Activities Director (AD) who stated that the activities department was responsible for completing the Safe Smoking Evaluations for the residents upon admission, quarterly, annually, and as needed if there was a change in the resident's cognitive or physical function. The AD stated that the facility evaluated the residents for safety, mental and physical capability of holding the cigarettes, lighting the cigarette, and extinguishing it. The AD stated safety was the most important component of the safe smoking evaluation. The AD was familiar with Resident #19 and stated that the facility implemented the smoking apron after a burn mark was identified on the resident's clothes. The AD stated that the resident never burned his/her skin and had been wearing the apron for a few years now. The AD told the surveyor that the</p>	F 689			

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F 689	<p>Continued From page 11</p> <p>activities department staff gave the residents his/her cigarettes and apron. The AD stated, "when we give the resident [his/her] cigarette they make sure [he/she] was wearing the smoking apron, also communicate to the security staff that the resident needs a smoking apron." The AD explained that the resident could be non-compliant at times related to smoking, therefore we have him/her on smoking restrictions for safety and monitoring. The AD further stated that if activity department staff noticed the resident did not have cigarettes the day of the scheduled smoking assessment, we were supposed to go back and generate a new smoking assessment to evaluate the resident's smoking capabilities.</p> <p>On 12/21/22 at 12:55 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the resident should have been wearing his/her smoking apron prior to going outside and smoking. The RN/UM further stated that the resident's Care Plan would be updated to reflect the non-compliance with not wearing the smoking apron and the activity department was responsible for performing the Safe Smoking Evaluation which should have been completed.</p> <p>A review of the facility's, "Resident Smoking Policy" dated 03/05/07 indicated that all residents had to follow the smoking rules the facility implemented. The policy further indicated, "Residents will be assessed for their ability to smoke safely upon admission/readmission, quarterly, and when experiencing a significant change in status. Areas to be assessed include: a. Cognition and decision making skills b. Ability</p>	F 689			

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

PRINTED: 09/27/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315343</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/22/2022</b>
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F 689	Continued From page 12 to independently propel to and from designated smoking area c. Ability to safely light a cigarette d. Ability to safely hold a cigarette e. Ability to keep ashes from falling on a person f. Ability to extinguish a cigarette safely." The facility's, "Resident Smoking Policy" indicated that residents that are placed on a smoking restriction must be reassessed by the activities department to determine their ability to smoke safely.	F 689			
F 761 SS=D	NJAC 8:39-27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal	F 761		1/24/23	

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F 761	<p>Continued From page 13 and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to remove an expired controlled medication (██████████) from the active back up supply for one (1) of three (3) medication storage rooms that were inspected for proper medication storage.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 12/20/22 at 11:48 AM, the surveyor observed a Registered Nurse/Unit Manager (RN/UM) and a Licensed Practical Nurse (LPN) perform an inventory count for the controlled medications stored in the electronic back up supply machine for the facility.</p> <p>During the inventory count the RN/UM stated that there were eight (8) ██████████ in inventory and that was an accurate count. The surveyor, with the RN/UM and LPN, observed an expiration date of 11/19/22 for two (2) of the eight (8) tablets. The RN/UM stated that the two (2) tablets were expired and would need to be removed and destroyed appropriately. The RN/UM further stated that she was responsible for any discrepancies in the electronic back up supply machine for the controlled medications and that the expiration dates should be checked when an inventory was completed. The RN/UM added that the controlled medications in the back up supply machine were counted every shift by two (2) nurse supervisors. The RN/UM also stated that</p>	F 761	<p>F-761: SS=D - Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <ul style="list-style-type: none"> <li>¿ The two (two) tablets of expired controlled medication (██████████) that were found in the facility's electronic back up supply machine were immediately destroyed.</li> <li>¿ Involved Nursing Staff were counseled and re-educated on the facility's policy re: Storage of Medications, with major emphasis on the following excerpt from the policy; Discontinued, outdated or deteriorated drugs or biologicals are to be returned to the dispensing pharmacy or destroyed."</li> </ul> <p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <ul style="list-style-type: none"> <li>¿ All residents in the facility have the potential to be affected by the same deficient practice.</li> </ul> <p>III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <ul style="list-style-type: none"> <li>¿ All nurses were educated on the</li> </ul>	

