STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315343	A. BUILDING ______ B. WING ______	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	298 BROADWAY NEWARK, NJ 07104

(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 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations. Complaint #: NJ168872 and NJ182337 Survey Dates: 02/17/25 - 02/26/25 Survey Census: 65 Sample Size: 21 Supplemental Residents: 9 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		4/7/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/20/2025

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 600

Continued From page 1

physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, r the facility failed to ensure residents were NJ Exec Order 26.4b1 for one of one resident reviewed for NJ Exec Order 2 (Resident (R) 3) out of 21 sampled residents. R3 was NJ Exec Order 26.4b1 by R119. This failure placed the resident at risk for NJ Exec Order 26.4b1 ry and NJ Exec Order 26.4b1.

Findings include:

Review of a facility policy titled "Abuse," dated 01/01/25 indicated ". . .Physical Abuse. . .Any inappropriate physical contact with a resident, such as hitting, slapping, striking with an open or closed hand, pinching, biting, kicking, rough handling, pulling of hair, twisting of limbs, or punching. . ."

Review of a document provided by the facility titled "Resident Face Sheet" indicated R3 was admitted to the facility on NJ Exec Order 26.4b1

Review of a document provided by the facility titled quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of NJ Exe out of 15 which indicated the resident was NJ Exec Order 26.4b1.

Review of a document provided by the facility titled "Resident Face Sheet" indicated R119 was admitted to the facility on NJ Exec Order 26.4b.

Review of a document provided by the facility

F 600

1. Resident R3 was assessed by a Registered Nurse. No signs and symptoms of NJ Exec Order 26.4b1 or indications of NJ Exec Order 26.4b1. Resident denied being NJ Exec Order 2 or NJ Exec Order 2
Resident R3 was placed on NJ Exec Orde for safety. Resident R119 was discharged to NJ Exec Orde unit on NJ Exec Order 26.4b1 for evaluation and upon return to the facility on NJ Exec Order 26.4b1 was maintained on 1 NJ Exec Or until discharge on NJ Exec Order 26.4b1.

2. All residents have the potential to be affected by this practice.

3. All staff will be re-educated on the facility□s policy on Abuse Prevention and Management Policy. Emphasis was made on promptly identifying resident behaviors and addressing potential resident-to-resident conflicts to prevent physical altercations.

4. The Director of Nursing or designee will conduct interviews with 3 residents weekly x 4 weeks, then 3 residents monthly x 3 months to ensure that residents feel safe and free from abuse from other residents.
The Director of Nursing or designee will conduct observation audits of all units weekly x 3 months to identify resident behaviors and address potential resident-to-resident conflicts to prevent

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F 600	Continued From page 2 titled nursing "Progress Notes" dated NJ Exec Order 26.4b1 indicated R3 was overheard by Licensed Practical Nurse (LPN) 1 when R3 and R119 were NJ Exec Order 26.4b The progress notes revealed by the time LPN1 approached the two residents, R119 NJ Exe R3 NJ Exec Orde in the NJ Exec Ord LPN1 NJ Exec Order 26.4b1 R119 from R3. LPN1 assessed R3 and NJ Exec Order 26.4b1. Both the physician and the responsible party were notified of the NJ Exec Order 26.4b1. An order was obtained to transfer R119 to a NJ Exec Orde unit, and initially R119 voiced that NJ Exe did not want to go but then spoke with a family member and R119 complied. A review was conducted of R119's clinical records and there were NJ Exec Order 26.4b1 identified with other residents. Review of a document provided by the facility titled "Summary of Investigation" dated NJ Exec Order 26.4b1 indicated a NJ Exec Order 26.4b1 which involved R3 and R119. The facility's investigation revealed R119 had a BIMS score of NJ Exe out of 15 which revealed the resident was NJ Exec Order 26.4b1. The investigation indicated R3 was sitting in NJ Exec wheelchair and in front of the nursing station when R119 approached R3 and stepped on NJ Exec NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. As part of the facility's investigation the US FOIA (b)(6) watched camera footage of the incident between R3 and R119 and verified the NJ Exec Order 26.4b1. The investigation revealed R3 was placed NJ Exec Order 26.4b1 and R119 was sent to the emergency room for NJ Exec Orde and was eventually transferred back to the facility on NJ Exec Order 26.4b. During an interview on 02/18/25 at 2:03 PM, LPN1 confirmed she witnessed R119 NJ Exe R3.	F 600	physical altercations. Any potential indicators of conflict between residents will be addressed immediately by separating the residents. Audit results will be reviewed monthly at QAPI committee.	

