STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD CALIFON, NJ 07830**

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F 000	INITIAL COMMENTS	F 000		

Complaint #'s: NJ174200, NJ173220

STANDARD SURVEY: 10/22/2024 through 10/30/2024

CENSUS: 32

SAMPLE SIZE: 13 + 1 closed record

A Recertification/LSC survey conducted from 10/23/2024 through 10/30/2024, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities.

During the survey, a finding which constituted Immediate Jeopardy (IJ) was identified under 42 CFR 483.25 (d) F689 as the facility failed to ensure a NJ Ex Order 26.4(b)(1) resident with a physician's order (PO) for NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) was served the appropriate NJ Ex Order to prevent NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) During a lunch observation on 10/23/24, the surveyor observed Resident #19 NJ Ex Order 26.4(b)(1) The Licensed Practical Nurse (LPN #1) stated the resident started NJ Ex Order 26.4(b)(1) after they NJ Ex O the NJ Ex Order 2 in its own NJ Ex Order LPN #1 confirmed that Resident#19 was on NJ Ex Order 26.4(b)(1)

An interview with the U.S. FOIA (b) (6) revealed the resident had a diagnosis of NJ Ex Order 26.4(b)(1) which contributed to a NJ Ex Ord that would lead to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26

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

Electronically Signed | 11/22/2024

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

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F 000	Continued From page 1 Interview with the U.S. FOIA (b) (6) revealed that the resident was on NJ Ex Ord and could not be served NJ Ex Order 26.4(b)(1) in its own NJ Ex Orde because the resident's NJ Ex Order 26.4(b)(1) would not be able to NJ Ex Order 26.4(b)(1) and the NJ Ex Order would go NJ Ex Order 26.4(b)(1) and cause NJ Ex Order 26.4(b)(1) A Partial Extended Survey was initiated after the deficiency was identified at the IJ/SQC (substandard quality care) level. The U.S. FOIA (b) (6) was informed of the F689 IJ and was provided with the IJ template on 10/23/24 at 5:00 PM. An acceptable removal plan was received on 10/24/24 at 2:11 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including Resident #19 was assessed by the US FOIA (b)(6)]; all nursing and kitchen staff were in-serviced on the facility's consistency and diet policy; any food with liquid consistency added such as sauces, gravies, natural juices, and syrups will have added thickener for appropriate diet consistency and any diet changes will be communicated to the charge nurse who will communicate to the kitchen. The survey team verified the removal plan on site on 10/24/24 and determined the IJ for F689 was removed as of 10/24/24 at 2:11 PM.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		12/9/24

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F 550	Continued From page 2 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

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F 550	Continued From page 3 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Complaint #: NJ174200 Based on observation, interview, and record review, it was determined that the facility failed to maintain resident's dignity by, a. not providing an NJ Ex Order 26.4(b)(1) resident the correct size of NJ Ex Order 26.4(b)(1)) and b. standing over the resident while feeding during mealtime. This deficient practice was observed for 2 of 13 residents reviewed (Resident #21 and Resident #18) and was evidenced by the following: 1. On 10/28/24 at 9:00 AM, the surveyor observed Resident #21 in their room seated in an upward position in their bed. Resident #21 was observed eating their breakfast. The surveyor observed the Certified Nurse Aide (CNA #1) feeding Resident #21 while standing over them. The surveyor interviewed CNA #1, who stated they know they should be seated next to the resident during feeding assistance but could not provide an explanation why they were not seated. A review of the Admission Record (AR) (an admission summary) for Resident #21 which revealed that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) A review of Resident #21's Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that Resident #21 NJ Ex Order 26.4b1 to complete a Brief Interview for Mental Status	F 550	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: A. Resident #18 secured the appropriately NJ Ex Order 26.4(b)(1). The facility has purchased and is securing an emergency supply of all NJ Ex Order 26.4(b)(1) to ensure resident #18 always has the correct NJ Ex Or [redacted] available. B. The US FOIA (b [redacted] observed feeding the resident while standing was given corrective action for not providing the resident with dignity while feeding. She was re-educated on Resident rights, and the policy and procedure for assisting residents with meals. Identifying other residents who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: A. The facility has purchased and will maintain an emergency stock of all sized IB to ensure if there is a future delivery issue, residents will not be affected. B. All employees were re-inserviced on	

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F 550	Continued From page 4 (BIMS) due to NJ Ex Order 26.4(b)(1). The MDS further reflected that the resident was dependent of staff NJ Ex Order 26.4(b)(1). A review of Resident #21 care plan (CP) with a reviewed date of NJ Ex Order 26 revealed under the NJ Ex Order 26.4(b) portion of the CP a Focus titled, "NJ Ex Or by staff". A review of the interventions included, "Assist with NJ Ex Order 26.4(b On 10/28/24 at 12:26 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated all staff must be seated when feeding residents. The U.S. FOIA (b stated that standing while feeding a resident was not a dignified manner. On 10/28/24 at 1:15 PM, the U.S. FOIA (b provided the surveyor with a facility policy titled, "Assistance with meals" with a reviewed date of October 2024. Under the policy interpretation and implementation indicated, "3. Residents Requiring Full Assistance ...b. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: 1. Not standing over residents while assisting them with meals." On 10/29/24 at 1:44 PM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) and U.S. FOIA (b) (6) to discuss the above concern. There were no further information provided. 2. On 10/22/24 at 11:30 AM, the surveyor investigated an anonymous complaint which stated that approximately around NJ Ex Order 26.4(b)(1), the facility did not have an adequate supply of NJ E	F 550	the policy and procedure for assisting residents with meals. The DON or designee will make rounds during mealtime to ensure that all staff are providing residents with dignity and following the policy and procedure for assisting residents with meals. Monitoring the continued effectiveness of systemic change: A. The DON or designee will conduct weekly audits for 4 weeks to ensure there is a surplus of all IB sizes. They will then conduct monthly audits for 2 months to ensure there is a surplus supply of all sized IBs. B. The DON or designee will conduct weekly audits randomly for each shift for 4 weeks to ensure staff are sitting while assisting residents with meals. They will then conduct monthly audits for 2 months to ensure staff remain seated while assisting residents with meals. The DON or designee will report the results of these audits to the QAPI Committee until substantial compliance is achieved. The Administrator will ensure compliance of these audits and take corrective action as needed.	

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F 550	Continued From page 5 specifically the NJ Ex Order 26.4(b)(1) . The complaint also indicated for the residents who were NJ Ex Order 26.4(b) those specific NJ Ex Order were provided to NJ Ex Order the NJ Ex Order 26.4(b)(1) because it was the only NJ Ex Or available due to inadequate supplies. During the resident council meeting that was conducted on 10/24/24 at 11:01 AM attended by 7 NJ Ex Order 26.4b1 facility residents which included Resident #18. Resident #18 stated to the surveyor, they recalled being provided a NJ Ex Order or at times a NJ Ex Order 26.4(b)(1) for them. Resident #18 added they NJ Ex Order 26.4(b)(1). The resident further stated it didn't NJ Ex Order 26.4(b)(1) but 'NJ Ex Order 26.4(b)(1)". A review of the Resident #18's AR revealed that the resident was admitted to the facility with diagnosis which included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) A review of Resident #18's Q/MDS, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(, reflected that Resident #18 had a BIMS score of NJ Ex out of 15 indicating the resident was NJ Ex Order 26.4(b)(1). On 10/23/24 at 11:25 AM, the surveyor interviewed the facility's U.S. FOIA (b) (6) who stated that around NJ Ex Order 26.4(b)(1) , the facility had shortage of NJ E due to a problem with shipment. The U.S. FOIA (b agreed that some residents were provided NJ E which was not their NJ Ex Orde The facility could not provide a policy for the use of NJ Ex On 10/29/24 at 1:44 PM, the survey team met	F 550		

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F 550	Continued From page 6 with the [redacted] and [redacted] to review the above concern. No further information as provided.	F 550		
F 582 SS=D	N.J.A.C. 8:39-4.1(a)12 Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		11/21/24

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F 582	Continued From page 7 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to issue the required Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) for 2 of 3 residents (Resident #14 and Resident #27) reviewed. This deficient practice was evidenced by: The SNF ABN provides information to beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by [redacted] and assume financial responsibility. If the SNF provides the beneficiary with the SNF ABN, the facility has met its obligation to inform the beneficiary of his or her	F 582	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 27 and resident 14 remain in the facility and are currently under [redacted] They were both provided with a SNF / ABN notice. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be	

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F 582	Continued From page 8 potential financial liability and related standard claim appeal rights. On 10/22/24 at 10:27 AM, the facility provided the surveyor with a list of residents who were covered under NJ Ex Order 26.4(b)(1), was discharged from the facility within the last NJ Ex Order 26.4(b)(1) from NJ Ex Order 26.4(b) and should have received the SNF ABN form. The surveyor reviewed Resident #14 and Resident #27 who were listed discharged from NJ Ex Order 26.4(b)(1) stay and were documented that they remained in the facility. 1. Resident #14 was admitted to the facility on NJ Ex Order 26.4(b). The last documented covered day from NJ Ex Order 26.4b1 service was on NJ Ex Order 26. A review of the form titled, "SNF Beneficiary Notification Review" that was filled out by the facility's U.S. FOIA (b) (6) indicated the SNF ABN was not provided to the resident. There was no additional documentation about the communication of these forms to the resident or the resident's representative. 2. Resident #27 was admitted to the facility on NJ Ex Order 26.4(b). The last documented covered day from NJ Ex Order 26.4(b)(1) service was on NJ Ex Order 26.4(b). A review of the form titled, "SNF Beneficiary Notification Review" that was filled out by the U.S. FOIA (b) indicated the SNF ABN was not provided to the resident and or the representative prior to the last cover date. There was no additional documentation about the communication of these forms to the resident or the resident's representative. On 10/28/24 at 1:10 PM, the surveyor interviewed the U.S. FOIA (b) who stated that the beneficiary notifications were usually sent out by one of the staff at the facility. The U.S. FOIA (b) stated that resident	F 582	affected by this practice. Measures or systemic changes to ensure that the deficiencies will not recur: The MDS coordinator re-inserviced facility staff on the Advance Beneficiary Notice Policy, and on completing Form CMS-10055 skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) The MDS coordinator or designee will be responsible to ensure all residents or their responsible parties are provided with the SNF ABN form prior to the end of their services. Monitoring the continued effectiveness of systemic change: The MDS coordinator or designee will conduct weekly audits for 4 weeks to ensure any residents whose services will be ending are provided with the SNF/ ABN notice within the required timeframe. The MDS coordinator or designee will then conduct monthly audits for 2 months to ensure residents or their responsible parties are receiving the SNF/ABN form prior to their services ending. The MDS coordinator or designee will report the results of these audits to the QAPI Committee on a monthly basis for 90 days, or until substantial compliance is achieved. The Administrator will ensure compliance	

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F 582	Continued From page 9 # 27 was sent on [NJ Ex Order 26.4(b)(1)] and that Resident # 14 was not sent out. On 10/24/24 at 12:49 PM, the surveyor discussed the above concerns with the facility's [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)]. No additional information was provided.	F 582	of these audits and take corrective action as needed	
F 609 SS=D	NJAC 8:39-4.1(a)(8) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		11/21/24

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F 609	Continued From page 10 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint NJ#173220 Based on interview and record reviews, it was determined that the facility failed to report an allegation of NJ Ex Order 26.4(b)(1) to the New Jersey Department of Health (NJ DOH) in the required timeframe for 2 of 2 sampled residents, (Residents #29 and Resident #81). This deficient practice was evidenced by the following: On 10/28/24 at 10:30 AM, the surveyor reviewed a "Reportable Event Record/Report Form" (RER/RF) provided by the facility. The form was dated NJ Ex Order 26.4b1 and documented an event that occurred on NJ Ex Order 26.4(at 3:30 PM involving Resident #81 and Resident #29. The report documented Resident #81 NJ Ex Order 26.4(b Resident #29's NJ Ex Ord and attempted to NJ Ex Order 26.4(b the resident's NJ Ex Order 26.4(b from Resident #29's NJ Ex Order Resident #29 who was NJ Ex Order 26.4(and reacted by NJ Ex Order 26.4(b) Resident #81's NJ Ex Order 26.4(b)(1). The facility's U.S. FOIA (b) (6) was present during the time of the incident and was able to separate both residents and notified the nurse. Further review of the REF/RF form revealed an event date of NJ Ex Order 26.4(at 3:30 PM and the NJ DOH was notified by the facility via a phone call on NJ Ex Order 26.4b1 at 12:56PM. A review of Resident #81's Admission Record (AR) (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but not limited to,	F 609	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents 81 and 29 were immediate separated from one another. Residents were both assessed and NJ Ex Order 26.4(b)1 noted. AAS45 was submitted to the DOH and Office of the Ombudsman on NJ Ex Order 26.4(b. Care plans were updated after the incident with interventions to prevent recurrence. Resident #81 has been NJ Ex Order 26.4b1. Identifying other residents who could be affected by the deficient practice: All residents have the potential to be affected by the same deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The facility's policy for Resident Abuse Prohibition was updated to include the required time frames to report an incident or observation of an abuse including Resident to Resident abuse. All staff have been inserviced on the updated Abuse Prohibition policy and procedure, and specifically to ensure that all alleged violations involving abuse are reported immediately, but not later than 2	

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	315467	A. BUILDING _____ B. WING _____	C 10/30/2024

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NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)); NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)

A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated that the resident's cognition was NJ Ex Order 26.4(b)(1).

A review of the progress notes (PN) revealed a nurse's note dated NJ Ex Order 26.4(at 4:07 PM (16:07) which documented that an incident occurred on NJ Ex Order 26.4(at 3:30 PM when a facility staff reported to the nurse that Resident #81 NJ Ex Order 26.4(b) Resident #29's NJ Ex Order NJ Ex Order 26.4(b) before attempting to take Resident #29's . The PN further revealed that Resident #29 NJ Ex Order 26.4(b) Resident #81's NJ Ex Order 26.4(b)(1) The PN also indicated both residents were assessed by the NJ Ex Order 26.4(b)(1) (U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) was notified of the incident.