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NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>		
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F 761	Continued From page 14 the two (2) expired [REDACTED] were missed during the inventories that had been done.  A review of the November and December 2022 facility Control Inventory Record reflected that the controlled medications in the electronic back up supply machine had been counted every shift. The records reflected two (2) nurses signed every shift that the controlled medications were counted. The records had not reflected any discrepancies or expired medications.  On 12/20/22 at 1:05 PM the surveyor was provided a facility policy for "Storage of Medications" by the Chief Operating Officer (COO).  A review of the undated facility policy for "Storage of Medications" reflected that "Discontinued, outdated or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed."  On 12/20/22 at 1:30 PM, the survey team met with the facility administrative team. The COO stated that the undated facility policy for the "Storage of Medications" was the current policy.	F 761	regulations related to Proper Labeling and Storage of Drugs and Biologicals. Emphasized that Discontinued, outdated or deteriorated drugs or biologicals must be returned to the dispensing pharmacy or destroyed.  IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Pharmacy Consultant or designee will conduct observation/inspection audits of the facility's electronic back up supply machine monthly x 6 months to ensure that there are no expired medications in the machine. Any issues identified will be rectified immediately. Findings will be reported to the Director of Nursing monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.  COMPLETION DATE: January 24, 2023		
F 947 SS=D	NJAC: 8:39-29.4(g)(h) Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)  §483.95(g) Required in-service training for nurse aides. In-service training must-  §483.95(g)(1) Be sufficient to ensure the	F 947		1/24/23	

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F 947	<p>Continued From page 15</p> <p>continuing competence of nurse aides, but must be no less than 12 hours per year.</p> <p>§483.95(g)(2) Include dementia management training and resident abuse prevention training.</p> <p>§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.</p> <p>§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that Certified Nursing Aides (CNA) received 12 hours of mandatory annual in-service training that included abuse training for 1 of 5 CNA files reviewed (CNA #1).</p> <p>The deficient practice was evidenced by the following:</p> <p>On 12/20/22 at 12:30 PM, the surveyor reviewed the in-service education hours for five randomly selected CNA files, which were provided by the facility.</p> <p>The Nursing Education Record and Transcripts provided showed the following:</p> <p>CNA #1 had a hire date of 11/20/19. According to the Nursing Education Record and Transcript provided by the facility, CNA #1 had completed</p>	F 947	<p>F-947: SS=D - Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)</p> <p>I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>¿ CNA #1 was provided with training on Abuse &amp; Neglect: Recognition and Prevention by the Nurse Educator. Since the involved CNA received only 6.5 hours during his/her employment year from 11/20/21 to 11/20/22, CNA #1 will also receive additional trainings of at least 5.5 hours by January 20, 2023. This is to ensure the continuing competence of the nurse aide. Staff Educator will make sure that CNA #1 will complete at least 12 hours of mandatory annual in-service training on a yearly basis, thereafter.</p> <p>¿ Staff/Nurse Educator was counseled</p>		