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F 600	Continued From page 3 LPN1 confirmed R119 was sent to another facility. LPN1 verified she heard R3 tell R119 to NJ Exec Order 2, and when she began to go towards the two residents, she witnessed R119 NJ Exe R3 NJ Exec Orde in the NJ Exec Ord LPN1 stated she considered the NJ Exec Order 26.4b1 and reported the incident immediately to her supervisor. LPN1 confirmed she was interviewed by the US FOIA (b) as part of the facility's investigation. A subsequent interview was conducted on 02/19/25 at 8:50 AM, LPN1 verified R119 was immediately sent out to the emergency room to be evaluated by a NJ Exec Orde team and considered NJ Exec Order 26.4b1. LPN1 stated R119 was eventually transferred to another facility. During an interview on 02/19/25 at 11:44 AM, R3 confirmed R119 NJ Exec Order 26.4 on NJ Exec Order 26 but did not remember if NJ Exec Order 26.4b1. R3 stated NJ Exe believed the actions made by R119 were NJ Exec Order 26 R3 stated NJ Exe was NJ Exec Order 26.4b1 of R119. During an interview on 02/19/25 at 1:12 PM, the US FOIA (b) stated her expectation was to protect R3 and the staff provided NJ Exec O with NJ Exec Order 26.4b1. The US FOIA (b) stated both R3 and R119 had NJ Exec Order 26.4b1 related to the incident. The US FOIA (b) stated there were no prior incidents which involved R119 and other residents. The US FOIA (b) stated R119 was placed on the NJ Exec O floor and R3 was on the NJ Exec Order 26 floor. During a subsequent interview on 02/19/25 at 3:24 PM, the US FOIA (b) and the US FOIA (b)(6) were present. The US FOIA (b) stated R119's NJ Ex Order 26.4 on R3 was NJ Exec Order 26.4b1 The US FOIA (b) stated the goal was to keep R3 NJ Exec Order 26.4b1 and we wanted to make sure no one suffered any triggers as a result of the	F 600		

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F 600	Continued From page 4 NJ Exec Order 26.4b1 and this was why both residents received NJ Exec Order 26.4b1 after the incident. NJAC 8:39-4.1(a)5 NJAC 8:39-9.4(f)	F 600		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		4/7/25

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F 625	Continued From page 5 by: Based on interview, record review, and policy review, the facility failed to ensure two of two residents discharged to the hospital (Resident (R) 51 and R57) out of a total sample of 21 residents were provided with a bed hold notice within 24 hours of emergent transfer to the hospital. This failure increased the potential that residents would not know to request a bed hold and may be unable to return to the facility. Findings include: Review of the facility's policy titled "Bed-Holds and Returns" dated 01/01/25 revealed the following "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy....(3) Prior to a transfer, written information will be given to the residents and resident representatives that explains in detail: (a) the rights and limitations of the resident regarding bed-holds; (b) the reserve bed payment policy as indicated by the state plan (Medicaid Residents) (c) the facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid Residents); and (d) the details of the transfer (per the Notice of Transfer)." 1. Review of R57's undated "Admission Record," located in the resident's electronic medial record (EMR) under the "Resident Summary" tab revealed R57 was admitted to the facility on NJ Exec Order 26.4b1 Review of R57's "Progress Note" located in the EMR under the "Resident Summary" tab dated NJ Exec Order 26.4b1 revealed the following "resident in bed	F 625	1. Residents R51 and R57 were re-admitted without issues to the facility upon leaving for an emergent transfer to the hospital. Resident R51 and Resident R57 were assessed to ensure that they were NJ Exec Order 26.4b1 by this practice. The Nurses who worked when Resident R51 and Resident R57 were transferred to the hospital were educated on the regulation re: providing a bed hold notice to the resident/resident□s Responsible Party within 24 hours for emergent transfers to the hospital. 2. All residents have the potential to be affected by this practice relating to facility policy on bed holds and returns. 3. The Bed Hold Notice Policy was reviewed and the Bed Hold Notice for residents/residents□ families was revised on 3/19/2025 to include all required elements in Bed Hold Notification for transfers to the hospital. The Admissions Department, all Nurses and social workers were educated on the regulation re: providing a bed hold notice to the resident/resident□s Responsible Party within 24 hours for emergent transfers to the hospital. 4. The Director of Social Work/ Designee will audit 5 charts per month x 3 months of residents who were transferred to the hospital to ensure that a Bed Hold Notice was provided to resident/	