The surveyor reviewed the closed record for Resident #29.

A review of Resident #29's AR reflected that the resident was admitted to the facility with a diagnoses which included but not limited to NJ Ex Order 2 (NJ Ex Order 26.4(b)(1)

hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

The facility staff were re-educated to call the DON and Administrator immediately if there is an allegation of abuse, so that in addition to being addressed immediately, it will be reported timely.

Monitoring the continued effectiveness of systemic change:

The DON and Administrator will review the 24 hour daily clinical report and will maintain a log of all incidents – and ensure that any allegation of abuse has been reported to the DOH and Ombudsman's office within the required timeframe.

The administrator will review and audit the incident logs daily for 4 weeks, then weekly for 5 weeks.

The log of incidents will be reported monthly to the QAPI meeting for 6 QAPI meetings to ensure on-going compliance.

The Administrator will ensure compliance of these audits and take corrective action as needed.

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NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted]), and NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted]).

A review of the quarterly MDS, an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a BIMS score of [redacted] out of 15, which indicated that the resident was NJ Ex Order 26.4(b)(1).

A review of the PN revealed a nurse's note dated [redacted] at 7:16 PM, which documented when the nurse was alerted by a facility staff of an incident which involved both Resident #81 and Resident #29 on [redacted] at 3:30 PM.

On 10/29/24 at 11:10 AM, the surveyor interviewed the [redacted] who acknowledged that the incident should have been reported to the NJ DOH within 24-hours. The [redacted] also acknowledged that she reported the incident late but was unable provide a reason why it was not reported to the NJ DOH in a timely manner according to federal and state regulations. There was no further information provided by the facility.

A review of and undated facility's policy titled, "Resident Abuse Prohibition Policy" that was provided by the DON which did not indicate a time frame to report an incident or observation of an abuse including Resident to Resident abuse.

NJAC 8:39-4.1(a)(5)
NJAC 8:39-13.4(c)(2)(v)

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F 623	Continued From page 13	F 623		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623		11/22/24

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F 623	Continued From page 14 required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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F 623	Continued From page 15 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to notify the resident's representative and the Office of the Ombudsman in writing for an emergency transfer to the hospital. This deficient practice was identified for 1 of 1 resident, Resident #9, reviewed for hospitalization. On 10/23/24 at 9:28 AM, the surveyor reviewed the electronic medical record for Resident #9. A review of the physician's progress note dated [NJ Ex Order 26.4(d)], revealed that the resident had a recent hospitalization. A review of the Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the	F 623	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #9 is currently in the facility and was provided with a copy of the notice of transfer to the hospital. Identifying all residents could be affected by the deficient practice from January through April 2024 Residents with unplanned transfers/ discharges from January through April 2024 were affected by this deficient practice. The facility identified this deficient practice	

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F 623	Continued From page 16 management of care dated [redacted], reflected that Resident #9 was discharged to the hospital with a return anticipated to the facility. On 10/23/24 at 12:06 PM, the surveyor interviewed the [redacted]), who stated she reviewed the "book of letters" which contained a report to the Office of the Ombudsman and to the residents' representatives but was unable to find them. The [redacted] further stated that in [redacted], she started to do the notification because there had not been a [redacted] in the facility for a while, so there were no notifications sent for the month of [redacted] On 10/24/24 at 12:58 PM, the surveyor informed the [redacted] and the [redacted] regarding the above concerns. A review of the facility's policy titled "Transfer, or Discharge, Emergency," with a review date of 2024, indicated that 1. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institutions, our facility will implement the following procedure ... the facility will notify the representative (sponsor) or other family members, and others as appropriate or as necessary. NJAC 8:39-5.3; 5.4	F 623	and did a QAPI plan for it, and it was corrected by 5/1/24. A review of all unplanned transfers for Jan □ April 2024 was completed and copies were provided to those who still reside in the facility. A log of unplanned transfers for the above timeframe has been sent to the Office of the Ombudsman. Measures or systemic changes to ensure that the deficiencies will not recur: Facility staff were re-inserviced on the policy and procedure for resident emergency Discharge/transfers. The Business office manager was trained as a back- up for the Social Worker □ to be responsible for ensuring the notices are provided within the required timeframes. Monitoring the continued effectiveness of systemic change: The BOM or designee will audit all unplanned transfers/discharges weekly X 4 weeks, then monthly X 3 months to ensure that notices for transfers / discharges are made within the required timeframes. The BOM will present the results of these audits to the QAPI committee on a monthly basis. The Administrator will ensure compliance	

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F 623	Continued From page 17	F 623	of these audits and take corrective action as needed.	
F 640 SS=F	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. §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: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment.	F 640		11/21/24

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F 640	Continued From page 18 (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately transmit the Minimum Data Set (MDS) for 20 of 32 residents reviewed, Residents #25, #3, #13, #10, #28, #1, #7, #17, #31, #231, #32, #33, #22, #27, #28 and was evidenced by the following: On 10/23/24 at 10:44 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. 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 the MDS, it will generate a quality measure to enable a facility to monitor the residents decline and progress. The following residents were identified that the MDS were not transmitted timely:	F 640	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: The MDS's for resident # 25,3,13,10,28,1,7,17,31,231,32,33,22,27 and 28 were submitted. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The facility staff responsible for completing assessments were re-inserviced on the Policy & Procedure for Electronic Transmission of the MDS, and specifically on the timely completion	

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F 640	Continued From page 19 1. Resident #25 was triggered under the survey facility task as "MDS record over 120 days old." Resident #25 was observed to have an Admission MDS with Assessment Reference Date (ARD) of [NJ Ex Order 26.4(b)] and was due to be transmitted no later than [NJ Ex Order 26.4(b)]. The MDS was not transmitted until [NJ Ex Order 26.4(b)(1)]. Further review of Resident #25's completed MDS's revealed a Quarterly MDS (Q/MDS) with an ARD of [NJ Ex Order 26] and was due to be transmitted no later than [NJ Ex Order 26.4(b)]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)(1)]. 2. Resident #3 was triggered under the survey facility task as "MDS record over 120 days old." Resident #3 was observed to have a Q/MDS with an ARD of [NJ Ex Order 26.4(b)] and was due to be transmitted no later than [NJ Ex Order 26.4(b)]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)]. Further review of Resident #3's completed MDS's revealed a Q/MDS with an ARD of [NJ Ex Order 26.4(b)] and was due to be submitted no later than [NJ Ex Order 26.4(b)(1)]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)(1)]. 3. Resident #13 was triggered under the survey facility task as "MDS record over 120 days old." Resident #13 was observed to have an Annual MDS with an ARD of [NJ Ex Order 26.4(b)] and was due to be transmitted no later than [NJ Ex Order 26.4(b)(1)]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)(1)] 4. Resident #10 was triggered under the survey facility task as "MDS record over 120 days old." Resident #10 was observed to have an Annual MDS with an ARD of [NJ Ex Order 26] and was due to be transmitted no later than [NJ Ex Order 26.4(b)]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)(1)]. Further review of	F 640	of resident assessments. The MDS coordinator will create a communication tool of what assessments will be needed by specific disciplines along with the completion dates required. The MDS Coordinator will ensure this is communicated to the IDCP team in advance of due dates to ensure compliance. Monitoring the continued effectiveness of systemic change: The MDS coordinator will audit admission, annual, significant changes in status, and quarterly resident assessments on a weekly basis for 4 weeks, then on a monthly basis for 5 months to ensure assessments are completed and transmitted timely. The MDS coordinator will report the findings of these audits to the QAPI committee on a monthly basis. The Administrator will ensure compliance of these audits and take corrective action as needed.	

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F 640	Continued From page 20 Resident #3's completed MDS's revealed a Q/MDS with an ARD of [NJ Ex Order 26.4] and was due to be submitted no later than [NJ Ex Order 26.4]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)]. 5. Resident #28 was triggered under the survey facility task as "MDS record over 120 days old." Resident #28 was observed to have a Q/MDS with an ARD of [NJ Ex Order 26.4] and was due to be transmitted no later than [NJ Ex Order 26.4(b)]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)]. Further review of Resident #28's completed MDS's revealed an Annual MDS with an ARD of [NJ Ex Order 26] and was due to be submitted no later than [NJ Ex Order 26.4(b)]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)(1)]. 6. Resident #1 was triggered under the survey facility task as "MDS record over 120 days old." Resident #1 was observed to have a Q/MDS with an ARD of [NJ Ex Order 26.4(b)] and was due to be transmitted no later than [NJ Ex Order 26.4(b)(1)]. The Q/MDS was not transmitted until [NJ Ex Order 26.4]. Further review of Resident #1's completed MDS's revealed a Q/MDS with an ARD of [NJ Ex Order 26.4] and was due to be submitted no later than [NJ Ex Order 26.4]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)]. 7. Resident #7 was observed to have an Admission MDS with ARD of [NJ Ex Order 26.4] and was due to be transmitted no later than [NJ Ex Order 26.4]. The Admission MDS was not transmitted until [NJ Ex Order 26.4(b)]. Further review of Resident #7's completed MDS's revealed a Q/MDS with an ARD of [NJ Ex Order 26.4(b)] and was due to be transmitted no later than [NJ Ex Order 26.4]. The Q/MDS was not transmitted until [NJ Ex Order 26.4(b)(1)]. 8. Resident #17 was observed to have an	F 640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 640	Continued From page 21 Admission MDS with ARD of [redacted] was due to be submitted no later than [redacted]. The Admission MDS was not transmitted until [redacted]. Further review of Resident #17's completed MDS's revealed a Discharge MDS with an ARD of [redacted] and was due to be submitted no later than [redacted]. The Discharge MDS was noted to be open and was not transmitted. 9. Resident #31 was observed to have an Admission MDS with ARD of [redacted] was due to be submitted no later than [redacted]. The Admission MDS was noted to be open and was not transmitted. Further review of Resident #31's completed MDS's revealed a Discharge MDS with an ARD of [redacted] and was due to be submitted no later than [redacted]. The Discharge MDS was noted to be open and was not transmitted. 10. Resident #231 was observed to have an Admission MDS with ARD of [redacted] was due to be submitted no later than [redacted]. The Admission MDS was noted to be open and was not transmitted. 11. Resident #32 was observed to have an Admission MDS with ARD of [redacted] was due to be submitted no later than [redacted]. The Admission MDS was noted to be open and not transmitted. 12. Resident #33 was observed to have a Discharge MDS with ARD of [redacted] was due to be submitted no later than [redacted]. The Discharge MDS was not transmitted until [redacted]. 13. Resident #22 was observed to have a Q/MDS with ARD of [redacted] was due to be submitted no later than [redacted]. The Q/MDS was not	F 640		

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F 640	Continued From page 22 transmitted until [NJ Ex Order 26.4b]. Further review of Resident #22's completed MDS's revealed another Q/MDS with an ARD of [NJ Ex Order 26.4(b)] and was due to be submitted no later than [NJ Ex Order 26.4(b)(]. The Q/MDS was not submitted unti[NJ Ex Order 26.4(b)(1)]. 14. Resident #27 was observed to have a NJ Ex Order 26.4(b)(1) MDS ([NJ Ex Orde]/MDS) with ARD of [NJ Ex Order 26.4(] was due to be submitted no later than [NJ Ex Order 26.4(]. The [NJ Ex Orde]/MDS was not transmitted until [NJ Ex Order 26.4(]. On 10/28/24, at 01:52 PM, the survey team interviewed the U.S. FOIA (b) (6) via phone who could not provide further information. On 10/29/24 at 8:52 AM, the survey team met with the U.S. FOIA (b) (6) and [U.S. FOIA (b)] to discuss the concern. No additional information was provided. 20. Resident #28 was observed to have an Annual MDS with an ARD of [NJ Ex Order 26] and was due to be transmitted no later than [NJ Ex Order 26.4(]. The Annual MDS was not transmitted until [NJ Ex Order 26.4(b)(]. Further review of Resident #28's completed MDS's revealed another Q/MDS with an ARD of [NJ Ex Order 26.4(] and was due to be transmitted no later than[NJ Ex Order 26.4(b)]. The Q/MDS was not submitted until [NJ Ex Order 26.4(]. The surveyor observed another Q/MDS for Resident #28 with an ARD of [NJ Ex Order 26.4(b)(] and was due to be transmitted no later than [NJ Ex Order 26.4(b)(]. The Q/MDS was not submitted unti[NJ Ex Order 26.4(] A review of the facility's policy and procedure titled: "Electronic Transmission of the MDS" with	F 640		

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F 640	Continued From page 23 a review date in 2024 revealed under "Policy Interpretation and Implementation" that "5. MDS electronic submissions shall be conducted in accordance with current OBRA OBRA (Omnibus Budget Reconciliation Act) regulations governing the transmission of such data." On 10/24/24 at 10:10 AM, the surveyor interviewed the U.S. FOIA (b) who stated that the U.S. FOIA (b) [redacted] was not a full-time employee and completed MDS's remotely. The U.S. FOIA (b) further stated that she had not seen the U.S. FOIA (b) (6) for a long time in the facility. On 10/28/24, at 01:52 PM, the survey team conducted a telephone interview with the U.S. FOIA (b) (6) regarding the above concern who stated that the MDS assessments were not completed and submitted in a timely manner due to other disciplines U.S. FOIA (b) (6) U.S. FOIA (b) (6), U.S. FOIA (b) (6) not completing their assigned sections. The U.S. FOIA (b) (6) further stated that she worked remotely and was employed part-time in the facility. On 10/29/24 at 8:52 AM, the survey team met with the U.S. FOIA (b) (and U.S. FOIA (b) to discuss the above concern. Both acknowledged that the MDS's were submitted late according to the federal and state guidelines.	F 640		
F 641 SS=D	NJAC 8:39 - 11.2(e) Accuracy of Assessments CFR(s): 483.20(g)	F 641		11/21/24