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F 947	<p>Continued From page 16</p> <p>6.5 hours of training from 11/20/21 to 11/20/22 which did not include training on abuse and the additional 5.5 hours of the required 12.</p> <p>On 12/20/22 at 1:05 PM, the surveyor interviewed the Nurse Educator (NE) regarding the education provided. The NE stated that the education provided was everything that she could find for each person.</p> <p>On 12/20/22 at 1:13 PM, the surveyor interviewed the NE regarding CNA #1's education. The NE confirmed that CNA #1 had 6.5 hours in the time frame from 11/20/21 to 11/20/22. The NE also confirmed that CNA #1 did not have training on abuse in that time frame.</p> <p>On 12/21/22 at 12:08 AM, in the presence of the survey team, the Chief Operating Officer confirmed that CNA #1 did not have the appropriate training and confirmed that CNA #1 should have had the training.</p> <p>On 12/21/22 at 12:52 PM, in the presence of the survey team, the NE stated that staff should have had 12 hours of education including abuse training within their anniversary year.</p> <p>The facility could not provide any documented evidence that CNA #1 had completed the mandatory 12 hours training including abuse training.</p> <p>Review of the facility provided policy titled, "In-Service Training" with a revised date of 12/21/22, included the following:</p> <p>Under Policy Statement</p>	F 947	<p>regarding the regulations related to the Required In-Service Training for Nurse Aides.</p> <p>No residents were adversely affected by the deficient practice.</p> <p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <p>¿ All residents have the potential to be affected by the same deficient practice.</p> <p>III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR</p> <p>¿ Staff Educator developed and implemented the following Educational Plan, effective January 1, 2023:</p> <ol style="list-style-type: none"> <li>1. Mandatory training sessions will be held every other month with CNA staff. This 8-hour training day will include the following topics: <ol style="list-style-type: none"> <li>1. Abuse &amp; Neglect: Recognition and Prevention</li> <li>2. Dementia Management</li> <li>3. LGBTQI+/Residents Rights</li> <li>4. Proper Use of PPE</li> <li>5. Hand Hygiene</li> <li>6. Blood Borne Pathogen Review</li> <li>7. Principles of Isolation</li> <li>8. Safety/Fire Prevention</li> <li>9. Falls Prevention</li> </ol> </li> </ol> <p>Trainings will be conducted by a multi-disciplinary team including Nurse Educator, Infection Prevention Specialist, Plant Operations Officer, Physical</p>		

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F 947	<p>Continued From page 17</p> <p>All nursing assistant personnel shall participate in regularly scheduled in-service training classes. Under Policy Interpretation and Implementation</p> <p>1. All personnel are required to attend regularly scheduled in-service training classes ...</p> <p>3. Annual in-services must:</p> <p>a. Ensure the continuing competence of the nursing assistant</p> <p>b. Be no less than 12 hours per employment year</p> <p>c. Address areas of weakness as determined by the performance reviews</p> <p>d. Include training that addresses the care of the residents, as determined by facility staff</p> <p>e. Include training that addresses the care of the residents with cognitive impairment</p> <p>f. Include training in dementia management and abuse prevention ...</p> <p>6. All training classes attended by the employee shall be recorded on the respective employee's Education File by the staff educator.</p> <p>N.J.A.C. 8:39-43.17 (b)</p>	F 947	<p>Therapy, and Social Worker.</p> <p>2. Additional 4 hours of training topics will be presented on alternate dates and will include:</p> <ol style="list-style-type: none"> <li>1. COVID/Influenza Update</li> <li>2. Review of Use of the Hoyer Lift</li> <li>3. Review of Use of the Evacuation Chair</li> <li>4. Specific areas of weakness identified in the employee's performance evaluation</li> </ol> <p>All trainings will be scheduled by the staff educator with attendance monitored. Records kept on file in the staff educator office.</p> <p>IV. MONITORING OF CORRECTIVE ACTIONS</p> <p>¿ Director of Nursing or Designee will conduct a random review of 5 CNA personnel files a month x 6 months to ensure that the Certified Nursing Aides received 12 hours of annual in-service training, including abuse training and other mandatory in-services and trainings. Any issues identified in the audits will be rectified immediately. Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program for on-going compliance.</p> <p>COMPLETION DATE: January 24, 2023</p>		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315343	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/14/2023	Y3
NAME OF FACILITY BROADWAY HOUSE FOR CONTINUING			STREET ADDRESS, CITY, STATE, ZIP CODE 298 BROADWAY NEWARK, NJ 07104		

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 F0640	Correction	ID Prefix F0689	Correction	ID Prefix F0761	Correction
Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	01/24/2023	LSC	01/24/2023	LSC	01/24/2023
ID Prefix F0947	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.95(g)(1)-(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/24/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON 12/22/2022