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

PRINTED: 07/30/2025
FORM APPROVED
OMB NO. 0938-0391

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with NJ Exec Order Resident NJ Exec Order 26.4b with NJ Exec Order 26.4b on NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1. Vitals: NJ Exec Order 26.4b1 Resident NJ Exec Order 26.4b1 and NJ Exec to NJ Exec Order 2 no complaint of NJ Exec Order 26.4b1. Nurse notified supervisor and the US FOIA (b)(6)). The US FOIA notified staff to send resident out to hospital to r/o [rule out] NJ Exec Order 26 NJ Exec Order 26.4b1 given prior to transport to hospital. Family notified."

Review of R57's "Progress Note" dated NJ Exec Order 26.4b1 located under the "Resident Summary" tab of the EMR revealed "Resident readmitted to the facility at 3:00 pm ..."

2. Review of R51's "Admission Record" located in the resident's EMR under the "Resident Summary" tab revealed R51 was admitted on NJ Exec Order 26.4b1.

Review of R51's "Progress Note" dated NJ Exec Order 26.4b1 and located in the resident's EMR under the "Resident Summary" tab revealed "Resident NJ Exec Order 26.4b1, observed with a NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 of the NJ Exec Orde US FOIA made aware, ordered to send resident to the ER for NJ Exec Order 26.4b1 of the NJ Exec Order 2

A review of the EMR did not reveal any evidence to indicate R51 received a bed hold notice.

During an interview on 02/19/25 at 10:42 AM, the US FOIA (b)(6)) stated the facility did not provide the residents and/or their representatives with a bed hold policy when they were sent to the hospital.

During an interview on 02/19/25 at 1:58 PM, the

F 625

Responsible Party within 24 hours of their emergent transfer to the hospital.
Findings will be reported monthly to the QAPI Committee.

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F 625	Continued From page 7 US FOIA (b)(6)) stated they do not provide the residents or their representatives with a bed hold policy when they are sent to the hospital. NJAC 8:39-4.1(a)31 NJAC 8:39-5.1 NJAC 8:39-5.3(b)	F 625		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		4/7/25

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F 880	Continued From page 8 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 9 Based on observation, interview, and record review, the facility's failed to have an adequate water management program. The facility's water management program was incomplete and was not consistent with current ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) Guideline, which specifically called for design and maintenance procedures for the potential exposure of Legionnaire's disease (a serious pneumonia infection) within a healthcare facility. This failure created the potential for the 65 facility residents, who were either over the age of 65 and/or were autoimmune compromised, to be infected by Legionella. Findings include: Review of website for ASHRAE titled "Successfully Managing the Risk of Legionellosis" dated 04/07/21 indicated ". . . Legionellae the biological classification name for a genus of bacteria. . .is the plural, referring to more than one Legionella bacterium. . .Legionellosis: any illness (disease) caused by the exposure to Legionella. Legionnaires' disease (LD) and Pontiac fever (PF) are the two known types of legionellosis. . .Potentially fatal, multisystem respiratory illness, accompanied by pneumonia. . .Symptoms. . .high fever, chills, muscle pain, headache, dry cough, diarrhea, vomiting, confusion, and delirium common. . .Immune suppressed. . .transplant patients, cancer, cardiac, diabetes, steroid/drug therapy. . .Sick/in poor health. . . Elderly/infirm. . .Heavy smokers, lung/COPD diseases. . .Describe the building water systems using flow diagrams & a written description: Include details such as where the building connects to the (municipal) water supply,	F 880	1. No residents were affected by this issue. 2. All residents have the potential to be affected by this practice. 3. Boiler room schematics were obtained on 2/20/2025 from the building manager and made part of the facility water management plan. Maintenance Director in-serviced the maintenance staff on 4/7/2025 regarding the facility's water management plan and boiler room schematics. 4. The Director of Maintenance/designee will continue to conduct weekly temperature checks. The building manager continues to test the water system for Legionella and keep the facility informed of results. Facility weekly temperature results and any water results obtained from the building manager will be reported to QAPI committee.	