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F 641	Continued From page 24 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) to reflect the resident status in accordance with federal guidelines. This deficient practice was identified for 1 of 12 residents (Resident #7) reviewed. The deficient practice was evidenced by the following: The MDS is a comprehensive tool that is federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. 1. On 10/23/24 at 10:10 AM, the surveyor observed Resident #7 seated in the wheelchair inside the room, watching television. The resident NJ Ex Order 26.4b1 answer the surveyor's inquiry. On 10/24/24 at 11:15 AM, the surveyor reviewed the hybrid (paper and electronic) medical record (HMR) of Resident #7, which revealed the following: A review of the Admission Record (AR) (an admission summary) reflected that Resident #7 was admitted to the facility with diagnoses that included, but were not limited to, NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1). A review of admission MDS (A/MDS), dated	F 641	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 7's MDS Section O was corrected and re-submitted to reflect the accuracy of NJ Ex Order 26.4(b)(1) status. Ide:ntifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this practice. Measures or systemic changes to ensure that the deficiencies will not recur: All MDS were reviewed by MDS coordinator and DON to ensure accuracy of assessments. Corrections were made as needed and those MDSs were resubmitted. The MDS coordinator will work in the facility 4 hours per week to assure accuracy of assessments. Monitoring the continued effectiveness of systemic change: The DON or designee will audit Section O of the MDS for accuracy weekly x 4 weeks and then monthly x 2 months. The	

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F 641	Continued From page 25 [redacted], reflected under Section [redacted] for NJ Ex Order 26.4(b)(1) [redacted]) which indicated as "not offered." A review of the recent quarterly Minimum Data Set (Q/MDS), dated [redacted], reflected that Resident #7 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating NJ Ex Order 26.4(b)(1) [redacted]. Further review of the Q/MDS under Section [redacted] for [redacted] which indicated as "not offered." A review of the "NJ Ex Order 26.4(b)(1) Consent Form" provided by the U.S. FOIA (b) (6) [redacted]) on [redacted]. The form was signed and dated [redacted] by the resident's representative indicating Resident #7 received the [redacted] According to the CMS (Centers for Medicare & Medicaid Services) MDS 3.0 RAI (Resident Assessment Instrument) Manual of October 2024, the RAI manual was revealed under Version 3.0 Manual, pages O-17. "Coding Instructions O0300B, If Pneumococcal Vaccine Not Received, State Reason If the resident has not received a pneumococcal vaccine, code the reason from the following list: o Code 1, Not eligible: if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize. o Code 2, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine. o Code 3, Not offered: resident or responsible party/legal guardian not offered the	F 641	results of these audits will be presented at the monthly QAPI meeting. The DON and MDS coordinator will meet weekly x 4 weeks then monthly x 2 months to review MDS.	

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F 641	Continued From page 26 pneumococcal vaccine." A review of policies and procedures titled: "Subject: MDS" with a revision in 2024 revealed under "Procedure" that "1. r) ...The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. 6. The assessment will accurately reflect the resident's status." On 10/24/24 at 10:10 AM, the surveyor interviewed the U.S. FOIA (b) who stated that the U.S. FOIA (b) [redacted] was not a full-time employee and completed MDS's remotely. The U.S. FOIA (b) further stated that she had not seen the U.S. FOIA (b) (6) for a long time in the facility. On 10/24/24 at 12:49 PM, the survey team met with the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) to discuss the concern. The U.S. FOIA (b) acknowledged that Resident #7 was offered a NJ Ex [redacted] but refused them because the resident received them previously. The U.S. FOIA (b) further stated it should be coded accordingly in their MDS assessment. On 10/28/24, at 01:52 PM, the survey team conducted a telephone interview with the U.S. FOIA (b) (6) regarding the above concern	F 641		
F 689 SS=J	NJAC 8:39-33.2(d) Free of Accident Hazards/Supervision/Devices	F 689		11/20/24

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F 689	Continued From page 27 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: Part A Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to ensure a NJ Ex Order 26.4(b)(1) resident with a PO (physician's order) for NJ Ex Order 26.4(b)(1) to prevent NJ Ex Order 26.4(b)(1)). This deficient practice was identified for 1 of 18 residents reviewed for NJ Ex Order 26.4(b)(1) On 10/23/24 at 12:28 PM, during lunch observation, the surveyor observed Resident #19 NJ Ex Order 26.4(b)(1) while the Licensed Practical Nurse (LPN #1) was assisting Resident#19 with their meal. LPN #1 informed the surveyor that the resident started NJ Ex Order 26.4(b)(1) after LPN #1 NJ Ex Order 26.4(b)(1) Resident #19 NJ Ex Order 26.4(b)(1) in its own NJ Ex Order 26.4(b)(1) LPN #1 stated that Resident #19 was on NJ Ex Order 26.4(b)(1). The surveyor observed NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1) on the resident's meal tray. The surveyor checked the meal card which revealed a NJ Ex Order 26.4(b)(1) dot, and	F 689	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: A.Resident #19 was assessed by RN and MD on NJ Ex Order 26.4(b)(1). Resident #19 has NJ Ex Order 26.4(b)(1) as a result of this deficient practice. The administrator and DON reviewed the policy for color coded food labels on 10/23/24. B. The DON completed a comprehensive review of Resident #15 NJ Ex Order 26.4(b)(1) Identifying other residents who could be affected by the deficient practice A. All residents had the potential to be affected by this deficient practice. B. All residents who have had a fall incident or accident are at risk of this deficient practice	

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F 689	Continued From page 28 no NJ Ex Order 26.4(b)(1) was identified. The surveyor asked LPN #1 what the NJ Ex Order 26.4(b)(1) meant; LPN #1 did not know what the NJ Ex Order 26.4(b)(1) meant and stated that the resident was on a 'NJ Ex Order 26.4(b)(1)). The surveyor interviewed the U.S. FOIA (b) (6) who stated that the kitchen staff plated the resident's meal tray, and that a NJ Ex Order 26 indicated a NJ Ex Order 26.4(b)(1)). The U.S. FOIA stated that a NJ Ex Order 26.4(b)(1) with a 'NJ Ex indicated NJ Ex Order Resident #19's meal card did not have a NJ Ex Order 26 dot with a 'NJ Ex The surveyor interviewed the US FOIA (b)(6)] who confirmed that Resident #19 NJ Ex Order 26.4(b)(1)) and had a NJ Ex Order that could lead to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 The surveyor interviewed the U.S. FOIA (b) (6) , who revealed that the resident was on NJ Ex Ord and could not be served NJ Ex Order 26.4(b)(1) in its NJ Ex Order 26.4(b)(1) because the resident's NJ Ex Order 26.4(b)(1) would not be able to NJ Ex Order 26.4(b)(1) and the NJ Ex Order would go into NJ Ex Order 26.4(b)(1) and cause NJ Ex Order 26.4(b)(1) The facility's failure to ensure a NJ Ex Order 26.4(b)(1) resident with a PO for NJ Ex Ord was provided the appropriate NJ Ex Order 26.4(b)(1) posed a likelihood of NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1) which could result in serious harm, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 10/23/24 at 12:28 PM, when Resident#19 was observed NJ Ex Order 26.4(b after being served NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1). The	F 689	Measures or systemic changes to ensure that the deficiencies will not recur: A. The administrator and DON in-serviced the nursing and kitchen staff regarding color coded food labels. The Speech Therapist in-serviced the kitchen staff regarding mixed consistencies: Modification for diet levels and thickened liquids. All diet changes will be printed and given to the dietary department. The speech therapist will in service the dietary department on changes of food consistencies. The Speech Therapist in-serviced the nursing and kitchen staff regarding Diet Texture Levels. The food cart will have a colored label packet placed on the cart with the name of the resident, diet and food consistency. The colored labels will match the food consistency and diet. The labels will be consistent with the diet and food consistency of the tray card. All food consistency for nectar and honey thickened food will be puree and thickener added per manufacturer instructions. Food consistency using the commercial thickener will be in serviced by the speech therapist to all dietary and nursing personnel. B. The administrator and DON reviewed the facility fall policy. No changes were made.	

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F 689	Continued From page 29 facility's Administration was notified of the IJ on 10/23/24 at 5:00 PM. The facility submitted an acceptable removal plan (RP) on 10/24/24 at 2:11 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 10/23/24. The evidence was as follows: A review of the facility "Food Labels for Dietary Consistency" policy with a review date of 2024, included "food diets are marked by colored labels ... yellow labels are soft chopped ... yellow dot with N is nectar thick liquids ... the colored dots are placed on the name cards and the tray cart ... the color is changed if the diet is changed ..." On 10/23/24 at 12:28 PM, during the lunch observation, the surveyor observed Resident #19 NJ Ex Order 26.4(b)(1) while LPN #1 was assisting the resident with their meal. LPN #1 informed the surveyor that the resident started NJ Ex Order 26.4(b)(1) after LPN #1 fed Resident #19 NJ Ex Order 26.4(b)(1) in its own NJ Ex Order 26.4(b)(1). LPN #1 stated that Resident #19 was on NJ Ex Order 26.4(b)(1). The surveyor observed NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1) on the resident's meal tray. The surveyor checked the meal card which revealed a NJ Ex Order 26.4(b)(1) and no NJ Ex Order 26.4(b)(1). LPN #1 stated they did not know what a NJ Ex Order 26.4(b)(1) meant and added the resident was on a 'NJ Ex Order 26.4(b)(1). On 10/23/24 at 12:35 PM, the surveyor interviewed the U.S. FOIA who stated they plated Resident #19's meal tray and a NJ Ex Order 26.4(b)(1) indicated a NJ Ex Order 26.4(b)(1) and a NJ Ex Order 26.4(b)(1) with a 'NJ Ex indicated NJ Ex Order 26.4(b)(1). The surveyor did not observe a 'NJ Ex on the resident's	F 689	All nursing staff were re in-serviced on facility fall policy and procedure of reporting falls or accidents with the correct date and time to the DON or administrator post incident Monitoring the continued effectiveness of systemic change: A. The DON or designee will audit meal trays daily for proper thickened liquid and diet consistencies x 7 days, then 3 times per week x 4 weeks, then weekly x 2 months. The finding of these audits will be presented at the monthly QAPI meeting. B. The DON and administrator will review the 24 hour report daily to assure no falls or accidents occurred. The DON or designee will audit all accidents and incidents weekly to ensure staff had reported the incident and investigation of incidents are being conducted in a timely manner. The findings of these audits will be presented at the monthly QAPI meeting.	

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F 689	Continued From page 30 meal card. On 10/23/24 at 12:45 PM, the surveyor interviewed LPN #1 and LPN #2 who both stated they did not receive education regarding [redacted] On 10/23/24 at 1:19 PM, the surveyor interviewed the facility's [redacted] who was also Resident #19's US FOIA (b)(6) [redacted]. The [redacted] stated that the resident had a medical diagnosis which included NJ Ex Order 26.4(b)(1) which contributed to a high risk of [redacted] that could lead to [redacted] and [redacted] as a result. On 10/23/24 at 2:39 PM, the surveyor conducted a telephone interview with the U.S. FOIA (b)(6) [redacted]) who confirmed that Resident#19 had a PO for [redacted] and it was not appropriate for the resident to be served the NJ Ex Order 26.4(b)(1) [redacted] in its own [redacted] as it could lead to [redacted] On 10/23/34 at 3:24 PM, the surveyor interviewed the facility's [redacted] who stated the NJ Ex Order 26.4(b)(1) in its own [redacted] cannot be served to a resident who was on [redacted] because the [redacted] would not be able to [redacted] and the [redacted] could go NJ Ex Order 26.4(b)(1) and cause [redacted] On 10/23/24 at 1:10 PM, the surveyor reviewed Resident #19's electronic medical record. A review of the quarterly Minimum Data Set, an assessment tool used to facilitate the management of care dated [redacted], reflected Resident#19 had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating that the resident had NJ Ex Order 26.4(b)(1) . A	F 689		

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F 689	Continued From page 31 review of Section [redacted] revealed the resident received a NJ Ex Order 26.4(b)(1) . A review of the Admission Record face sheet (an admission summary) revealed that Resident #19 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of a PO dated [redacted], revealed a [redacted] order for "NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) ." A review of the individualized comprehensive care plan included a focus area dated [redacted] that the resident had a potential [redacted] risk due to a NJ Ex Order 26.4(b)(1) . The goal included that the resident would tolerate their diet order without signs and symptoms (s/s) of [redacted] Interventions included to provide NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1). A review of the key information section located in the electronic medical record revealed Special Instructions, "Takes medications [redacted] with NJ Ex Order 26.4(b)(1) ." A Review of the Physician's progress notes dated [redacted] at 3:02 PM, included the resident was seen and examined while seated in a chair. The resident was awake but [redacted] with [redacted] and NJ Ex Order 26.4(b)(1). A review of the NJ Ex Order 26.4(b)(1)) Progress Notes (PN) documented by the [redacted] on [redacted] at 12:53 PM, included the resident was seen in their wheelchair in the dining room for [redacted]) evaluation due to reported	F 689		

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	315467	A. BUILDING _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 32 NJ Ex Order 26.4(b)(1) during meals. The resident was currently on NJ Ex Order 26.4(b)(1) with NJ Ex Ord with a recommendation to continue current NJ Ex Ord. The recommendation was reviewed with nursing. A review of the NJ Ex Order 26.4(b)(1) quarterly note dated NJ Ex Order 26.4(b)(1) at 8:11 AM, documented by the NJ Ex O included the resident continued on a NJ Ex Order 26.4(b)(1) with NJ Ex Order. The resident was seen by the U.S. FOIA on NJ Ex Order 26.4(b), with no new NJ Ex Or orders, but it was recommended the resident be NJ Ex Orde On 10/23/24 at 5:00 PM, the survey team interviewed the U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA (b) (6)) who all confirmed Resident #19 should not have been fed the NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1) since the resident was on a NJ Ex Order 26.4(b)(1). No further information was provided to the survey team. The acceptable RP on 10/24/24 at 2:11 PM, indicated the action the facility will have to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: Resident #19 was assessed by the US FOIA (b)(6) all nursing and kitchen staff were in-serviced on facility's consistency and added diet policy; any food with liquid consistency added such as sauce, gravies, natural juices and syrups will have added thickener for appropriate diet consistency and any diet changes will be communicated to the Charge Nurse who will communicate to the kitchen. The survey team verified the implementation of the RP during the continuation of the on-site survey on 10/24/24.	F 689		

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F 689	Continued From page 33 Part B Based on observation, interview, record review, it was determined that the facility failed to accurately investigate the cause of a NJ Ex Order 26.4(b)(1) for 1 of 3 residents (Resident #15) reviewed for NJ Ex Orde and was evidenced by the following: On 10/22/24 at 10:45 AM, the surveyor observed Resident #15 seated in their wheelchair in their room with family present. Resident #15's family stated that the resident had a recent NJ Ex in the NJ Ex Order 26.4(b)(1) The family member also stated that the facility notified them via telephone on the day of the NJ Ex incident. A review of Resident #15's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex O, and NJ Ex Order 26.4(b)(1). A review of a Quarterly Minimum Data Set dated NJ Ex Order 26, revealed that the resident was unable to complete a Brief Interview for Mental Status (BIMS) due to NJ Ex Order 26.4(b)(1). A review of the progress note (PN) dated NJ Ex Order 26.4(at 5:28 AM, revealed that Resident #15 was NJ Ex Order 26.4(b)(1). The PN also indicated the nursing staff assessed the resident and obtained vital signs. A review of the NJ Ex Order 26.4(b)(evaluation completed on NJ Ex Order 26.4(, revealed that Resident #15 was at a NJ Ex Order 26.4(b)(1) for NJ Ex Orde A review of the Physician Orders (PO) dated NJ Ex Order 26.4(revealed a PO for NJ Ex Order 26.4(b)(1)	F 689		

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F 689	Continued From page 34 NJ Ex Order 26.4(b)(1)." A review of Resident #15's comprehensive Care Plan (CP) revealed under focus with a revision date of [NJ Ex Order 26.4(b)] titled, "The resident is [NJ Ex Order 26.4(b)] for NJ Ex Order 26.4(b)(1), and had an NJ Ex Order 26.4(b)(1) with [NJ Ex Order 26.4(b)(1)]. Further review of the CP included an intervention dated [NJ Ex Order 26.4(b)], to encourage resident to use [NJ Ex Order 26.4(b)] for help. On 10/24/24 at 9:46 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated the facility does not complete [NJ Ex Order 26.4(b)] investigation reports and any information regarding a [NJ Ex Order 26.4(b)] incident would be documented under the nursing progress note found in the electronic medical record. The [U.S. FOIA (b) (6)] further added that there were no witness statements obtained after the [NJ Ex Order 26.4(b)] On 10/24/24 at 9:55 AM, the [U.S. FOIA (b) (6)] provided the surveyor a facility policy titled Falls, with an implementation date of 6/2024, under the policy section which revealed, "All falls are to be investigated and monitored. The facility will maintain a record that contains a list of all incidents and falls." Under the program steps of the policy included, "F... Complete Incident/Event Report. G. Start Investigation Report. H. Obtain detailed statements from any witnessed. Statements must be signed with the correct date and time for fall with serious injuries." On 10/24/24 at 12:21 PM, the survey team met with the U.S. FOIA (b) (6) [U.S. FOIA (b) (6)] and U.S. FOIA (b) (6) to review the above concern. The [U.S. FOIA (b) (6)] stated a complete [NJ Ex Order 26.4(b)] investigation that included statements from witnesses was not completed for Resident #15's [NJ Ex Order 26.4(b)(1)] that occurred on	F 689		

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F 689	Continued From page 35 [redacted]. On 10/31/24 at 11:15 AM, the survey team met with the [redacted] and the [redacted] of the facility to discuss the above concern. There was no additional information provided.	F 689		
F 692 SS=D	NJAC 8:39-27.1(a); 31.4(a); 33.1(d) NJAC 8:39-17.4 (a)1-2; 27.1(a) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to	F 692	How any corrective action will be accomplished for those residents found to	11/22/24

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F 692	Continued From page 36 ensure residents with NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) were addressed by the U.S. FOIA (b) (6) in a timely fashion. This deficient practice was identified for 2 of 2 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #3 and #14), and was evidenced by the following: 1. On 10/22/24 at 10:30 AM, the surveyor observed Resident #3 seated in their wheelchair on the outside deck of the facility. Resident #3 stated they had NJ Ex Order 26.4(b)(1) and NJ Ex Order 26. but was not sure of their current NJ Ex Order 26.4 A review of Resident #3' Admission Record (AR) (admission summary) revealed that the resident was admitted to the facility with diagnosis that included but were not limited to NJ Ex Order 26.4(b)(, NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) . A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(reflected a Brief Interview for Mental Status (BIMS) was NJ Ex Order 26.4b1 . A review of the NJ Ex Order 26.4b1 documented in the electronic medical record (EMR) revealed that on NJ Ex Order 26 and NJ Ex Order 26.4(, Resident #3's NJ Ex Order 26. was NJ Ex Order 26.4(b)(1) and on NJ Ex Order 26.4(, the resident's weight was NJ Ex Order 26.4(b)(which indicated a NJ Ex Order 26.4(or NJ Ex Order 26.4(b)(1) in the last 30 days. A review of the nutrition progress notes in the EMR revealed the last NJ Ex Order 26.4(b) note documented for Resident #3 was dated NJ Ex Order 26.4(b)(.	F 692	have been affected by the deficient practice: Resident # 3 and Resident # 14 were NJ Ex Order 26.4(b)(1) on 10/26/24 The DON conducted a comprehensive review of Residents # 3 and 14. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. A company has been contacted for recalibration and the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) will be re-calibrated by December 12, 2024. The RD and Nursing administration will complete a comprehensive review and audit of all residents with weight loss or gain. They will ensure MD orders and RD recommended interventions are care planned for weight loss or gain, and that the RD is addressing them in a timely manner. Measures or systemic changes to ensure that the deficiencies will not recur: All nursing staff were re-inserviced on the Weight management policy and procedure for obtaining resident weights. The DON and LNHA re-educated the RD	

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F 692	Continued From page 37 2. On 10/22/24 at 11:58 PM, the surveyor observed Resident #14 who was seated in a wheelchair while organizing personal items on their dresser. The resident NJ Ex Order 26.4b1 to the surveyor during the interview. A review of Resident #14's AR revealed that the resident was admitted to the facility with diagnosis that included but not limited to; NJ Ex Order 26.4(b)(1) ( ), NJ Ex Order 26.4(b)(1) ( ), NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). A review of the Q/MDS, an assessment tool used to facilitate the management of care, dated , reflected a BIMS score of out of 15, which indicated that the resident had a . A review of the weights documented in the EMR revealed that on and , Resident #14's was and on , the resident's was . which indicated a or NJ Ex Order 26.4(b)(1) since . A review of the nutrition progress notes documented in the EMR revealed the last note documented for Resident #14 was on .	F 692	and nursing staff on the policy and procedure for managing weight loss and weight gain. The DON will audit all residents for weight loss or gain to ensure the RD is addressing in a timely manner. Monitoring the continued effectiveness of systemic change: The DON or designee will audit all residents for weight loss or gain to ensure the RD is addressing in a timely manner weekly x 4 then monthly x 2 and report finding to monthly QAPI meeting.	

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F 692	Continued From page 38 A review of Resident #14's comprehensive care plan revealed the following [redacted] care area with a focus titled, "The resident has [redacted] problem or potential [redacted] problem [redacted] and [redacted]." A review of the goal included, "The resident will maintain [redacted] as evidenced by maintaining [redacted] with [redacted] of [redacted]), no sign and symptoms of [redacted] and [redacted] at leas[redacted] of at least 2 meals daily." On 10/23/23 at 11:45 AM, the survey team conducted a telephone interview with the [redacted] who stated, resident's [redacted] were done monthly by the 5th of the month and will be documented in the EMR. The [redacted] further stated for any resident with a [redacted], they will be immediately [redacted] to confirm the [redacted] change. The [redacted] also stated, after the resident would be [redacted], the [redacted] will document a [redacted] immediately to address the possible reasons for the [redacted] and would add interventions if needed. The [redacted] further stated that not all the residents with significant [redacted] have been addressed at this time. The [redacted] could not provide an information why the residents with [redacted] have not been addressed. On 10/24/24 at 9:00 AM, the [redacted] provided the surveyor with a facility policy titled, "Resident Rights - Weight Management" with a reviewed date of 10/2024. Under the procedure section of the policy, it stated, "3. Monthly weights will be completed by the fifth (5th) of each month. 4. Dietary will evaluate all weights by the seventh (7th) of each month. 5. A	F 692		

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F 692	Continued From page 39 reweight will be obtained for any weight change of +/- three (3) lbs. (pounds) from the previous weight unless other parameters have been ordered by the physician." On 10/24/24 at 12:21 PM, the survey team met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)) to review concerns. The stated the comes in twice a week but could not provide an explanation why the residents with NJ Ex Order 28.4(b)(1) had not been addressed. On 10/30/24 at 11:15 AM, the survey team met with the and the of the facility to conduct the exit interview. There was no further information provided. NJAC 8:39 - 11.2(e)(1)(f), 17.1(c), 17.2(c)(d), 27.1(a)	F 692		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation, it was determined that the facility failed to ensure that the Certified Nursing Aide (CNA) received a performance review for one (1) of five (5) CNA files reviewed.	F 730	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were negatively affected by	11/21/24

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F 730	Continued From page 40 This deficient practice was evidenced by the following: On 10/22/24 at 10:27 AM, the surveyor requested from the facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) (the annual education, competencies, and performance reviews for five randomly selected CNAs. The facility provided a copy for each of the five CNA's records which contained their post tests for the education they received. The facility did not provide performance reviews for the five CNAs. On 10/29/24 at 12:02 PM, the surveyor interviewed the U.S. FOIA (b) regarding performance reviews who stated that she did not complete all the required annual performance review for everyone who was hired within the NJ Ex Order 26.4(b) except for 1 CNA. The U.S. FOIA (b) confirmed that the other 4 CNAs did not have performance reviews. A review of the facility's policy titled, "Job Descriptions - Written" with a 2024 review date revealed under #4. Department Directors are responsible for reviewing the job description with the employee during the employee's orientation process, when changes are made in the job description, and during annual performance and comptency evaluations." On 10/29/24 at 01:44 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) and U.S. FOIA (b) and discussed the above concern that the four CNAs did not have an annual performance review. The U.S. FOIA (b) stated the facility was working on the performance reviews. The	F 730	this deficient practice. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: All employee files were audited to ensure there is a current performance review on file. A performance review was completed for any CNA who did not have a current performance review on file. Monitoring the continued effectiveness of systemic change: The BOM will audit 5 employee files a week for 4 weeks, then 5 files a month for 2 months to ensure all employees have a current performance review on file. The findings will be presented at QAPI meeting monthly.	

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F 730	Continued From page 41 facility did not provide any additional information. FACILITY POLICY	F 730		
F 755 SS=D	N.J.A.C. 8:39-43.17 (b) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		11/21/24

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F 755	Continued From page 42 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow acceptable standards of clinical practice for accurately administering medications according to the physician's order (PO). This deficient practice was identified in 1 (one) of 12 (twelve) residents (Resident #20) observed during the medication observation pass. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and	F 755	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #20 was immediately ordered the[redacted] Identifying other residents who could be affected by the deficient practice: All residents had the potential to be impacted by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: All nursing staff were in-serviced by the DON on following proper med pass guide lines. Monitoring the continued effectiveness of systemic change: The DON or Pharmacy Consultant will conduct med pass audits on each nurse randomly over the next 3 months. Findings will be presented at QAPI meeting monthly.	

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	315467	A. BUILDING _____ B. WING _____	C 10/30/2024

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F 755	Continued From page 43	F 755		

restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

On 10/28/24 at 9:10 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse #1 (LPN#1) in the room of Resident #20. The surveyor observed LPN #1 checked the resident's identification bracelet prior to administering Resident #20's medications.

On 10/28/24 at 9:15 AM, the surveyor observed LPN #1 prepared to administer six (6) medications to Resident #20 which included NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). The surveyor observed LPN #1 NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(and NJ Ex Order 26.4 then added the NJ Ex Order 26.4(b) medications into a medication cup and then NJ Ex Order 26.4(b)(1) . The surveyor then observed LPN #1 opened the NJ Ex Order 26.4(b)(1) and emptying the contents of the NJ Ex Order 26.4(b) into the NJ Ex Order 26.4(b)(1) that contained all the other NJ Ex Order 2 . The surveyor then observed LPN#1 administered the medications to Resident #20.

A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)( ), NJ Ex Order 26.4(b)(1) (NJ

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NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)).

A review of the Annual Minimum Data Set, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b)(1) reflected that the resident's NJ Ex Order 26.4(b)(1) for NJ Ex Orde score was NJ Ex Order 26.4(b)(out of 15, which indicated that the resident's cognition was NJ Ex Order 26.4(b)(1).

A review of the NJ Ex Order 26.4(b)(1) Order Summary Report revealed a PO dated NJ Ex Order 26 , for NJ Ex Order 26.4(b)(oral tablet NJ Ex Order 26.4(b)(1)) give 1 tablet by mouth one time a day for NJ Ex Order 26.4(b)(1)

A review of the NJ Ex Order 26.4(b)(1) electronic Medication Administration Record revealed a PO dated NJ Ex Order 26 , for NJ Ex Order 26.4(b)(1) oral tablet (NJ Ex) give 1 tablet by mouth one time a day for NJ Ex Order 26.4(b)(1)

A review of the manufacturer's specification for the medication NJ Ex Order 26.4(b)(1) revealed to, "Swallow the tablets, film-coated tablets, and extended-release tablets whole; do not split, chew or crush them."

On 10/29/24 at 12:00 PM, the surveyor interviewed LPN#1 who acknowledged that NJ Ex Order 26.4(b)(1) should have not been NJ Ex Order 26.4(b)(LPN #1 further stated that if the resident NJ Ex Orde the NJ Ex Order 26.4(b)(1) tablet, she would obtain a PO for NJ Ex Order 26.4(b)(1) liquid.

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F 755	Continued From page 45 A review of the facility's policy titled, "Administering Medication" with a review date of 12/31/12 provided by the DON revealed, "Medications must be administered in accordance with the orders, including the required time frames." On 10/29/24 at 1:00 PM, the survey team met with the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)) to discuss the above concerns. There was no additional information provided.	F 755		
F 761 SS=D	NJAC 8:39-11.2 (b), 29.2 (d) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		11/21/24

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F 761	Continued From page 46 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store, and dispose medications in one (1) of two (2) medication carts inspected. This deficient practice was evidenced by the following: On 10/28/24 at 11:35 AM, the surveyor inspected medication cart #1 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened vial of Fiasp insulin with an opened date of 9/28/24 and was expired. The surveyor also observed two opened bottles of Pro-Stat AWC (protein supplement), one bottle had an opened date of 7/1/24 and a second bottle with an opened date of 7/2/24. Both bottles of Pro-Stat AWC were expired. At that time, the surveyor interviewed LPN#1 who acknowledged that both the Fiasp insulin vial and the two bottles of Pro-Stat AWC were expired and should have been removed from the medication cart. A review of the manufacturer's specifications for the following medications revealed that the Fiasp insulin had an expiration date of 28 days once opened and Pro-Stat AWC had an expiration date of 90 days once the bottle was opened.	F 761	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: All expired medications were removed from Med Cart 1 by nurse Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice Measures or systemic changes to ensure that the deficiencies will not recur: All medication carts and storage areas were audited for expired medications by the DON. All licensed nursing staff were in-serviced by the DON on medication storage and expiration dates. Pharmacare Consultant will audit all medication carts monthly for expired medications. Medication carts and medication storage areas will be audited by the DON or	

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F 761	Continued From page 47 A review of the facility's policy titled "Storage of Medications" that was undated and provided by the U.S. FOIA (b) (6)) revealed the following: "4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." On 10/29/24 at 1:00PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA (b) to discuss the above concerns. There was no additional information provided.	F 761	designee weekly x 2 weeks, Bi weekly x 2 weeks then monthly x 1 month. Results of audit will be reported at the monthly QAPI meeting. Monitoring the continued effectiveness of systemic change:	
F 812 SS=F	NJAC: 8:39-29.4 (a) (h) (d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		11/21/24

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F 812	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 10/22/24 9:07 AM, the surveyor in the presence of the U.S. FOIA (b) (6) observed the following during the kitchen tour: 1. The surveyor observed three dented cans (6 lb. peaches, 6 lb. potatoes, and 6 lb. shredded potatoes) stored with all intact canned goods. U.S. FOIA stated those cans should have been removed and placed in the dented can area. 2. The surveyor observed the canned goods stored on the top of the storage unit were warm to the touch with a heat vent observed on ceiling next to the canned goods. 3. The surveyor observed three portable window air conditioning units (AC). All three AC units were observed with a blackish dust like build up on the vents. The AC unit located next to the 3 compartment sink and food prep area was also noted with a brown colored sticky substance on the left vent. The U.S. FOIA stated the maintenance department was in charge of cleaning the AC units. 4. The surveyor observed the U.S. FOIA tested the sanitizing solution on the low temperature dish machine (LTDM). The U.S. FOIA recorded the sanitizer	F 812	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1.The Kitchen Manager removed the dented cans from the intact canned goods area and placed them in the dented can area on 10/22/24 2.The Kitchen Manager disposed of the warm cans that were stored near the heat vent on 10/22/24 3. The Maintenance Director cleaned the 3 kitchen AC units vents on 10/22/24 4. The kitchen supervisor checks the chemical sanitizer concentration each day with the paper strip and records the results. The supervisor makes corrective changes if needed. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The Administrator in-serviced the U.S. FOIA (b) (6) and kitchen staff on Receiving Policy. The Administrator in-serviced the dietary staff on food storage policy.	

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F 812	Continued From page 49 concentration at zero parts per million (PPM). The surveyor further observed the LTDM log which was used to record the daily temperatures of the LTDM and the sanitizing solution. The daily temperatures were recorded except the sanitizer PPM. The U.S. FOIA stated sanitizer PPM test must be recorded. The U.S. FOIA could not provide an explanation why the sanitizer PPM has not been recorder. The surveyor observed an empty bottle of sanitizing solution connected to the dish machine. On 10/24/24 at 9:00 AM, the U.S. FOIA (b) (6) provided the surveyor with facility policies titled, "Food Storage, Equipment" with a revision date of 5/2024 and revealed under the procedure section, "8. Dented cans are removed to a separate area and returned to sender." The equipment policy with a revision date of 10/2024, states under the procedures section, "1... All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions ...4. All non-foods contact equipment will be cleaned and free of debris. A review of the policy titled, "Dishwashing Machine Use " with a revision date of 10/2024 under the procedures section, "4. Dishwashing machine chemical sanitizer concentrations and contact times will be as followed, Chlorine 50-100 PPM for 10 seconds. 5. A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution. Concentrations will be recorded in a facility approved log. 6. Corrective actions will be taken immediately of sanitizer concentration are too low." On 10/24/24 at 12:21 PM, the survey team met with the U.S. FOIA (b) (6)	F 812	The Administrator in-serviced the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) on the Equipment Policy. The Kitchen Manager will submit any requests for kitchen maintenance to the Maintenance Director as needed. Monitoring the continued effectiveness of systemic change: The Administrator/DON will audit the kitchen 2x weekly x 4 weeks, to ensure all cans are stored properly. The Administrator/DON will audit the chemical sanitizer log sheet weekly for 4 weeks and then monthly for 2 months. The Administrator or Designee will inspect kitchen monthly for any service repairs or maintenance requests. The results of these audits will be presented at the monthly QAPI meeting.	

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F 812	Continued From page 50 (U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b to review the above concerns. No further comments provided.	F 812		
F 842 SS=D	NJAC 8:39-17.2(g) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		11/21/24

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F 842	Continued From page 51 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for (1) one of	F 842	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 842	Continued From page 52 (5) five residents (Resident #28) reviewed for unnecessary medication. This deficient practice was evidenced by the following: On 10/23/24 at 10:15 AM, the surveyor observed Resident #28 in bed, awake, covered with a blanket, and NJ Ex Order 26.4(b)(1) the surveyor's inquiry. On 10/23/24 at 11:23 AM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #28, which revealed the following: A review of the Admission Record (an admission summary) reflected that Resident #28 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) . A review of the recent annual Minimum Data Set (An/MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, reflected that Resident #28 had a Brief Interview for Mental Status score (BIMS) score of NJ Ex Order 26.4(b) out of 15, indicating NJ Ex Order 26.4(b)(1) . A review of the NJ Ex Order 26.4(b)(1) Order Summary Report (OSR) included a physician's order (PO) dated NJ Ex Order 26.4(for NJ Ex Order 26.4(b)(1)) to be administered one tablet by mouth one time a day. A review of the NJ Ex Order 26.4(b)(1) electronic Medication Administration Record revealed the above PO for NJ Ex Order 26.4(b)(1) that was signed by the nurses which indicated that the medication was	F 842	The NJ Ex Order 26.4b1 sent in the progress notes for Resident #28. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. The DON audited all residents to determine when they were last seen by Psych services. The Psych NP sent in all progress notes, which were entered into the residents medical records. Measures or systemic changes to ensure that the deficiencies will not recur: The Administrator counseled the U.S. FOIA (b)(and advised him that he needs to leave a copy of his progress notes by the end of the day of his visit. The administrator will audit 5 residents a week for 4 weeks, then 5 residents a month for 2 months to ensure the Psych NP is providing his progress notes. Monitoring the continued effectiveness of systemic change: The results of these audits will be presented by the LNHA to the QAPI committee monthly. The Administrator will ensure compliance	

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F 842	Continued From page 53 administered from NJ Ex Order 26.4(through NJ Ex Order 26.4(. A review of the form "Initial Consultation/Evaluation" revealed Resident #28 was seen by [Name Redacted] NJ Ex Order 26.4(b)(1) Service on NJ Ex Order 26.4(. Further review of the hybrid medical records revealed no other NJ Ex Order 26.4(b)(1) consults NJ Ex Orde sheets after NJ Ex Order 26.4(. On 10/24/24 at 9:58 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who confirmed that there were no NJ Ex O sheets found in the hybrid medical record. The U.S. FOIA (b stated that she was waiting for the U.S. FOIA (b) (6) to send it to the facility. The facility did not provide a policy regarding medical record keeping. On 10/29/24 at 8:52 AM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA (b) who acknowledged that the NJ Ex Order 26.4(b)(1) notes were not in the chart. The U.S. FOIA (b stated that the U.S. FOIA (b) (6) had it with him in his possession.	F 842	of these audits and take corrective action as needed	
F 880 SS=F	NJAC 8:39-35.2(a)(d)4 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	F 880		12/9/24

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	315467	A. BUILDING _____ B. WING _____	C 10/30/2024

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LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD CALIFON, NJ 07830**

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F 880	Continued From page 54 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: (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	F 880		

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F 880	Continued From page 55 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to 1. ensure the sharps container (SC) that were filled with contaminated sharps/needles were disposed properly, 2. ensure the used NJ Ex Order 26.4(b)(1) NJ Ex test card was discarded after use, 3.ensure the clean linen room was free from NJ Ex Order 26.4(b)(1) and 4. ensure the Personal Protective Equipment (PPE) cart was cleaned to prevent the spread of infection. This deficient practice was evidenced by the following: 1. On 10/22/24 at 9:00 AM, two surveyors observed a used NJ Ex Order 26.4(b)(1) test card exposed laying on the table right by the entrance door where all the visitors and staff enter the facility. The surveyor further observed that the NJ Ex Order 26.4(b)(1) test card showed a "NJ Ex Order 26.4(b)(1)" indicating	F 880	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: NJ Ex Order 26.4(b)(1) was called by the LNHA. All used sharp containers were picked up on 10/23/24. The Used NJ Ex Order 26.4(b)(1) test was immediately discarded in the red biohazard bin on 10/22/24 The NJ Ex Order 26.4(b)(1) was immediately removed from the clean linen room by the DON/IP on 10/23/24. The inactively used PPE cart was	

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F 880	Continued From page 56 the results was NJ Ex Order 26.4(b)(1) The surveyor also observed a red bio hazard bin next to the table where the test card was observed. On 10/22/24 at 9:15 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated the facility provided NJ Ex Order 26.4(b)(1) to all the visitors and staff who wish to test themselves. The unused test kits were observed inside the basket by the entrance door. The U.S. FOIA (b also added the used NJ Ex Order 26.4(b)(1) test card was supposed to be discarded in the red bio hazard bin after the results are revealed. On 10/22/24 at 11:25 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that the NJ Ex Order 26.4(b)(1) card was supposed to be discarded after use. A review of the facility's policy titled, "Used Covid Test Cards" revealed under Procedure: "Upon administrating a COVID PRC test the recipient must wait, read the results of the test and place the exposed Covid Card in the Stericycle container next to the testing area... At the beginning of each shift the Charge Nurse will ensure all used COVID cards are placed in the Stericycle container." On 10/24/24 at 12:49 PM, the surveyor discussed the above concerns with the facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) No additional information was provided. 2. On 10/23/24 at 11:25 AM, the surveyor together with the facility's U.S. FOIA (b) (6)) toured the clean storage room located in a	F 880	removed from the hallway on 10/23/24. The cart was cleaned by the housekeeper. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The Administrator re-educated the U.S. FOIA (b) (6) to have an automatic pickup every other month for Sharps containers. The Administrator in-serviced U.S. FOIA (b on new Used Covid Test Card Policy. The DON or designee will in-service nurses on new Used Covid Card Test Policy. The DON and Maintenance Director in-serviced the house keeping staff on proper storage of linen. The Maintenance Director and DON/IP in-serviced the house keeping staff on the Cleaning and Disinfection Policy. Monitoring the continued effectiveness of systemic change: The Maintenance Director will audit the sharps container storage weekly to ensure they are being stored appropriately	

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F 880	Continued From page 57 shed adjacent to the facility. Upon entering the locked storage room, the surveyor observed several SC boxes piled up in a bio-hazard bag that were overflowing in a bin next to the clean incontinence briefs and toilet papers. The surveyor further observed that the bin had a lock that wasn't secured. The U.S. FOIA (b) stated they were unable to secure the lock since the SC overflowed the bin. The U.S. FOIA (b) added that the SC box were filled with contaminated needles. The surveyor interviewed the U.S. FOIA (b) who stated it was the U.S. FOIA (b) (6) responsibility to call the company who will then come and pick up the SC bins. The U.S. FOIA (b) further stated to the surveyor that the SC was overflowing and it was long overdue to be picked up by the licensed vendor. On 10/23/24 at 12:30 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated the last time their SC were picked up was in January 2024. A review of the facility's policy titled, "Medical Waste, Handling of" with a review date of 2024 revealed under General Guidelines "#2. All sharps must be handled as medical waste, placed in approved sharps containers, and sent for eventual incineration." The DON provided the surveyor another policy titled, "Needle Handling and/or Disposal" with a review date of 2024 and revealed under Safety Precautions "#2. Place used needles in the needle disposal box. Do not bedm break, or cut needles. When the disposal box is three-quarter filled or at fill line seal the box and store it in a closed, puncture-resistant container marked "Biohazard" until incinerated or picked up by a licensed vendor for proper	F 880	and are picked up regularly The DON or Charge will audit Covid testing area to assure all used Covid test cards are placed in the red biohazard bin 2x per shift daily. The DON or designee will audit the clean linen room daily x 1 week, then 3x per week x 2 weeks, then weekly x 4 to assure no soiled devices are stored in clean linen area. The DON/IP will audit the PPE carts for soilage and proper storage daily x 1 week, then 3x per week x 2 weeks, then weekly x 4 to assure compliance. The findings of the audit for sharps container pickup, Covid test card disposal and PPE carts for soilage will be presented at the Monthly QAPI meeting.	

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F 880	Continued From page 58 disposal." On 10/29/24 at 1:44 PM, the survey team discussed the above concern to the facility's U.S. FOIA (b) (6) , U.S. FOIA (b) and U.S. FOIA (b) No further information was provided. 3. On 10/23/24 at 10:18 AM, the surveyor toured the clean linen room in the presence of the U.S. FOIA (b) (6)). The surveyor observed a dark blue colored heel elevator device (HED) with a white stain on the side and was placed on top of the clean gown. The U.S. FOIA (b) (6) acknowledged that the device does not belong to the clean linen room. The U.S. FOIA (b) (6) could not provide an explanation why the HED was inside the clean linen room that was placed on top of the clean gown. 4. On 10/23/24 at 10:23 AM, the surveyor observed a 3 drawer cart during the tour with the U.S. FOIA (b) (6) in the hallway. The surveyor observed the cart with a splatter of dark brown substances on the right side from the first drawer to the third drawer of the cart. The U.S. FOIA (b) (6) stated that it was a PPE cart that was "inactively used." The U.S. FOIA (b) (6) acknowledged that the PPE cart should not placed be in the hallway if not in use and a housekeeping staff should clean it before putting them away. A review of the policy and procedure titled "Cleaning and Disinfection of Resident-Care Items and Equipment," with a review date in 2024, stated that under "Policy Interpretation and Implementation 2. Critical and semi-critical items will be sterilized/disinfected in a central	F 880		

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F 880	Continued From page 59 processing location and stored appropriately until use ..." On 10/24/24 at 1:10 PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) regarding the above concern. The U.S. FOIA (b) (6) acknowledged that any therapy devices should not be inside the clean linen room and that the unused PPE cart should not be in the hallway. NJAC 8:39-19.3(a);19.4(l);21.1(a)	F 880		

New Jersey Department of Health

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes	S 560	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this deficient practice. Identifying other residents who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. Measures or systemic changes to ensure	11/21/24

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

Electronically Signed | 11/22/24

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S 560	Continued From page 1 effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including	S 560	that the deficiencies will not recur: The DON and BOM were educated on CNA staffing minimal ratios by the DOH. The DON and the BOM will report to the administrator if minimal staffing ratios have not been met. The administrator will review staffing daily for each day, evening and night shift to ensure the minimum CNA staffing ratios are met. The administrator will continue to focus on recruitment and retention, including but not limited to use of web-based recruitment advertising, contract utilization, sign on bonuses, referral bonuses, shift differentials ,and employee moral incentives. Monitoring the continued effectiveness of systemic change: The Administrator will assess and evaluate staffing outcomes based on offered rates, job fairs, recruitment packages, and staff retention weekly, making necessary adjustments based on analysis and findings. The Administrator or designee will create audit tools to utilize for recruitment to track and trend recruitment efforts weekly, x 4 then monthly x 3 or until compliance is met. All audits results will be presented at the monthly QAPI meeting.	

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S 560	Continued From page 2 certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week staffing prior to survey beginning 10/6/2024 and ending 10/19/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 5 of 14 day shifts as follows: -10/08/24 had 3.6 CNAs for 32 residents on the day shift, required at least 4 CNAs. -10/09/24 had 3.5 CNAs for 32 residents on the day shift, required at least 4 CNAs. -10/13/24 had 3.5 CNAs for 34 residents on the day shift, required at least 4 CNAs. -10/15/24 had 2.9 CNAs for 34 residents on the day shift, required at least 4 CNAs. -10/16/24 had 3.8 CNAs for 34 residents on the day shift, required at least 4 CNAs.	S 560		

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S 560	Continued From page 3 On 10/30/24 at 11:18 AM, the surveyor met with the facility's Licensed Nursing Home Administrator, Director of Nursing and Business Office Manager. There was no additional information provided by the facility.	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day	S1680		11/21/24

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S1680	Continued From page 4 Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 10/6/2024 through 10/19/2024, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 14 days.	S1680	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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S1680	Continued From page 5 The required staffing hours and actual staffing hours are as follows: For the week of 10/13/24 Required Staffing Hours: 88.75 -10/15/24 had 78.4 actual staffing hours, for a difference of -10.35 hours. On 10/30/24 at 11:18 AM, the surveyor met with the facility's Licensed Nursing Home Administrator, Director of Nursing and Business Office Manager. There was no additional information provided by the facility.	S1680	No residents were affected by this deficient practice. Identifying other residents who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: 1. The DON and BOM were educated on the Supplemental Nurse Staffing Report by the NJ DOH, in addition they have been educated to notify the administrator of any shortfalls in staffing compliance. 2. The DON and BOM will utilize the created nursing spreadsheet, nurse schedules to compare actual hours to maintain compliance utilizing NJDOH staffing reports, and the NJDOH Supplemental Nurse Staffing Reports. The Administrator, DON, BOM scheduler reviewed the master schedule pattern on 10/23/2024. The ads for open positions we have been recruiting for were re-posted to recruit nurses and CNAs to provide an adequate number of nursing staff to address the acuity and diagnoses of the facility's resident population in accordance with the facility assessment, resident census, and daily care required by the resident. Monitoring the continued effectiveness of systemic change:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061003	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCEI	78 SLIKER ROAD CALIFON, NJ 07830

(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
S1680	Continued From page 6	S1680	The DON and BOM will meet weekly to discuss the accruals of current resident acuities and adjust staffing accordantly to meet the needs of any new residents. The administrator will conduct audits of the staffing reports weekly x 4, then bi weekly x 2, then monthly x 3 months or until compliance is maintained. Findings of these audits will be presented at the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	R-C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 An onsite revisit was conducted regarding the 10/30/2024 Recertification survey. The facility was found not to be in compliance with their implementation of their Plan of Correction. Census: 33 Sample: 9	{F 000}		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined that the facility staff failed to ensure a resident received [NJ Ex Order 25] in the appropriate [NJ Ex Order 26.4(b)(1)] at meals in accordance with physician orders for 1 of 1 resident (Resident #1). This deficient practice was evidenced by the following: On 12/26/24 at 11:37 AM, during the kitchen inspection, the surveyor observed Resident #1's lunch tray with tray card listing the resident's diet,	F 808	1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 1#s tray was removed before serving the resident. The [NJ Ex Order] [redacted] was changed to the current physician's order to [NJ Ex Order 26.4(b)(1)] [redacted]. 2. Identifying other residents who could be affected by the deficient practice.	1/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/14/2025

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
	315467	A. BUILDING _____ B. WING _____	R-C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 808	Continued From page 1 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The surveyor further observed Resident #1's tray card which revealed the current diet order was NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). The surveyor observed a cup with a clear liquid labeled 'NJ Ex Order 26.4' on Resident #1's tray. A review of the Resident Face Sheet (an admission summary) reflected that Resident #1 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4, and NJ Ex Order 26.4(b)(1). A review of the Admission Minimum Data Set (an assessment tool used to facilitate care management) dated NJ Ex Order 26.4(b)(1), reflected that the resident had a Brief Interview for Mental Status (BIMS), which revealed that the BIMS score was not assessed. A review of the Physician Order's (PO) reflected an order dated NJ Ex Order 26.4(b)(1), for 'NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)." On 12/26/24 at 12:15 PM, the surveyor interviewed Dietary Aide #1 (DA#1), who stated they were not aware the Resident #1's NJ Ex Order 26.4 had changed. DA#1 further stated to the surveyor the nurses on the unit would alert the dietary staff for any diet changes.	F 808	All residents have the potential to be affected by this deficient practice. 3. Measures or systemic changes to ensure that the deficiencies will not recur. The Director of Nursing will provide an Inservice to all kitchen staff on following the diet texture liquid consistency and therapeutic diet orders from the physician. 4. Monitoring the continued effectiveness of systemic change. The DON and/or assignee will conduct random meal reviews for accuracy, one meal a day for 1 week on 3 residents. These findings will be presented at the monthly QAPI meeting by the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	R-C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD CALIFON, NJ 07830**

(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 808	Continued From page 2 On 12/26/24 at 12:30 PM, the U.S. FOIA (b) (6) provided the surveyor with a facility policy titled, "Following Physician Orders" with a revised date of 5/2024, Under the procedure section of the chart revealed, "All staff are required to follow physician orders without question." Another facility policy provided titled, "Food and Nutrition Service" with a revised date of 5/20204 stated under the procedure section, "9... The dietary staff will change the diet texture, liquid consistency, and therapeutic diet order from the physician." On 12/26/24 at 1:00 PM, the survey team met the U.S. FOIA (b) (6) and U.S. FOIA (b) to review the above concern. No further comments provided.	F 808		
{F 880} SS=D	NJAC 8:39-17.4(a)(1) 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,	{F 880}		1/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	R-C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD CALIFON, NJ 07830**

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{F 880}	Continued From page 3 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: (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	{F 880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	R-C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 880}	Continued From page 4 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: NOT CORRECTED Based on observation, interview, and review of facility policies, it was determined that the facility failed to follow appropriate hand hygiene for 1 of 6 staff (Dietary Aide #1) (DA #1) to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ...Before moving from work on a soiled body site to a clean body site on the same patient ...After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal.	{F 880}	1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this deficient practice. 2. Identifying other residents who could be affected by the deficient practice All residents have the potential to be affected by this deficient practice. 3. Measures or systemic changes to ensure that the deficiencies will not recur. The dietary aide was instructed by the DON to wash her hands by vigorously lathering hands with soap and rubbing them together, creating friction to all surfaces for a minimum of 20 seconds. Rinse hands thoroughly under running water. This is the facility's policy "Handwashing and Hand Hygiene.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	R-C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD CALIFON, NJ 07830**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 880}	Continued From page 5 On 12/26/24 at 11:50 AM, during the kitchen inspection the surveyor observed DA#1 apply hand soap to both hands and immediately place their hands under running water and began scrubbing their hands for 12 seconds, then proceeded to dry both hands using a paper towel. DA#1 disposed the paper towels in a garbage receptacle. The surveyor further observed DA#1 moved the garbage receptacle to a different area of the kitchen. DA#1 returned to the hand washing station and again applied hand soap to both hands and immediately placed their hands under running water and began scrubbing their hands for 12 seconds, then dried both hands using a paper towel. The surveyor interviewed DA#1 who stated they should scrub their hands for 20 seconds with the soap. The surveyor discussed to DA#1 regarding the two hand washing observations that DA #1 performed. DA#1 stated they thought they performed hand hygiene correctly. DA #1 also stated that they had multiple education of how to perform proper handwashing. On 12/26/24 at 12:30 PM, the U.S. FOIA (b) (6) [redacted]) provided the surveyor with a facility policy titled, "Handwashing and Hand Hygiene" with a revised date of 8/2015. Under the policy interpretation and implementation section of the policy it stated, "2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." Under the procedure section of the policy it stated, "Washing hands. 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces for a minimum of 20 seconds. 2. Rise hands thoroughly under running water."	{F 880}	4. Monitoring the continued effectiveness of systemic change. The Director of nursing will Inservice and check with competency testing for all staff according to hand washing/ hand hygiene procedures of the facility's policy. Disciplinary action will be given to those employees non complaint with hand washing policy. These results will be presented at the monthly QAPI by the administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	R-C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD CALIFON, NJ 07830**

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{F 880}	Continued From page 6 On 12/26/24 at 1:00 PM, the survey team met the U.S. FOIA (b) (6) and U.S. FOIA (b) to review the above concerns. No further comments provided. NJAC 8:39-19.4 (a) (1) (n)	{F 880}		

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
315467 Y1	A. Building B. Wing Y2	12/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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 F0550	Correction	ID Prefix F0582	Correction	ID Prefix F0609	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	12/09/2024	LSC	11/21/2024	LSC	11/21/2024
ID Prefix F0623	Correction	ID Prefix F0640	Correction	ID Prefix F0641	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.20(g)	Completed
LSC	11/22/2024	LSC	11/21/2024	LSC	11/21/2024
ID Prefix F0689	Correction	ID Prefix F0692	Correction	ID Prefix F0730	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.35(d)(7)	Completed
LSC	11/20/2024	LSC	11/22/2024	LSC	11/21/2024
ID Prefix F0755	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	11/21/2024	LSC	11/21/2024	LSC	11/21/2024
ID Prefix F0842	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(h)(1)-(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/21/2024	LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/30/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
061003	A. Building B. Wing	12/26/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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 11/21/2024	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 11/21/2024	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
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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 10/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315467 Y1	A. Building B. Wing Y2	2/28/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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 F0808 Reg. # 483.60(e)(1)(2) LSC	Correction Completed 01/22/2025	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/22/2025	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

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 10/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING **01** B. WING _____	**10/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD** **CALIFON, NJ 07830**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E 006		11/22/24

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

Electronically Signed | 11/25/2024

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

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	315467	A. BUILDING **01** B. WING _____	**10/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD** **CALIFON, NJ 07830**

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E 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on document review and interview it was determined that the facility failed to establish and maintain a comprehensive emergency preparedness plan that include strategies for addressing emergency events identified by the risk assessment, including the management of	E 006	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this	

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E 006	Continued From page 2 the consequences of power failure, water outage, and other emergencies that would affect the facility ability to provide care. This deficient practice had the potential to affect all 33 residents and was evidence by the following: A document review on 10/24/2024 at approximately 12:40 PM of the Folder titled 'All Hazards Emergency Preparedness & Response Plan', revealed no written documentation related to the fire pump, management and consequences of power failure, water outage, and fire watch policy did not include for continuing normal operation of the building due to power failure and water outage. The finding was verified by the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) at the time of the document review. NFPA 8:39-31.2(e)	E 006	deficient practice. Identifying other residents who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The All Hazard facility based and community based risk assessment for Little Brook was reviewed and updated to include strategies for addressing emergency events that were identified by the risk assessment. The Emergency Preparedness and Response Plan was updated by facility administration 11/15/24. The Emergency Preparedness and Response Plan is comprehensive and includes strategies for addressing emergency events identified by the facility Risk Assessment, including the management of the consequences of a power failure, water outage, resident elopement (policy attached) and other emergencies that would affect the ability to provide care. The facility has a fire pump policy attached. The Facility Fire Watch Policy was	

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E 006	Continued From page 3	E 006	updated to include continuing normal operation of the building when there is a power failure and water outage. Monitoring the continued effectiveness of systemic change: The Emergency Preparedness and Response Plan will be maintained in the Administrator's office. This book will be reviewed on an annual basis and updated as needed. The Maintenance Director will audit the Emergency Preparedness and Response Plan on a quarterly basis, to ensure it remains based on the all hazards approach, and includes strategies for addressing emergency events identified by the risk assessment. The Maintenance Director will report the findings of the EPP audit to the QAPI Committee quarterly to ensure on-going compliance. The Administrator will ensure compliance of these audits and take corrective action as needed.	
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1)	E 015		11/22/24

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E 015	Continued From page 4 [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies.	E 015		

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E 015	Continued From page 5 (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility documents, it was determined that the facility failed to a.) have an emergency menu readily available and b.) have all of the menu items in stock, in accordance with facility policy and emergency menu. The deficient practice was evidenced by the following: On 10/22/24 at 9:07 AM, the surveyor conducted a kitchen tour with the U.S. FOIA (b) (6) . On 10/22/2024 at 9:43 PM, the surveyors observed the dry storage area of the kitchen in the presence of the U.S. FOIA (b There was no identified emergency food in a designated area. The U.S. FOIA stated, "we do not have a separate emergency food supply, we have two weeks' worth of food in the facility." U.S. FOIA further stated, we do not have an emergency menu. On 10/24/24 at12:21 PM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) to review survey concerns. The U.S. FOIA (b) (stated they have an emergency menu,	E 015	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this deficient practice. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The Dietary Department was inserviced on the policy and procedure for maintaining an Emergency Menu. An emergency menu was made available to all staff. A copy is posted by the emergency food. All of the food items were purchased for the emergency menu, and are being stored in a separate area with clear	

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E 015	Continued From page 6 but the food is not kept separately due to storage space issues. The [U.S. FOIA (b) (6)] could not state why the [U.S. FOIA] does not have a copy of the emergency menu. On 10/24/24 at 1:15 PM, the [U.S. FOIA (b) (6)] provided the surveyor with a copy of the emergency program, 3 day emergency menu, and emergency food supply stock list. The emergency program with a date of July 2023 states, under the emergency food, "Little Brook maintains food supplies for our disaster meal menus ...Our facility has identified the minimal resources needed to provide food and water service to residents, staff and visitors during a shelter in place of three days." On 10/24/24 at 1:45 PM, the surveyor interviewed the [U.S. FOIA (b)] The [U.S. FOIA] stated they have never seen the emergency program, 3 day emergency menu, or emergency food supply stock list. The [U.S. FOIA] stated they are now keeping a separate area for the emergency food supply and requested a copy of the emergency menu. On 10/24/24 at 2:00 PM, surveyor attempted to contact the [U.S. FOIA (b) (6)]) via phone to ask about the emergency food supply. [U.S. FO] unable to be contacted after multiple attempts. On 10/29/24 at 1:44 PM, the survey team met with the [U.S. FOIA (b) (6)] [U.S. FOIA (b)] and [U.S. FOIA (b)] to review concerns. No further comments made regarding the emergency food supply.	E 015	signage designating them as the emergency menu items, not to be used for routine menus. Emergency food will be stored in the kitchen with proper signage. Attached are pictures of the emergency food and signage and separation for storage. Monitoring the continued effectiveness of systemic change: Emergency food supplies will be monitored by and kept up to date by the Head Cook. The Administrator will check monthly that the emergency food supplies are available and up to date. The findings will be given by the Administrator at the monthly QAPI meetings.	
K 000	NJAC 8:39-31.6(n) INITIAL COMMENTS	K 000		

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K 000	Continued From page 7 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/23/24, 10/24/24 and 10/25/24. Little Brook Nursing Home was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Little Brook Nursing Home is a 1-story building that was built in 50's. It is composed of Type V construction. The facility is divided into 6- smoke zones. The exterior LP generator does 100% of the building. The building utilizes an electric fire pump that draws water from a black plastic-lined pond. The generator outside the facility is stated to be tied to the fire alarm control panel, fire pump, cross corridor door holds open devices, exterior door releases, emergency facility lighting, and life safety components utilized to preserve life. The facility has 36 certified beds. At the time of the survey, the census was 32.	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:	K 223		11/22/24

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K 223	Continued From page 8 * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/24/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure the Kitchen door closed and latched in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.2.1. This deficient practice had the potential to affect 13 of 33 residents and was evidenced by the following: An observation at 11:36 AM revealed the Kitchen door did not fully close when released, leaving a gap for the passage of smoke. During an interview at the time of the observation, the U.S. FOI [redacted] confirmed the door would not close. The facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM. NJAC 8:39-31.2(e)	K 223	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this deficient practice. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The Maintenance Director fixed and adjusted the kitchen door to ensure it fully closes and latches when released, and there is no gap. This was tested 3 times in from front of Facility Administrator and all were successful. The Administrator and Maintenance Director will complete the log that reflects the functionality of self-closing devices on the kitchen doors.	

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K 223	Continued From page 9	K 223	Pictures of the kitchen door fully closed when released- without gaps are attached. Monitoring the continued effectiveness of systemic change: The Administrator will audit the completion of the Fire door functionality log on a weekly basis for 4 weeks to ensure it is functioning properly- or immediately corrected if not. The Administrator will then audit monthly for 2 months or until substantial compliance is achieved. The results of these audits will be presented to the QAPI Committee on a monthly basis.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/23/2024 in the presence U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), it was determined that the facility failed to provide illumination for the means of egress that was either continuously in operation or capable of	K 281	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this	11/22/24

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K 281	Continued From page 10 automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all 33 residents and was evidence by the following: 1. Observations at approximately 9:22 AM in the West Hall, revealed the light switch supplied normal and emergency lighting for the means of egress. Four sections approximately ten feet in length of the exit access had no lighting when the switch was in the off position. 2. Observations at approximately 9:45 AM in the East Hall, revealed the light switch supplied normal and emergency lighting for the means of egress. Six approximately 19 feet long sections of the exit access had no lighting when the switch was in the off position. In an interview at the time, the [redacted] and [redacted] confirmed the observations. The facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM. N.J.A.C 8:39-31.2(e)	K 281	deficient practice. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The U.S. FOIA (b) (6) [redacted] was re-educated on the need to provide illumination for the means of egress which is either continuously in operation, or capable of automatic operation without the need for manual intervention. New switches were installed to obtain continuous illumination of means of egress. These provide efficient and effective lighting for emergency egress. Pictures attached of the new switches. Scheduling pictures are attached as well. Monitoring the continued effectiveness of systemic change: The Maintenance Director will conduct audits 5 days a week for 4 weeks, then weekly for 8 weeks to ensure the illumination for means of egress is either continuous in operation, or capable of automatic operation without manual intervention. The results of these audits will be presented to the QAPI Committee on a monthly basis.	

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K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 10/23/2024 and 10/24/2024 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) it was determined that the facility failed to to conduct functional testing of emergency lighting system in accordance with NFPA 101: 2012 Edition, Sections 19.2.9.1 and 7.9. This deficient practice had the potential to affect all 33 residents and was evidence by the following: An observation with the U.S. FO and the U.S. FOI on 10/23/24, revealed battery backup emergency lighting was provided in various locations of the facility. A documentation review on 10/24/2024, revealed no records on annual and monthly emergency lighting functional testing was conducted. During an interview on 10/24/24 at 4:10 PM, the U.S. FOI confirmed the facility did not have any documented evidence the emergency lighting system was tested monthly and annually. The facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM NJAC 8:39-31.1(c), 31.2(e)	K 291	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this deficient practice. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The U.S. FOIA (b) (6) was re-inserviced on the policy for conducting routine preventative maintenance, and specifically on the need to conduct functional testing of emergency lighting system in accordance with NFPA 101. 2012 Edition. A monthly and annual emergency lighting functionality test was conducted and passed on 11/27/2024. The functional testing of the emergency lighting	11/27/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 12	K 291	system will be tasked and documented by the Maintenance Director on a monthly and annual basis. Monitoring the continued effectiveness of systemic change: The Administrator or Designee will audit the Log for monthly functional testing of emergency lighting system for 6 months to ensure it is being completed and documented appropriately to ensure compliance. The results of the audit will be presented to the QAPI meeting on a monthly basis.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		11/22/24

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	315467	A. BUILDING 01 B. WING _____	10/30/2024

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K 321	Continued From page 13 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/23/2024 in the presence U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101: 2012 Edition, Sections 19.3.2.1,19.3.2.1.3,19.3.2.1.5,19.3.6.3.5,19.3.6.4, 8.3, 8.3.5.1,8.4,8.5.6.2 and 8.7. This deficient practice had the potential to affect 33 all residents and was evidenced by the following: Observations from 9:15 AM to 4:10 PM revealed the following: 1. The physical therapy storage room was approximately 55 square feet containing combustibles and had no self-closing device on the door. 2. The East Utility/Supply Room was being used to store combustibles had no self-closing device on the door. 3. The West Clean Linen /Supply Room was being used to stored combustibles had no self-closing device on the door.	K 321	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were harmed by this deficient practice. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: Self-closing devices were installed on all 3 doors (PT, Utility & Linen rooms) After installation all self-closing devices work properly. Administrator and or designee will in-service the U.S. FOIA (b) (6) to inspect and test that all these doors and their self-closing devices work properly. Monitoring the continued effectiveness of	

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K 321	Continued From page 14 In an interview at that time, both the [redacted] and the [redacted] confirmed the observations. The facility's [redacted] and [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM.	K 321	systemic change Maintenance Director will have a log to maintain a monthly inspection of these doors. These results will be documented on a specified log. The Administrator or designee will audit the results of the log that will be presented by the Administrator at the monthly QAPI meeting.	
K 324 SS=F	NJAC 8:39-31.2(e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		11/22/24

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K 324	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review of facility documents on 10/23/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that 1 of 1 kitchen hood suppression systems was inspected monthly in accordance with NFPA 96, NFPA 10 and NFPA 17. This deficient practice had the potential to affect all 33 residents and was evidenced by the following: At 12:50 PM, the surveyor and U.S. FOIA (b) (6) observed in the facility kitchen, that the monthly inspection tag was blank and no required monthly inspection of the hood suppression system was logged. At that time, the surveyor interviewed the U.S. FOI ,who confirmed that the monthly inspection tag was not completed and left blank. The facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM. NJAC 8:39-31.2(e) NFPA 10,17,96	K 324	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was harmed by this deficient practice. Our vendor, NJ Ex Order 26.4(came and inspected fire hood suppression system. Tags were hole punched for dating. They sent an email to verify the results of the inspection. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The Administrator and Maintenance Director verified that tags were hole punched and up to date for kitchen hood inspection. Attached are pictures of the fire suppression system and tag hole punched. Monitoring the continued effectiveness of systemic change: Maintenance Director will maintain monthly log inspection of the hood suppression system to verify that the date	

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K 324	Continued From page 16	K 324	is written on the tag instead of hole punched. The log will be audited by the Administrator or designee. Results will be presented by the Administrator at the monthly QAPI meeting	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview and documentation review on 10/23/24 and 10/24/24 in the presence of the U.S. FOIA (b) (6)) U.S. FOIA (b) (6)), it was determined that the facility failed to a.) Ensure that their automatic sprinkler system fire pump pond was clean and free of debris from the pond water and	K 353	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were harmed. Our vendor for fire pump, pond and sprinkler, i.e. NJ Ex Order 26 conducted our annual	11/22/24

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K 353	Continued From page 17 maintained in optimal condition in accordance with the National Fire Protection Association (NFPA) 20 & 25, b.) Ensure the electric fire pump was tested monthly and documented as per NFPA 25, c) Ensure Sprinkler Quarterly Inspections were performed as required and d.) Ensure fire sprinkler heads are maintained in optimal condition as per NFPA 13. This deficient practice had the potential to affect all 33 residents and was evidenced by the following: 1. An observation at 9:45 AM in the kitchen, revealed 1 of 4 sprinkler heads was dirty with a coating of grease surrounding the activation and spray deflector of the head assembly. 2. At 10:15 AM, the surveyor, [redacted] and [redacted] observed the exterior pond that provided water to the fire pump. The pond was dirty and contained debris from the surrounding trees. 3. At 10:19 AM, the surveyor and [redacted] reviewed the Weekly Fire Pump Run Report in fire pump room. The last documented run date was 7/17/2024. In an interview at that time, the [redacted] confirmed the findings. A documentation review on 10/24/2024, revealed the following: A) Only one Quarterly sprinkler inspection dated 07/17/2024 was performed in the last 12 month and no further document was provided. B) The weekly task-maintenance document was provided by the [redacted] The record indicated under Fire Pump, "test pump that it's working" only, and	K 353	inspection in front of Administrator, MD and 2 NJ surveyors. The fire pump was evaluated to be compliant. Annual fire pump inspection report will be sent via email. The Maintenance Director obtained better equipment to maintain the pond clear of debris. This has been done and verified by the Assistant Administrator, on 11/19/24. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: Administrator or designee re-in-serviced maintenance director on monthly tasks and recording of findings on the status of the fire pump and the clarity of the water in the pond. Monitoring the continued effectiveness of systemic change: Attached are pictures of the cleaned sprinkler head, the pond clarity, and the inspection report completed on 10/25/2024. Maintenance director will conduct monthly tests on the fire pump and clarity of water. These results will be recorded on a monthly log. If any deficiencies arise during inspections, Maintenance director	

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K 353	Continued From page 18 initialed by the [U.S. FOIA] No indication for the run Time and the Results. D) There was no record on monthly pond maintenance inspections for 10/23, 11/23, 12/23, 1/24. 2/24 and 3/24. The Facility's policy for Fire Sprinkler and Pond Maintenance stated to document the findings of each monthly inspection, including the dates, inspection task performed and to maintain a record of inspection reports for future reference and compliance purposes. The [U.S. FOI] confirmed the findings during the observations and document review. The [U.S. FOIA] indicated he did not know the procedure for testing and documenting the fire pump information properly. The facility's [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM. This deficient practice was cite at the previous standard survey on 06/15/2023 NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 20, 25	K 353	will address them accordingly and promptly. The Administrator or designee will audit the monthly inspections of the fire pump and pond clarity. The results will be presented by the Administrator or designee at the monthly QAPI meeting.	
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	K 355		11/25/24

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K 355	Continued From page 19 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/23/24 and 10/24/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to conduct monthly inspections on fir extinguishers and provide the required instructional placards near the Class K portable fire extinguisher in accordance with NFPA 101: 2012 Edition, Sections 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition. This deficient practice had the potential to affect all 33 residents and was evidenced by the following: Observations on 10/23/2024 with U.S. FO and U.S. FO from 9:50 AM to 3:45 PM, revealed the following: 1. Ten of 10 fire extinguishers, including one (1) K-extinguisher, were last inspected and signed on 08/2024, more than a year ago. 2. The K-type portable extinguisher in the Kitchen was blocked with garbage can and had no instructional placards near the Class K portable fire extinguisher indicating the portable extinguisher is to be used only after the main system has been discharged. In an interview at that time, U.S. FOI confirmed the observations. An observation with the U.S. FOI on 10/24/2024 at 8:48 AM in the front Lobby, revealed extinguisher by the front door was blocked with a wheelchair. In an interview at that time, both U.S. FO and U.S. FOI	K 355	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this deficient practice. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The U.S. FOIA (b) (6) was re-educated on the need to ensure all fire extinguishers including the K-extinguisher are inspected monthly and signed off on within 30 days of the previous inspection. Appropriate signage was placed by the fire extinguisher next to the kitchen door. Attached is a picture of the cleared extinguisher and the K- Extinguisher appropriate signage. The Garbage receptacle was removed and placed in another location within the kitchen to make signage and fire extinguisher visible in case of emergency. Monitoring the continued effectiveness of systemic change.	

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K 355	Continued From page 20 confirmed the observations. The facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM. NJAC 8:39-31.2(e) NFPA 10	K 355	The Maintenance Director will be conducting monthly audits to verify that all fire extinguishers are clear of any blockage. The Administrator or designee will audit the results of the monthly extinguisher log, and verify that all fire extinguishers are not blocked. The Administrator or designee will present results of the audit to the QAPI Committee on a monthly basis.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363		11/25/24

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K 363	Continued From page 21 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/23/24 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke and door labels were legible in accordance with the requirements of NFPA 101: 2012 LSC Edition, Sections 19.3.6, 19.3.6.3, 19.3.6.3.1, 19.3.6.5 and 19.3.6.3.14. This deficient practice was identified for 6 of 20 resident rooms and 3 of 3 hallway doors observed, had the potential to affect all 33 residents and was evidenced by the following: Observations from 1:10 PM to 3:15 PM in the presence of the U.S. FOIA revealed the following: 1. Resident Rooms #10, 12, 16 and 18 had a gap on top of the doors when tested by the U.S. FOIA 2. Resident Rooms #6 and 8 doors were not latching when tested by U.S. FOIA 3. The East and West hallway Corridor Door	K 363	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were harmed. Door gaps in rooms 10, 12, 16, 18 were filled and show no more gaps when door is closed. These projects were observed and approved by Maintenance Director, Administrator and Administrative Assistant. Rooms 6 and 8 latches were fixed so that door fully closes. These fixtures and functionality were tested and approved by Maintenance Director, Administrator and Administrator Assistant. East and West Hallway corridor door fire labels were fixed to be visible.	

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K 363	Continued From page 22 labels were painted not legible to indicate door rating. At the time of observations, the surveyor interviewed the [redacted] who confirmed the above findings. The facility's [redacted] and [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The Administrator and or designee will create and in-service [redacted] on a monthly log to check the fire/smoke safety and appropriate measures on all doors. The Maintenance director will conduct and record the status of these doors. If any deficient is found within the inspection, the Maintenance Director will repair accordingly. Monitoring the continued effectiveness of systemic change: The Administrator will review the monthly log. The Administrator will present the results at the monthly QAPI meeting.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		11/25/24

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K 511	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/23/2024 in the presence U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to ensure that 1 of 1 boiler was equipped with a remote manual stop station in accordance with NFPA 101:2012 Edition, Sections 9.5 and 19.5.1, NFPA 54 National Fuel and Gas Code, and NFPA 70 National Electric Code. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:50 PM in the boiler room, revealed that 1 of 1 boiler was not equipped with a Remote Manual Emergency Stop Switch remote from the unit. There was an emergency stop located on the boiler that was not remote from the unit to shut down in a catastrophic failure. In an interview at the time of observation, the U.S. FOIA and U.S. FOIA confirmed the boiler was not equipped with a manual stop station that was remote from the unit. The facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were informed of the deficient practice during the Life Safety Code exit conference on 10/25/2024 at 3:55 PM. NJAC 8:39-31.2(e) NFPA 54,70	K 511	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: A remote manual stop station has been placed by room 23. This has a switch to remotely turn off boiler in an emergency. Attached is a picture of the shut off switch. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The Maintenance Director will have a log to check that the remote shut off switch is tested monthly. The Administrator or designee will review the remote shut off switch log. These findings will be presented by the Administrator at the monthly QAPI meeting.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		11/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING 01 B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 761	Continued From page 24 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 10/23/2024 and 10/24/2024 in the presence of U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the fire doors assemblies were inspected, tested and documented annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101:2012 Edition, Section 19.7.6, 8.3.3.1 and NFPA 80: 2010 Edition, Section 5.2,5.2.3. This deficient practice had the potential to affect all 33 residents and was evidenced by the following: Observations with U.S. FO and U.S. FOI during the tour on 10/23/2024 from 9:15 AM to 3:35 PM, revealed fire rated doors at various locations including, horizontal exit, hazardous enclosures and exits. A documentation review on 10/24/2024 at 9:25 AM, revealed that facility did not provide policy	K 761	How any corrective action will be accomplished for those residents found to have been affected by the deficient: No residents were harmed. Abcode, fire alarm security, inspected on 7/8/24 tested, and documented that all fires doors released on alarm and passed. Attached is the report. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. The Maintenance Director will log monthly that all doors close properly and that there are no gaps, doors close and shut completely and there is visible wear and tear on the doors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING 01 B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 761	Continued From page 25 and procedures for fire door assemblies and no documentation to indicate fire door assemblies were inspected and tested annually. In an interview at the time, the [U.S. FOI] confirmed the observation. The facility's [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	The Administrator will create a policy and procedure plan for fire door assemblies and that the fire doors are inspected and tested annually by an individual who could demonstrate knowledge and understanding of operating components. The Administrator re-inserviced the [US FOIA (b)(6)] to schedule an annual inspection of all fire doors by the fire alarm company. This will be added to the yearly LB Calendar of inspections. Measures or systemic changes to ensure that the deficiencies will not recur: The Administrator will review the monthly fire door inspection log and monitor the LB calendar of inspections. These findings will be presented at the monthly QAPI meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or	K 914		11/25/24

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	315467	A. BUILDING 01 B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 26 equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review on 10/24/2024 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 20 of 20 resident rooms, had the potential to affect all 33 residents and was evidenced by the following: At 9:45 AM, while reviewing documentation provided by the U.S. FOIA the surveyor observed that no annual electrical inspection was performed for the facilities, non-hospital grade outlets in resident rooms for polarity, grounding, and tension. The U.S. FOI confirmed that the facility had non-hospital outlets installed in resident rooms but could not provide any documentation indicating the Annual electrical inspection was being performed. The facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM.	K 914	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were harmed. Annual electrical inspection was conducted on 11/27/2024. The U.S. FOIA (b) (6) was re-inserviced to test all non-hospital grade receptables. The electrical receptacles in all resident rooms will be tested for grounding, polarity, and blade tension on a semi annual basis. These records will be logged by the Maintenance Director. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: Monitoring the continued effectiveness of systemic change: The Administrator or designee will review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING **01** B. WING _____	**10/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD** **CALIFON, NJ 07830**

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K 914	Continued From page 27 NJAC 8:39-31.2(e) NFPA 70, 99	K 914	the inspections bi-annual by the Maintenance Director. The Administrator will present the findings at the monthly QAPI meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918		11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING 01 B. WING	10/30/2024

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K 918	Continued From page 28 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observations, interviews, and record review of facility documents on 10/23/24, 10/24/24 and 10/25/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) it was determined that the facility failed to a) exercise the emergency generator under full load monthly, b) Perform a weekly non-load test, c) conduct a load bank test on the emergency generator annually where the generator uses less than 30% of the rating, d) ensure the emergency generator assumed the building load within 10 seconds of a power failure, and e) ensure a remote manual stop station for the generator was provided in accordance with NFPA 101: 2012 Edition, NFPA 99: 2012 Edition, Sections 6.4.4,6.5.4, 6.6.4, and NFPA 110: 2010 Edition, Section 5.6.5, 5.6.5.1, 8.4,8.4.1, 8.4.2, 8.4.2.3, 8.4.9, 8.4.9.1 to 8.4.9.7. These deficient practices had the potential to affect all 33 residents and were evidenced by the following: 1. On 10/23/2024 at 12:18 PM, the surveyor, U.S. FOI and U.S. FOIA observed that the facility generator was outside and encased. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. In an interview at the time, the U.S. FOI and U.S. FOIA confirmed there was no remote manual stop station.	K 918	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were harmed. Weekly tests were printed to show the results of weekly tests and functionality of the generator. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: Weekly tests are run and tests results are emailed. Documentation has been printed and put within the maintenance task book. Monitoring the continued effectiveness of systemic change: The Maintenance Director will print out the results of weekly generator tests and place within the maintenance book. Our vendor will be conducting a yearly generator full load test, as well as installing a remote shut off switch to kill	

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K 918	Continued From page 29 2. A documentation review on 10/24/24 for the emergency generator provided by the [U.S. FOIA] revealed the following: a) The provided inspection document from the [U.S. FOI] did not indicate any weekly generator testing. b) No records on monthly generator load testing with the required transfer times. c) The annual generator maintenance report-dated 9/9/24 by vendor #1 did not indicate whether the generator was run or that a load test was performed. d) The report dated 9/27/2024 by Vendor #2 indicated the generator runs and produces voltage 242.3, "Customer did not want to do a Transfer Test". In an interview at the time, [U.S. FOI] and [U.S. FOIA] confirmed the findings. The facility's [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] [redacted] were informed of the deficient practice during the Life Safety Code exit conference on 10/25/2024 at 3:55 PM. This deficient practice was cited at the previous standard survey on 06/15/2023 NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	power to the generator in case of an emergency. This will be completed on 11/27/24. The Administrator will review the weekly generator tests and present the findings at the monthly QAPI meeting.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc	K 921		11/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING **01** B. WING _____	**10/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD** **CALIFON, NJ 07830**

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K 921	Continued From page 30 CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 10/23/2024, 10/24/2024 and 10/25/2024 in the presence of the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to provide	K 921	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING 01 B. WING _____	10/30/2024

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K 921	Continued From page 31 the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all 33 residents and was evidenced by the following: Observations on 10/23/2024 from 9:15 AM to 3:45 PM, revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility. In an interview at the time, the U.S. FOI and U.S. FO confirmed the findings. A documentation review on 10/24/2024, revealed no policy on patient care related electrical equipment. In an interview at that time, the U.S. FOI and U.S. FO confirmed the findings and acknowledged that there was no policy. The facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at Life Safety Code survey exit conference on 10/25/2024 at 3:55 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	No residents were harmed. Inspection stickers were purchased and have been placed on fixed and portable patient care related equipment after inspection. A policy was created by the Administrator to properly test and maintain electrical equipment in the facility. Attached is the electrical policy. Identifying other residents who could be affected by the deficient practice: All residents had the potential to be affected by this deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: The Administrator or designee re-educated the U.S. FOIA (b) (6) on the policy and procedure for testing and maintenance of electrical equipment. Monitoring the continued effectiveness of systemic change: A maintenance task log was created so that monthly checks will be conducted, documented and fixed accordingly by the Maintenance Director. The results of the log will be audited by the Administrator and given at the monthly QAPI meeting.	

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
315467 Y1	A. Building B. Wing Y2	2/28/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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 E0006 Reg. # 483.73(a)(1)-(2) LSC	Correction Completed 11/22/2024	ID Prefix E0015 Reg. # 483.73(b)(1) LSC	Correction Completed 11/22/2024	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	
10/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315467 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/28/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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 K0223	11/22/2024	LSC K0281	11/22/2024	LSC K0291	11/27/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	11/22/2024	LSC K0324	11/22/2024	LSC K0353	11/22/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	11/25/2024	LSC K0363	11/25/2024	LSC K0511	11/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0761	11/25/2024	LSC K0914	11/25/2024	LSC K0918	11/27/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0921	11/25/2024	LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/30/2024	☐ YES ☐ NO