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>060738</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/22/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>
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S 000	Initial Comments  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: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in CNA staffing for 14 of 14-day shifts reviewed.  Findings include:  Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	S-560 - 8:39-5.1(a) Mandatory Access to Care <input type="checkbox"/> STATE <input type="checkbox"/> S STAFFING RATIOS I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The facility actively seeks to hire CNAs, that all shifts are scheduled to comply with ratios, and that any callouts or no-shows result in calls made by the Staffing Coordinator or Shift Supervisor in relentless attempts to obtain replacement(s). No residents have been adversely affected by this deficient practice.	1/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  01/12/23
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>060738</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/22/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	<p>Continued From page 1</p> <p>codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>A review of the "Nurse Staffing Report" completed by the facility for the weeks of 11/27/2022 through 12/03/2022 and 12/04/2022 through 12/10/2022, revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below:</p> <p>The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <p>-11/27/22 had 6 CNAs for 64 residents on the day shift, required 8 CNAs. (10.66 residents per CNA)                      -11/28/22 had 6 CNAs for 63 residents on the day shift, required 8 CNAs. (10.5 residents per CNA)                      -11/29/22 had 6 CNAs for 63 residents on the day shift, required 8 CNAs. (10.56 residents</p>	S 560	<p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <p>¿ All residents have the potential to be affected by this situation.</p> <p>III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR</p> <p>¿ Facility's Recruitment and Retention Strategies and Efforts to comply with the State's Staffing Ratios have been in progress, which include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>o Offer Sign on bonuses to attract staff</li> <li>o Recruitment bonus to encourage referrals from current staff</li> <li>o Offering daily and weekend bonuses to attract overtime or PRN staff shifts</li> <li>o Aggressively running ads in various social media</li> <li>o Currently have contracts with multiple staffing agencies</li> </ul> <p>IV. MONITORING OF CORRECTIVE ACTIONS</p> <p>¿ Staffing Coordinator will provide monthly reports to the Director of Nursing or Designee x 6 months regarding all efforts made to try to comply with the State's Staffing Ratios. Reports will be submitted to the QAPI Committee on a monthly basis.</p> <p>¿ Director of Human Resources (HR) will provide monthly reports to the Administrator that document status of all recruitment and retention efforts. Reports will be submitted to the QAPI Committee</p>	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>060738</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/22/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>
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S 560	<p>Continued From page 2</p> <p>per CNA)</p> <p>-11/30/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs. (9 residents per CNA)</p> <p>-12/01/22 had 6 CNAs for 63 residents on the day shift, required 8 CNAs. (10.5 residents per CNA)</p> <p>-12/02/22 had 5 CNAs for 63 residents on the day shift, required 8 CNAs. (12.6 residents per CNA)</p> <p>-12/03/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs. (9 residents per CNA)</p> <p>-12/04/22 had 5 CNAs for 63 residents on the day shift, required 8 CNAs. (12.6 residents per CNA)</p> <p>-12/05/22 had 3 CNAs for 63 residents on the day shift, required 8 CNAs. (21 residents per CNA)</p> <p>-12/06/22 had 6 CNAs for 63 residents on the day shift, required 8 CNAs. (10.5 residents per CNA)</p> <p>-12/07/22 had 3 CNAs for 63 residents on the day shift, required 8 CNAs. (21 residents per CNA)</p> <p>-12/08/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs. (9 residents per CNA)</p> <p>-12/09/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs. (9 residents per CNA)</p> <p>-12/10/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs. (9 residents per CNA)</p> <p>During an interview with the surveyor on 12/20/22 at 11:45 PM, the Staffing Coordinator (SC) stated that she had been employed at the facility for 2 years and worked part-time 8:30 AM</p>	S 560	<p>on a monthly basis.</p> <p>The QAPI Committee will determine the need for on-going monitoring or further action plan(s).</p> <p>COMPLETION DATE: JULY 24, 2023</p>	

New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>
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S 560	<p>Continued From page 3</p> <p>to 2:30 PM daily in the position as Staffing Coordinator. The SC stated that her job description was to assign Nurses, CNAs (Certified Nursing Assistants), HHAs (Home Health Aides), and contracted Nursing agencies to staff the facility. The SC stated that she did not know the state's minimum staffing requirements for nursing homes. The SC stated that she staffed the facility according to the facility census. The SC said that she staffs 6-7 CNAs and 2 sitters for the day shift, 6 CNAs and 2 sitters for the evening shift, and 4 CNAs and 2 sitters for the night shift. The SC showed the surveyor the facility's own online staffing program that both facility and agency staff had access to and are able to pick shifts that are open and available. The SC added that the facility would give monetary bonuses or an extra day off to staff for incentive to fill gaps in staffing. The SC stated that she reports any staffing concerns directly to the DON (Director of Nursing).</p> <p>During an interview with the surveyor on 12/20/22 at 12:02 PM, the Chief Operating Officer (COO) was unable to tell the surveyor the state's minimum requirement for staff to resident ratio in a nursing home. The COO stated, "I would have to look."</p> <p>On 12/20/22 at 01:42 PM, in the presence of the survey team, the Facility Administrator (FA) stated that the staff to resident ratio requirements for CNAs was 8 to 1 on day shift. The FA was not able to state the staff to resident ratio requirements for evening and night shift.</p> <p>NJAC 8:39-5.1(a)</p>	S 560		

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060738	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/14/2023	Y3
NAME OF FACILITY BROADWAY HOUSE FOR CONTINUING			STREET ADDRESS, CITY, STATE, ZIP CODE 298 BROADWAY NEWARK, NJ 07104		

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 _____	01/24/2023	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/22/2022		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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

PRINTED: 06/28/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315343</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/22/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments	E 000			
K 000	<p>An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/22/21. The facility was found to be in compliance with 42 CFR 483.73.</p> <p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/22/22 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.</p> <p>Broadway House for Continuing Care is one building that was built in 1925. It is composed of Type II protected construction. The facility is divided into six smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director. The current occupied beds are 63 of 74.</p>	K 000			
K 351 SS=E	<p>Sprinkler System - Installation CFR(s): NFPA 101</p> <p>Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative</p>	K 351		1/24/23	

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

TITLE

(X6) DATE

Electronically Signed

01/12/2023

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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NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>		
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K 351	<p>Continued From page 1</p> <p>protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.</p> <p>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure the building was protected throughout by an approved automatic sprinkler system in accordance with NFPA 101 Life Safety Code (2012 Edition) 19.3.5 and 9.7.1 and NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition). This deficient practice had the potential to affect 37 residents.</p> <p>Findings include:</p> <p>An observation on 12/22/22 at 1:10 PM, with the Director of Building Services, revealed the storage room, located on One West, measured four and one-fourth feet by three and one-half feet, had Ultraviolet lights stored and did not have sprinkler coverage. This observation was confirmed by the Director of Building Services, who measured the room.</p> <p>During an interview at the time of the observation, the Director of Building Services confirmed the storage room did not have</p>	K 351	<p>K351 SS=E - Sprinkler System - Installation CFR(s): NFPA 101</p> <p>I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>↷ The Maintenance Director removed the ultraviolet lights that were stored in the small room without sprinkler coverage in One West. The involved staff who put the ultraviolet lights in the room without sprinkler coverage was in-serviced regarding not utilizing the room for storage.</p> <p>No residents were adversely affected by this deficient practice.</p> <p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <p>↷ All residents have the potential to be affected by the same deficient practice. The Maintenance Director conducted</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315343</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/22/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>		
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K 351	Continued From page 2 sprinkler coverage.  A review of the facility's document titled, "Fire Sprinkler Inspection Report" dated 02/18/22, 07/17/22, and 10/27/22 revealed no evidence to indicate a sprinkler head had been installed in the One West storage room.  NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	rounds to ensure that all rooms that are used for storage have sprinkler coverage.  III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All staff who have access to the small room in One West were in-serviced to ensure that the room will not to be used for storage.  IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Director of Maintenance or designee will conduct observation rounds in monthly x 6 months to make sure that small rooms with no sprinkler coverage are not used for storage. Findings will be reported to the Director of Plant Operations and will be presented in the quarterly Quality Assurance Meeting.  COMPLETION DATE: January 24, 2023		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101  Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for	K 372		1/24/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315343</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/22/2022</b>
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K 372	<p>Continued From page 3</p> <p>smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke. This deficient practice had the potential to affect all 63 residents.</p> <p>Findings include:</p> <p>An observation on 12/22/22 at 1:15 PM, revealed the smoke barrier, located on the first floor and adjacent to the Physician's Office, had a bundle of blue wires penetrating a 3-inch by 3-inch unsealed opening on both sides of the smoke barrier.</p> <p>An observation on 12/22/22 at 1:22 PM, revealed the smoke barrier, located on the first floor and adjacent to Room 131, had a four-inch diameter pipe penetrating an unsealed opening and one blue wire penetrating a two-inch diameter unsealed opening on both sides of the smoke barrier.</p> <p>An observation on 12/22/22 at 1:27 PM, revealed the smoke barrier, located on the second floor and adjacent to the Conference Room, had one white wire penetrating a one-half inch diameter unsealed opening on both sides of the smoke barrier.</p>	K 372	<p>K 372: SS=F - Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101</p> <p>I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <ul style="list-style-type: none"> <li>¿ Fire stops were installed on 1/5/2023 in the smoke barrier locations listed below to ensure that the penetrations in smoke barriers are protected by a system/material capable of restricting the transfer of smoke. <ul style="list-style-type: none"> <li>o Smoke Barrier on the First floor and adjacent to the Physician's Office</li> <li>o Smoke barrier, located on the first floor and adjacent to Room 131</li> <li>o Smoke barrier, located on the second floor and adjacent to the Conference Room</li> <li>o Smoke barrier, located on the second floor and adjacent to Room 221</li> </ul> </li> </ul> <p>No residents wee adversely affected by this deficient practice.</p> <p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <ul style="list-style-type: none"> <li>¿ All residents have the potential to be affected by the same deficient practice.</li> </ul>		

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K 372	Continued From page 4 An observation on 12/22/22, at 1:40 PM revealed the smoke barrier, located on the second floor and adjacent to Room 221, had a bundle of white and blue wires penetrating a three-inch diameter unsealed opening on both sides of the smoke barrier.  During an interview at the time of each observation, the Director of Maintenance confirmed the penetrations in the smoke barrier were not protected.  NJAC 8:39-31.1(c), 31.2(e)	K 372	The Maintenance Director conducted rounds to ensure that any penetrations in smoke barriers are protected by a system/material capable of restricting the transfer of smoke.  III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ↳ The Director of Plant Operations updated the Maintenance Department's Monthly Environmental Rounds Checklist to include checking for any penetration in smoke barriers and if so, to ensure that the penetration is protected by a system/material capable of restricting the transfer of smoke.  IV. MONITORING OF CORRECTIVE ACTIONS: ↳ The Director of Plant Operations or designee will conduct monthly audits of the Maintenance Department's Environmental Rounds Checklist x 6 months. This is to ensure that the Director of Maintenance or designee identify any penetrations in the smoke barriers. Identified issues will be immediately corrected. Findings will be presented in the quarterly Quality Assurance Meeting.  COMPLETION DATE: January 24, 2023		
K 712 SS=F	Fire Drills CFR(s): NFPA 101  Fire Drills	K 712		1/24/23	

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NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 712	<p>Continued From page 5</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure fire drills were conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required under varied conditions in accordance with NFPA 101 Life Safety Code (2012 Edition) 19.7.1.6. This deficient practice had the potential to affect all 63 residents.</p> <p>Findings include:</p> <p>Document review of the facility's untitled survey notebook and fire drills reports revealed fire drills were not conducted quarterly on each shift. Fire drills were conducted for the First Shift (7:00 AM - 3:00 PM) on 12/30/21, 01/31/22, 02/01/22, 03/27/22, 04/20/22, 05/16/22, 07/14/22, 09/20/22, 10/19/22 and 11/28/22. A fire drill was conducted for the Second Shift (3:00 PM -11:00 PM) on 06/21/22. A fire drill was conducted for the Third Shift (11:00 PM - 7:00 AM) on 08/13/22. Fire Drills were not conducted quarterly on the Second and Third Shifts.</p> <p>During an interview on 12/22/22 at 11:00 AM, the</p>	K 712	<p>K 712: SS = F - Fire Drills</p> <p>I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>¿ The Director of Plant Operations Director immediately scheduled Fire Drills to be conducted on the 2nd (Second) and 3rd (Third) shifts.</p> <p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <p>¿ All residents have the potential to be affected by the deficient practice.</p> <p>III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>¿ The Director of Plant Operations will schedule Quarterly Fire Drills (for the First, Second and Third Shifts) a year in advance to ensure facility compliance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315343</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/22/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>		
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K 712	Continued From page 6 Director of Maintenance confirmed the fire drills were usually conducted on the First Shift due to scheduling and time constraints.  NJAC 8:39-31.2(e)	K 712	with the fire drill requirements (quarterly on each shift).  IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Director of Plant Operations or designee will submit monthly reports of fire drills conducted each month to the QAPI Committee x 6 months. Reports will include documentation of the dates and times of the fire drills) to ensure that a fire drill is conducted in every shift each quarter. Reports will be presented in the quarterly Quality Assurance Meeting.		
K 741 SS=E	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 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	K 741	COMPLETION DATE: January 24, 2023	1/24/23	

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NAME OF PROVIDER OR SUPPLIER  <b>BROADWAY HOUSE FOR CONTINUING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>298 BROADWAY NEWARK, NJ 07104</b>		
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K 741	<p>Continued From page 7</p> <p>where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(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.</p> <p>18.7.4, 19.7.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ashtrays of noncombustible material and safe design and a metal container with a self-closing cover device into which ashtrays could be emptied was readily available to the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (5)(6). This deficient practice has the potential to affect 23 residents.</p> <p>Findings include:</p> <p>A review of the facility's document titled, "Resident General Rules and Restricted Residents" did not indicate an ashtray of noncombustible material and safe design and a metal container with a self-closing cover device would be provided in the smoking area.</p> <p>An observation on 12/22/22 at 1:50 PM, revealed the smoking area, at the back entrance of the facility, had freestanding plastic cigarette butt receptacles and did not have an ashtray of noncombustible material. The facility did have a metal container with a self-closing cover device for cigarette butts and ashes to be emptied into;</p>	K 741	<p>K 741: SS = E - Smoking Regulations CFR(s): NFPA 101</p> <p>I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Director of Plant Operations purchased new ashtrays of noncombustible material and safe design to replace the freestanding plastic cigarette butt receptacles. A new metal container with self-closing cover device into which ashtrays can be emptied was also purchased, which will not be used for other purposes. All residents who smoke were reminded on proper use of ashtrays and safe disposal of cigarette butts.</p> <p>II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents who smoke have the potential to be affected by the same deficient practice.</p>		

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K 741	Continued From page 8 however, the container was also being used for other trash and items.  During an interview at the time of the observation, the Director of Building Services confirmed there was not an ashtray of noncombustible material in the smoking area and the metal container was also being used for other purposes.  NJAC 8:39-31.2(e) NJAC 8:39-31.6(e)	K 741	<p>III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <ul style="list-style-type: none"> <li>¿ New ashtrays of noncombustible material and safe design and the new metal container with self-closing cover device into which ashtrays can be emptied were properly placed in the designated Smoking area. All residents who smoke and staffs assigned to supervise appropriate residents were in-serviced on proper use of ashtrays and safe disposal of cigarette butts.</li> </ul> <p>IV. MONITORING OF CORRECTIVE ACTIONS:</p> <ul style="list-style-type: none"> <li>¿ The Director of Plant Operations or designee will conduct observation audits of the designated smoking area monthly x 6 months. This is to make sure that the facility is in compliance with the Smoking Regulations, including (a) ensuring that ashtrays in the smoking are of noncombustible material and safe design, and (b) the metal container with self-closing cover device into which ashtrays can be emptied is utilized for that sole purpose only. Findings will be presented in the quarterly Quality Assurance Meeting.</li> </ul> <p>COMPLETION DATE: January 24, 2023</p>		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315343	Y1	MULTIPLE CONSTRUCTION A. Building 02 - BROADWAY HOUSE FOR CC B. Wing	Y2	DATE OF REVISIT 2/14/2023	Y3
NAME OF FACILITY BROADWAY HOUSE FOR CONTINUING			STREET ADDRESS, CITY, STATE, ZIP CODE 298 BROADWAY NEWARK, NJ 07104		

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 K0351	01/24/2023	LSC K0372	01/24/2023	LSC K0712	01/24/2023
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0741	01/24/2023	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

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

**FOLLOWUP TO SURVEY COMPLETED ON** 12/22/2022

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