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F 880	Continued From page 10	F 880		

how water is distributed and used (processed), where hot tubs, water heaters, cooling towers, etc. are located. . ."

Review of a document provided by the facility titled "Water Management Plan and Procedure for Broadway House for Continuing Care (BHCC)" undated indicated ". . .The purpose of this Water Management Plan (WMP) is to ensure the safe and reliable delivery of water to all areas of the nursing home, with a focus on maintaining the health and safety of residents and staff, preventing waterborne illnesses, and managing water resources efficiently. . ." The facility failed to ensure their water management program contained a diagram or a description of the building's water system.

During an interview on 02/19/25 at 9:16 AM, the US FOIA (b)(6) stated he tested water temperatures on a daily basis as part of the facility's water management program. The US FOIA (b)(6) stated there was no diagram of the facility's water system which would identify potential areas for water pathogen development. The US FOIA (b)(6) stated there were no schematics of the building's water system. The US FOIA (b)(6) stated he would need to reach out to the owners of the building to see if they had any additional information.

During an interview on 02/19/25 at 3:24 PM, the US FOIA (b)(6) stated he had been recently hired as an interim US FOIA (b)(6) and said his expectations were to monitor the facility's water management program, which included reviewing the facility's water system.

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F 880	Continued From page 11 NJAC 8:39-19.1(a)(b) NJAC 8:39-19.4	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060738	A. BUILDING: ______ B. WING ______	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	**298 BROADWAY NEWARK, NJ 07104**

(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 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 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. 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, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1. 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). 2. All residents have the potential to be affected by this situation. 3. 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:	4/7/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 03/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060738	A. BUILDING: ______ B. WING ______	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	298 BROADWAY NEWARK, NJ 07104

(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 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 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 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. 1. For the week of Complaint staffing from 11/03/2024 to 11/09/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -11/03/24 had 7 CNAs for 69 residents on the day shift, required at least 9 CNAs. -11/04/24 had 7 CNAs for 68 residents on the day shift, required at least 8 CNAs. -11/05/24 had 7 CNAs for 67 residents on the day shift, required at least 8 CNAs. -11/06/24 had 7 CNAs for 67 residents on the day shift, required at least 8 CNAs. -11/07/24 had 7 CNAs for 67 residents on the day shift, required at least 8 CNAs. -11/08/24 had 7 CNAs for 67 residents on the day shift, required at least 8 CNAs. -11/09/24 had 7 CNAs for 67 residents on the day shift, required at least 8 CNAs. 2. For the week of Complaint staffing from 01/05/2025 to 01/11/2025, the facility was	S 560	" Offer Sign on bonuses to attract staff " Recruitment bonus to encourage referrals from current staff " Offering daily and weekend bonuses to attract overtime or PRN staff shifts " Aggressively running ads in various social media " Currently have contracts with multiple staffing agencies 4. 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. 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 on a monthly basis. The QAPI Committee will determine the need for on-going monitoring or further action plan(s).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	298 BROADWAY NEWARK, NJ 07104

(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 deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -01/05/25 had 7 CNAs for 65 residents on the day shift, required at least 8 CNAs. -01/06/25 had 6 CNAs for 65 residents on the day shift, required at least 8 CNAs. -01/08/25 had 7 CNAs for 65 residents on the day shift, required at least 8 CNAs. -01/09/25 had 7 CNAs for 65 residents on the day shift, required at least 8 CNAs. -01/11/25 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. 3. For the 2 weeks of staffing prior to survey from 02/02/2025 to 02/15/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -02/02/25 had 7 CNAs for 65 residents on the day shift, required at least 8 CNAs. -02/03/25 had 7 CNAs for 65 residents on the day shift, required at least 8 CNAs. -02/04/25 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/05/25 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/06/25 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/07/25 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/08/25 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/09/25 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/10/25 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/11/25 had 7 CNAs for 65 residents on the day shift, required at least 8 CNAs. -02/12/25 had 7 CNAs for 65 residents on the day	S 560		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060738	A. BUILDING: ____ B. WING ____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	**298 BROADWAY NEWARK, NJ 07104**

(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 shift, required at least 8 CNAs. -02/13/25 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. -02/14/25 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs. -02/15/25 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315343		4/15/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	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 F0600 Reg. # 483.12(a)(1) LSC	Correction Completed 04/07/2025	ID Prefix F0625 Reg. # 483.15(d)(1)(2) LSC	Correction Completed 04/07/2025	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 04/07/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/26/2025	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315343		4/15/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	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 F0600 Reg. # 483.12(a)(1) LSC	Correction Completed 04/07/2025	ID Prefix F0625 Reg. # 483.15(d)(1)(2) LSC	Correction Completed 04/07/2025	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 04/07/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/26/2025	☐ 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
060738 (Y1)	A. Building B. Wing (Y2)	4/15/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	298 BROADWAY NEWARK, NJ 07104

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/07/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/26/2025	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060738		4/15/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	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 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/07/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/26/2025	☐ 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
	315343	A. BUILDING 02 B. WING	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	**298 BROADWAY** **NEWARK, NJ 07104**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 02/26/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 02/26/25 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. Broadway House for Continuing Care is a seven-story building with a basement built in 1925. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator powers approximately 50 % of the building per the Maintenance Director. The current occupied beds are 65 of 78.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour.	K 311		4/7/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/20/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315343	A. BUILDING **02** B. WING ____	**02/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	**298 BROADWAY** **NEWARK, NJ 07104**

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K 311	Continued From page 1 An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one of six fire rated door assemblies for stairway exit doors was equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect all 68 residents and was evidenced by the following: Observations on 02/26/25 between 11:30 AM and 1:30 PM of all the facility's stairways' fire rated door assemblies revealed that one door from the kitchen going into the stairway was equipped with panic hardware which violated the listing of the rated fire door assembly. During an interview at the time of observations, the US FOIA (b)(6) confirmed the stairway exit door in the kitchen was equipped with panic hardware. NJAC 8:39-31.2(e)	K 311	1. The proper panic hardware for the fire rated door was ordered on 3/3/2025. 2. All residents have the potential to be affected by this practice. 3. The proper panic hardware for a fire rated door was installed on 3/7/2025. Maintenance staff were in-serviced on 4/7/2025 regarding the proper panic hardware for a fire rated door. 4. Maintenance Director/designee will audit doors with a panic bar to ensure the correct panic bar is installed on the door. Audits of doors with panic bars will be done monthly for 3 months then quarterly for 9 months. Audit results will be reported monthly to the QAPI Committee. See attachments.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation	K 351		4/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315343	A. BUILDING 02 B. WING ______	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	**298 BROADWAY NEWARK, NJ 07104**

(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 351	Continued From page 2 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 protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. 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. 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) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinklers were installed under fixed obstructions in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) Section 8.5.5.3.1. This deficient practice had the potential to affect all 16 residents on the second floor of the West Wing at the facility and was evidenced by the following: An observation on 02/26/25 at 2:29 PM revealed no fire sprinkler protection had been installed under the overhead Heating, Ventilation, and Air Conditioning (HVAC) duct over four feet wide on the second floor of the West Wing. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the HVAC duct did not have sprinkler coverage.	K 351	1. Additional sprinkler for the HVAC duct was ordered 3/3/2025 and installed 4/1/2025. 2. All residents have the potential to be affected by this practice. 3. All HVAC duct areas will be inspected by 4/7/2025 to ensure proper sprinkler coverage. Maintenance staff were in-serviced on 4/7/2025 regarding inspecting HVAC ducts on rounds for sprinkler system coverage.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315343	A. BUILDING 02 B. WING ________	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	298 BROADWAY NEWARK, NJ 07104

(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 351	Continued From page 3 NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	4. Maintenance Director/designee will audit all HVAC duct areas monthly for 3 months then quarterly for 9 months. Audit results will be reported monthly to the QAPI Committee. See attachments.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire extinguishers were serviced every six years in accordance with NFPA 10, Standard for Portable Fire Extinguishers (2010 Edition) Section 7.3.1.2.1. This deficient practice had the potential to affect the 21 residents on the first floor of the East Wing at the facility and was evidenced by the following: An observation on 02/26/25 at 1:29 PM of a 10 lbs. ABC fire extinguisher at the first floor East Wing revealed the extinguisher had a service collar that indicated it was serviced in 2017 and had not been serviced since. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the fire extinguisher had not been serviced since 2017, over the six-year requirement. NJAC 8:39-31.1(c), 31.2(e)	K 355	1 The fire extinguisher with the missing hydrostatic test label was replaced with a compliant one on 2/26/2025. 2 All residents have the potential to be affected by this practice. 3 All fire extinguishers were checked by our vendor on 3/31/2025 to ensure they have the proper hydrostatic testing label. Maintenance staff were in-serviced on 4/7/2025 on the importance of monitoring all fire extinguishers on rounds to ensure an updated hydrostatic testing label is in place.	4/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315343	A. BUILDING **02** B. WING	**02/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	**298 BROADWAY** **NEWARK, NJ 07104**

(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 355	Continued From page 4 NFPA 10	K 355	4 Maintenance Director/designee will audit all fire extinguishers monthly for 3 months then quarterly for 9 months for the required labels. Audit results will be reported monthly to the QAPI Committee. See attachments.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills 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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at least one fire drill per quarter per shift in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.7.1.6. This deficient practice had the potential to affect all 68 residents and was evidenced by the following: A review of the facility's fire drill records provided by the facility revealed no documented evidence fire drills were conducted on the third shift of the first quarter, first and second shifts of the second quarter, and the second and third shifts of the third quarter.	K 712	1 Fire drills will continue to take place on a monthly basis. As of January 2025, fire drills have taken place on 1/23/2025 (1st shift weekday), 2/20/2025 (2nd shift weekday), and 3/7/2025 (3rd shift weekday). 2 All residents have the potential to be affected by this practice.	4/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315343	A. BUILDING 02 B. WING ______	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	298 BROADWAY NEWARK, NJ 07104

(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	Continued From page 5 During an interview on 02/26/25 at 2:15 PM, the US FOIA (b)(6) confirmed the fire drills were not completed. The US FOIA (b)(6) stated that they were having problems with the company that conducted the drills and had switched companies. NJAC 8:39-31.2(e), 31.6(b)	K 712	3 Fire drills will continue to take place on a monthly basis, ensuring each shift is performed quarterly with one weekend drill per year. Maintenance staff were in-serviced on 4/7/2025 regarding the monthly requirements of fire drills. 4 Maintenance Director/designee will ensure that fire drills continue to take place monthly. Audit results will be reported monthly to the QAPI Committee. See attachments.	

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
315343 Y1	A. Building 02 - BROADWAY HOUSE FOR CC B. Wing Y2	4/15/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWAY HOUSE FOR CONTINUING CARE	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 Reg. # NFPA 101 LSC K0311	Correction Completed 04/07/2025	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 04/07/2025	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 04/07/2025
ID Prefix Reg. # NFPA 101 LSC K0712	Correction Completed 04/07/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/26/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO