STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	**303 ELM STREET PERTH AMBOY, NJ 08861**

(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 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) [(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.	E 015		1/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 01/16/2024

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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E 015	Continued From page 1 *[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. (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 upon observations, interviews and review of facility documents, it was determined that the facility failed to a.) develop an emergency menu for an ethnic population which followed a different menu and b.) have all menu items in stock and in amounts to meet resident needs, in accordance with facility policy and the emergency menu. The deficient practice was evidenced by the following: On 12/12/23 at 10:11 AM, the surveyor interviewed the Assistant Director of Nursing who stated that the third floor was the home for the facility's Indian population.	E 015	1. An emergency menu was developed for the ethnic resident population. All needed menu items will be kept in stock. 2. All residents on the Indian unit have the potential to be affected. No residents were affected. 3. The emergency menu was developed and approved by the Registered Dietitian. The emergency food supply order was placed and delivered. The RD or designee and Food Service Director or designee will check the supply weekly to ensure it is stocked appropriately. The RD and FSD were educated on the requirements of the emergency menu and emergency food	

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E 015	Continued From page 2 On 12/12/23 at 11:00 AM, the surveyor met with facility Vice President of Operations, the Licensed Nursing Home Administrator (LNHA), the Director of Nursing and the Infection Preventionist for an entrance conference meeting. The facility was licensed for 250 beds and the facility census was 227 (the number of residents who currently resided at the facility). On 12/12/23 at 11:25 AM, the surveyor conducted a kitchen tour with the Food Service Director (FSD) and observed the Indian kitchen preparation room. At 12:18 PM, the surveyor continued the kitchen tour with the FSD and observed the emergency food area which had juices, peanut butter, tuna, desserts, jelly, crackers, saltines, cans of three bean salad, chips and crispy rice cereal. The FSD stated, "I don't know what the Indian residents need for emergency food. For breakfast they are okay with cereal." On 12/14/23 at 10:00 AM, the surveyor interviewed the Program Director (PD) for the Indian unit. She stated that the facility started a program for Indian residents in 2005. The PD stated that she prepared the menus for the Indian residents with guidance from the Registered Dietitian (RD). She stated that the menus "go by seasons and by holidays" and that she followed the parameters provided by the RD so that the residents received the nutrient's they required. At 10:20 AM, the surveyor continued the interview with the PR. She stated that there was no emergency menu for the Indian population and that they would get food from either a restaurant	E 015	supply. 4. The FSD or designee will audit the Emergency supply weekly for 4 weeks and then monthly for 3 months, comparing the supply to the Emergency menu to ensure it is appropriately stocked. The RD or designee will audit the supply monthly for 3 months. The FSD or designee will be responsible for ensuring that the emergency supply is always stocked appropriately. Findings of audits will be reported to the Administrator and the Quality Assurance Committee which meets quarterly and as needed.	

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E 015	Continued From page 3	E 015		

or another an Indian facility nearby if there was an emergency. The PR further stated, the Indian residents could eat bread and butter, peanut butter and jelly sandwiches, vegetarian sandwiches, milk and Indian snacks (Bhel [made with puffed rice, vegetables and a tangy tamarind sauce] or Panipuri [a deep-fried breaded sphere filled with potato, onion, or chickpea.]).

On 12/14/23 at 11:23 AM, the surveyor observed 25 residents in the Indian activity room.

On 12/14/23 at 1:02 PM, the FSD provided the surveyor with an undated "Three Day Disaster Menu." The meal patterns were as follows:

BREAKFAST
Day 1

(1 box) Assorted Dry Cereal
6 Crackers
2 ounces (oz) Peanut Butter (PB)
8 oz Non-Fat Dry Milk
4 oz Orange Juice
3 Crackers

Day 2

(1 box) Assorted Dry Cereal
6 Crackers
2 ounces (oz) Peanut Butter (PB)
8 oz Non-Fat Dry Milk
4 oz Orange Juice
3 Crackers

Day 3

(1 box) Assorted Dry Cereal
6 Crackers

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E 015	Continued From page 4	E 015		

2 ounces (oz) Peanut Butter (PB)
8 oz Non-Fat Dry Milk
4 oz Orange Juice
3 Crackers

3 Day Supply Required for Breakfast for 227 Residents

681 boxes of Assorted Dry Cereal
4086 Crackers
1362 oz PB
2724 tablespoons (tbsp) Dry Milk Powder [4 tbsp Dry Milk Powder / 8 oz milk]
2724 oz Orange Juice
2043 Crackers

LUNCH

Day 1
2 oz PB & Jelly Sandwich (SW)
2 Cookies
4 oz Diced Pears
4 oz Cranberry or Apple Juice
4 oz Non-Fat Dry Milk

Day 2

3 oz Salmon Salad SW
4 oz Fruit Mix
4 oz Three-Bean Salad/Crackers
4 oz Cranberry or Apple Juice
4 oz Non-Fat Dry Milk

Day 3

3 oz Tuna Salad SW
4 oz Pineapples
4 oz Beet Salad

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E 015	Continued From page 5 4 oz Cranberry or Apple Juice 4 oz Non-Fat Dry Milk 3 Day Supply Required for Lunch for 227 Residents 454 oz PB, 681 oz Salmon, 681 oz Tuna Mayonnaise 454 Cookies, 908 oz Fruit Mix, 908 oz Pineapple 908 oz Diced Pears, 908 oz Three-Bean Salad/Crackers, 908 oz Beet Salad 2724 oz Cranberry or Apple Juice 1362 tbsp Dry Milk Powder DINNER Day 1 3 oz Tuna Salad SW Mayonnaise 4 oz Green Beans 4 oz Diced Peaches 4 oz Cranberry or Apple Juice 4 oz Non-Fat Dry Milk Day 2 2 oz PB & Jelly SW 2 Cookies 4 oz Mandarin Oranges 4 oz Cranberry or Apple Juice 4 oz Non-Fat Dry Milk Day 3 3 oz Salmon Salad SW 4 oz Diced Carrots/Crackers 4 oz Apricots 4 oz Cranberry or Apple Juice 4 oz Non-Fat Dry Milk	E 015		

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E 015	Continued From page 6	E 015		

Continued From page 6

3 Day Supply Required for Dinner for 227 Residents

454 oz PB, 681 oz Salmon, 681 oz Tuna
Mayonnaise
908 oz Green Beans, 454 Cookies, 908 oz Carrots
908 oz Diced Peaches, 908 oz Mandarin Oranges, 908 oz Apricots
2724 oz Cranberry or Apple Juice
1362 tbsp Dry Milk Powder

This document also included the following statement, "This menu does not require any cooking equipment."

On 12/20/23 at 9:51 AM, the surveyor conducted an additional kitchen tour, with the FSD, in the presence of a second surveyor. The following emergency food items were observed in a separate room in the basement:

Dry cereal 12 cases / 96 containers per case
Crackers 5 cases / 500 per case
Peanut butter 2 cases / 60 pounds per case
Orange Juice 12 cases / 6 quarts per case
Cranberry Juice 12 cases / 6 quarts per case
Apple Juice 12 cases / 6 quarts per case
Non-Fat Dry Milk 2 cases / 50 pounds per case
Pears 6 cases / 150 4 oz portions per case
Green Beans 2 cases / 150 4 oz portions per case
Carrots 2 cases / 150 4 oz portions per case
Cookies 12 cases / 100 per case
Peaches 2 cases / 150 4 oz portions per case
Mandarin oranges 2 cases / 150 4 oz portions per case
Jelly 2 cases
Three-bean salad 2 cases / 150 4 oz portions per

E 015 | E 015

Continued From page 7
case
Tuna 2 cases / 6 - 66.5 oz cans/ case

Menu items that the FSD acknowledged were not present included fruit cocktail mix, pineapple, beets, canned salmon and apricots. The FSD further stated that apricots were no longer available from the vendor.

A comparison of items in the facility's emergency stock verse the required amount to nourish 227 residents per the facility "Three Day Disaster Menu" was as follows:

Crackers 5 cases / 500 per case yielded 2500 portions
[6129 portions were required to satisfy the census per the menu]

Peanut butter 2 cases / 60 pounds per case yielded 1920 ounces
[2270 ounces were required to satisfy the census per the menu]

Orange Juice 12 cases / 6 quarts per case yielded 1920 ounces
[2270 ounces were required to satisfy the census per the menu]

Cranberry Juice 12 cases / 6 quarts per case yielded 2304 ounces
Apple Juice 12 cases / 6 quarts per case yielded 2304 ounces.
[collectively 5448 ounces of cranberry and/or apple juice were required to satisfy the census per the menu]

Non-Fat Dry Milk 2 cases / 50 pounds per case yielded 3200 tbsp.

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E 015	Continued From page 8	E 015		

[5448 tbsp. were required to satisfy the census per the menu]

Tuna 2 cases / 6 - 66.5 oz cans / case yielded 798 ounces
[1362 ounces were required to satisfy the census per the menu]

On 12/20/23 at 11:17 AM, the surveyor interviewed the RD in the presence of the survey team. She provided the surveyor with the "Indian Diet Manual" which included a food guide pyramid and the nutritional breakdown for a typical diet. Proteins listed on the pyramid included almonds, cashews, chicken, chickpeas, lentils, beef, lamb and shrimp. The RD stated that the population on the third floor, "would not eat beef, lamb, or shrimp and would sometimes eat chicken but 99 percent of the population are lacto-ovo vegetarians [primarily a plant-based diet which excludes meat, fish and poultry but includes dairy and eggs]." She further stated that she approved the emergency menu but was not involved with the purchase of emergency food or water or stock status. In addition, she stated that the emergency menu would not accommodate the Indian population. The RD stated that after surveyor inquiry, the FSD and the PD discussed this concern and decided that they "would be okay with the residents eating peanut butter and jelly sandwiches."

On 12/20/23 at 1:40 PM, the surveyor interviewed the FSD who stated the administrator was ultimately responsible for the emergency food "but it's my responsibility to order the emergency supplies and get them."

On 12/20/23 at 4:02 PM, the LNHA

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	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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E 015	Continued From page 9 acknowledged the concern related to the emergency menu and the Indian population and stated, "we are responsible for them." On 12/21/23 from 9:08 AM through 9:20 AM, the surveyor interviewed three unsampled residents who resided on the third-floor Indian unit. All three stated that they would not eat fish but would eat peanut butter and jelly sandwiches. They also stated that they would eat legumes. Review of the undated facility policy "Dinning Services Instructions for Implementing Menu to be Used in the Event of a Disaster or Emergency," included to "provide a planned menu that is simplified and nutritious to be used during an emergency or disaster event." It also included that "food items designated in the emergency must be available at all times." It further included that the " ... Dietary Manager utilizing the supply checklist (adjusted for number of beds in the facility), shall inventory the storeroom to verify all food and supply items are present in the quantities specified." The policy included "An adequate supply of canned or processed meats or meat substitutes, fruits, fruit juices, vegetables, dry cereal, crackers, peanut butter, jelly, cookies and powdered milk shall be in this facility to serve nutritionally adequate meals for at least three days ... in case of emergency." NJAC 8:39-31.6(n)	E 015		
F 000	INITIAL COMMENTS Complaint #: NJ156272, NJ159698, NJ160160, NJ162234, NJ166275, NJ166739, NJ168177	F 000		

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F 000	Continued From page 10 Survey Date: 12/21/2023 Census: 227 Sample: 35 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 observations, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 2 of 38 residents (resident #178 and #119) reviewed for accurately coding the MDS. This deficient practice was evidenced by the following: 1. On 12/12/2023 at 11:15 AM, the surveyor observed Resident #178, sitting in a wheelchair, in activities. On 12/13/2023 at 1:00 PM, the surveyor observed Resident #178 in the dining room after lunch. The resident was sitting upright in the	F 641	1. The MDS for residents 178 and 119 were corrected. 2. All residents have the potential to be affected. No other residents were found to be affected after audit. 3. The MDS were corrected and will be audited monthly for accuracy. The MDS coordinator was educated on accuracy of assessments. 4. Two MDS will be audited monthly by an MDS coordinator from a sister facility, regional MDS coordinator, or designee, for three montly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	1/30/24

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F 641	Continued From page 11 wheelchair and was awake and alert. The Resident responded verbally to the surveyor and stated that he/she was ok. On 12/14/2023 at 12:50 PM, the surveyor observed Resident #178 in the dining room for lunch, which was already served. The resident appeared well groomed and calm. A review of Admission Record (AR) revealed that resident #178 was admitted to the facility with diagnoses that included but were not limited to: Ex Order 26. 4B1 . Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, revealed under section Ex Order 26. 4B1 was coded "yes." Due to section Ex Order 26. 4B1 being coded as yes, no Ex Order 26. 4B1 was assessed. During the observation period of the MDS (the time-period in which the resident condition or status is captured by the MDS assessment) the progress notes were reviewed and there were no notes which identified the resident as being NJ Exec. Order 26:4.b.1 The progress notes titled "Skilled/COVID Documentation" on NJ Exec. Order 26:4.b.1 indicated that resident was awake, alert and verbally responsive	F 641		

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F 641	Continued From page 12 with confusion. A review of an assessment titled, "Social Service Department-Quarterly/Medicare Assessment/Discharge" dated Ex Order 26. 4B1, revealed: "Section II. Orientation/BIMS; A. ORIENTATION/COMMUNICATION: 1. NJ Exec. Order 26:4.b.1 On 12/14/23 at 1:14 PM, the surveyor interviewed the Registered Nurse /Unit Manager (RN/UM) regarding completion and accuracy of the MDS. The RN/UM stated, "I do not complete the MDS, the MDS Coordinator is responsible for completing and checking the MDS for accuracy." On 12/14/23 at 2:30 PM, the surveyor interviewed the MDS Coordinator in the presence of the survey team, who stated, "that she had been employed at the facility since Ex Order 26. and has been doing MDS since Ex Order 26. and that she was responsible for doing the MDS for the NJ Exec. Or floor (the floor Resident #178 resided on)." This surveyor discussed the coding of the MDS assessment dated Ex Order 26. 4B1 in which the resident was coded as being NJ Exec. Order 26:4.b.1 She stated , "Resident #178 was not in a Ex Order 26. 4 and that the section Ex Order 26. 4B1 was coded in error. This surveyor asked the MDS Coordinator who was responsible for checking the assessment for accuracy and she stated the MDS Director." This surveyor attempted to interview the MDS Director however was made aware by the Director of Nursing (DON) that she was away on vacation. On 12/18/23 at 9:41 AM, the surveyor interviewed	F 641		

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F 641	Continued From page 13 the DON on the accuracy and completion of the MDS. The DON stated the MDS's were completed by both the MDS Coordinator and the MDS Director. She stated that the MDS Director was responsible for checking the accuracy of the assessment. 2. On 12/18/2023 at 9:26 AM, the surveyor interviewed Resident #119, who stated that he/she used NJ Exec. Order 26:4.b.1 for repositioning in bed as well as an assist to get out of bed due to Ex Order . A review of the AR revealed the resident had diagnoses which included but were not limited to: Ex Order 26. 4B1 Review of the quarterly MDS dated Ex Order 26. 4B1, revealed the resident had BIMS score of Ex Or out of 15, which indicated that Resident #119 had an Ex Order 26. 4B1. The MDS also coded section Ex Order 26. 4B1 as the resident with a Ex Order 26. 4B1 with a NJ Exec. Order 26:4.b.1 less than daily. Review of the Order Summary Report reflected a physician's order dated Ex Order 26. 4B1 for NJ Exec. Order 26:4.b.1 " and "NJ Exec. Order 26:4.b.1 " On 12/14/23 at 2:30 PM, the surveyor interviewed the MDS Coordinator in the presence of the survey team. She reviewed the residents quarterly MDS dated Ex Order 26. 4B1 in the electronic medical record and acknowledged that she coded	F 641		

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F 641	Continued From page 14 the resident as having NJ Exec. Order 26:4.b.1 and "that was a coding error." On 12/18/23 at 9:45 AM, the surveyor interviewed the Licensed Practical Nurse (LPN/UM) who stated that the NJ Exec. Order 26:4.b.1 for Resident #119 were not NJ Exec. Order 26:4.b.1 . Review of the Consent for NJ Exec. Order 26:4.b.1, dated NJ Exec. Order 26:4.b reflected that NJ Exec. Order 26:4.b.1 were indicated as a NJ Exec. Order 26:4.b.1 as per resident preference. This document was signed and dated by the resident and the LPN/UM. Review of the "Job Description MDS Coordinator" revealed Job Summary:"The MDS Nurse is to assess the residents' physical and mental function and document data on the Minimum Data Set forms completely and accurately. Under Duties and Responsibilities: 1. Interview residents, residents' representatives and others for information related to the minimum data set assessment. 2. Examine residents to collect information related to the minimum data set assessment. 3. Review medical records and records related to residents' health status to collect information related to the minimum data set assessment. 4. Enter data onto the computer program for minimum data set assessments. 5. Assume accountability and responsibility for accuracy of minimum data set (MDS) assessment information. Review of the facility's policy titled "Resident Assessment Instrument (RAI) Process" which was revised 04/2023, revealed Purpose: "To ensure that the Minimum Data Sets (MDS) for	F 641		

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F 641	Continued From page 15 each resident is completed accurately and timely in accordance with State and Federal regulations. To ensure that each resident is assessed for specific needs in order to attain or maintain the resident's highest practicable well-being." NJAC 8:39-11.1	F 641		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to a.) change the oxygen tubing as directed by the Physician order and follow the facility policy, b.) develop a care plan to address the resident requiring oxygen upon readmission to the facility and c.) re-evaluate the Physician's Order for the continuous need of oxygen at 4 liters (L) via nasal cannula. This deficient practice was identified for 1 of 1 resident, Resident #63, which was reviewed for Ex Order 26. 4B1. This deficient practice was evidenced by the following: On 12/12/ 2023 at 11:20 AM, the surveyor entered the resident's room and observed the	F 695	1. The tubing for resident #63 was discarded and replaced. The order for resident #63 was changed to prn Ex Order 26. 4B1 . A care plan was developed for resident #63. 2. All residents on Ex Order 26. 4B1 have the potential to be affected. Residents on Ex Order 26. 4B1 were checked and no additional deficient practices were found. 3. Nursing staff were educated on changing of Ex Order 26. 4B1 supplies, orders for Ex Order 26. 4B1, weaning off Ex Order 26. 4B1, and care planning for Ex Order 26. 4B1 use. 4. The Director of Nursing or designee will audit one resident on Ex Order 26. 4B1 weekly for one month, and then monthly	1/30/24

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F 695	Continued From page 16 Ex Order 26. 4B1 connected to an Ex Order 26. 4B1 The surveyor observed the Ex Order 26. 4B1 was labeled with the date of Ex Order 26. 4B1. At this time, Resident #63 was observed sitting in the dining room, in a wheelchair, during group activities. The resident was not wearing Ex Order 26. 4B1. The surveyor reviewed the medical record of Resident #63. Review of the Admission Record (an admission summary) reflected that resident #63 was admitted to the facility with diagnoses which included but are not limited to: Ex Order 26. 4B1 Ex Order 26. 4 Review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, revealed that Resident #63 had a Ex Order 26. 4B1 score of Ex out of 15, which indicated that the resident was Ex Order 26. 4B1. In section (I) of the Ex Order 26. active Ex Order 26. 4B1 failure was checked and in section Ex Order 26. 4 it was documented that the resident had Ex Order 26. 4B1 unspecified with Ex Order 26. 4B1. In section O of the Ex Order 26. 4B1 number	F 695	for 2 months to ensure supplies have been changed as ordered and orders are accurate. Findings will be submitted to the Administrator and Quality Assurance committee which meets quarterly and as needed.	

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F 695	Continued From page 17 Ex Order 26. 4B1 was not checked in the column under while a resident. This section indicated that resident #63 was not on Ex Order 26. 4B1 during the observation period (the time period over which the resident's condition or status is captured by the MDS assessment). A review of the Ex Order 26. 4B1 Medication Administration Record (MAR) revealed a physician order dated Ex Order 26. 4B1 to "CHANGE Ex Order 26. 4B1 " every night shift every Tues (Tuesday). Further review revealed the order had been signed as completed on 11/7/23, 11/14/23, 11/21/23, and 11/28/23. A review of the December 2023 MAR revealed a physician order dated Ex Order 26. 4B1 to "CHANGE Ex Order 26. 4B1 " every night shift every Tues (Tuesday). Further review revealed the order had been signed as completed on 12/5/23; 12/12/23. A review of the Ex Order 26. 4B1 Treatment Administration Record (TAR) revealed a physician order dated NJ Exec. Order 26:4. for "Ex Orde continuously at NJ Exec. Order 26 via Ex Order 26. 4B1 every shift." Further review revealed that ordered had been signed as completed from 12/1/2023 to 12/11/2023 for the day, Eveni (evening), and night shifts. Review of the "Weights and Vitals Summary" revealed the resident's Ex Order 26. 4B1 was documented as Ex Order 26 or higher on room air from 09/24/2023 until 12/12/23. Review of the care plan revealed that there was no care plan developed or implemented for NJ Exec. Order 26:4.b.1.	F 695		

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F 695	Continued From page 18 On 12/18/2023 at 10:24 AM, this surveyor interviewed the Director of Nursing (DON), who stated prior to weaning a resident off continuous oxygen it should be discussed with the Physician or Nurse Practitioner, an assessment was completed for 3 or more days which included the oxygen saturation and the results were documented in the medication administration record and skilled nursing notes and discussed with the Physician or Nurse Practitioner to determine whether the order should be changed. The DON stated that respiratory equipment (nebulizer, oxygen tubing etc.) was changed on the 11-7 shift every Tuesday. On 12/18/2023 at 10:38 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that Resident #63 did not have Ex Order 26. 4B1 on because he/she kept removing it. She stated that he/she does not become NJ Exec. Order 26:4. Ex Order 26. 4B1. The LPN stated that Ex Order 26. 4B1 was changed weekly on the 11-7 shift. On 12/18/2023 at 10:47 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who stated the Resident #63 has not been wearing Ex Order 26. 4B1. She further explains that initially when it was ordered the resident would wear the Ex Order 26. 4B1 but when the resident began to feel better, he/she began to remove it. The RN/UM stated that Ex Order 26. 4B1 was changed weekly by the 11-7 shift. On 12/18/2023 at 11:30AM, the surveyor interviewed the Certified Nurse Assistant (CNA), who stated that Resident #63 does not wear Ex Order 26. 4B1 and that the resident does not become NJ Exec. Order 26:4.b.1 when being assisted with Ex Order 26. 4B1	F 695		

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F 695	Continued From page 19 Ex Order 26. 4B1. On 12/19/2023 at 9:45AM, the surveyor interviewed the MDS Coordinator, who stated that Resident #63 was coded as not using Ex Order 26. 4B1 during the observation period because the resident was not observed wearing Ex Order 26. 4B1 during that time. Therefore, she coded Resident # 63 as not wearing Ex Order 26. 4B1. On 12/19/2023 at 10:21 AM, during a follow-up interview with the RN/UM regarding the care plan for Resident #63's Ex Order 26. 4B1 was not initiated when the resident was readmitted to the facility. She stated, "I forgot to initiate the NJ Exec. Order 26:4 care plan." The RN/UM stated that the Interdisciplinary Care Team (IDCP) was responsible for initiating and updating the care plan. Review of the facility's policy "Oxygen Administration/Changing" which was revised April 2023, revealed Policy: "Oxygen administration will be carried out only with a physician's order. A licensed nurse or other staff person trained in the use of oxygen will be on duty and be responsible for the correct administration of oxygen to the resident."; Procedure: "11. Label oxygen tubing with the date and time opened. Change oxygen tubing weekly. NJAC 8:39-27.1(a)(b) NJAC 8:39-11.2(f)	F 695		
F 728 SS=E	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule.	F 728		1/30/24

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F 728	Continued From page 20 A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility allowed 9 of 13 Non-Certified Nursing Aides (NA) to continue working as an NA after the	F 728	1. The nurse aides were removed from the schedule. 2. All residents have the potential to be affected. No residents were affected.	

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F 728	Continued From page 21 specified 120 days from date of hire. This deficient practice was identified during NA review. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health memo dated April 21, 2023 sent to Nursing Homes included the following: Facilities are advised as follows: I. TNAs (Temporary Nursing Assistant) A. Individuals who are working as TNAs must pass the nurse-aide written or oral exam and the State-approved clinical skills competency exam by May 11, 2023, or the end of the federal PHE (Public Health Emergency), whichever comes first. B. If a TNA does not pass the exams by the end of the federal PHE, the TNA may not work after May 11, 2023, unless the TNA meets the requirements of Paragraph C below. C. In order to work beyond May 11, 2023, TNAs must, by May 11, 2023: 1. Be enrolled in a NATCEP CNA training program, and 2. Have completed the first 16 hours of training, and 3. Be working in a facility before May 11, 2023. 4. Note that the TNA only has until September 10, 2023 to complete the NATCEP (Nurse Aide Training and Competency Evaluation Program) program and pass the exams. II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State	F 728	3. A tracking system was created with Human Resources to monitor Nurse Aide hire dates and the date of 120 days from hire, after which they cannot work if not certified. The Human Resources director was educated on the regulation related to hiring and use of nurse aides and tracking 120 days from hire and progress of their education/certification process. 4. The Administrator or designee will audit the list of nurse aides weekly to ensure any that are active are within the 120 days- this will be audited monthly for 3 months and then as needed. Audit findings will be reported to the Quality Assurance Committee which meets quarterly and as needed.	

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F 728	Continued From page 22 approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 12/12/23 at 11:00 AM, during entrance conference the Licensed Nursing Home Administrator (LNHA) stated that they did not have any NAs. The LNHA was given the "Nursing Staffing Reports" to be completed for the two weeks of staffing prior to the recertification survey. On 12/14/23 at 10:05 AM, the surveyor met with the LNHA to inquire about the "Nursing Staff Reports" that listed 13 Non-Certified Aides in training (NAs). The LNHA apologized and stated "I found out after entrance conference that we (the facility) had NAs." The surveyor requested a list of the NAs along with proof of their enrollment in a Certified Nursing Aide (CNA) school. On 12/14/23 at 11:38 AM, the LNHA provided the NA list but stated they were still in the process of updating the list. He stated that "there should be a tracking process in place and they should have had the dates. HR was responsible for maintaining the records for the NAs." On 12/18/23 at 10:45 AM, the LNHA provided the updated NA list to the surveyor. On 12/18/23 at 12:51 PM, a review of the updated NA list provided by the facility revealed the following: NA #1, Date of Hire (DOH): Ex Order 26. 4B1, 120 days from date of hire: NJ Exec. Order 26:4.b.1, program	F 728		

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F 728	Continued From page 23 completion: NJ Exec. Order 26:4.b. NA #2, DOH: Ex Order 26. 4B1, 120 days from date of hire: NJ Exec. Order 26:4.b.1, program completion: NJ Exec. Order 26:4.b.1 NA #3, DOH: Ex Order 26. 4B1, 120 days from date of hire: 1NJ Exec. Order 26:4.b.1 program completion: NJ Exec. Order 26:4.b.1. NA #4, DOH: Ex Order 26. 4B1, 120 days from date of hire: NJ Exec. Order 26:4.b.1, program completion: NJ Exec. Order 26:4.b.1. NA #5, DOH: Ex Order 26. 4B1, 120 days from date of hire: NJ Exec. Order 26:4.b.1, program completion: NJ Exec. Order 26:4.b.1 NA #6, DOH: Ex Order 26. 4B1, 120 days from date of hire: NJ Exec. Order 26:4.b.1, program completion: NJ Exec. Order 26:4.b.1 NA #7, DOH: Ex Order 26. 4B1, 120 days from date of hire: 1NJ Exec. Order 26:4.b.1, program completion: NJ Exec. Order 26:4.b.1 NA #8, DOH: Ex Order 26. 4B1,120 days from date of hire: 11/24/2023, program completion: 9/6/2023. NA #9, DOH: Ex Order 26. 4B1, 120 days from date of hire:NJ Exec. Order 26:4.b.1, program completion:NJ Exec. Order 26:4.b.1 NA# 10, DOH AS NA: Ex Order 26. 4B1, 120 days from date of hire: NJ Exec. Order 26:4.b.1, program completion:1NJ Exec. Order 26:4.b.1. NA #11, DOH: Ex Order 26. 4B1, 120 days from date of hire:NJ Exec. Order 26:4.b.1, program completion:NJ Exec. Order 26:4.b.1. NA# 12, DOH: Ex Order 26. 4B1, 120 days from date of hire: NJ Exec. Order 26:4.b.1, program completion: NJ Exec. Order 26:4.b.1 NA# 13, DOH: Ex Order 26. 4B1, 120 days from date of hire:NJ Exec. Order 26:4.b.1, program completion: NJ Exec. Order 26:4.b.1.	F 728		

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F 728	Continued From page 24	F 728		

A review of the formal job offers letters to the above listed NAs revealed that "All Certified Nursing Assistants are required to pass the state examination within 120 days of graduation from an accredited program. This is mandatory in order to continue employment with Alameda."

A review of the facility's "Nursing Schedule" provided daily to the survey team from 12/12/2023 to 12/19/23, revealed the NAs listed as CNA's and were scheduled to work as follows:

NA #1: night shift: 12/12, 12/13; evening & night shift:12/14; night shifts: 12/15, 12/18, 12/19.

NA#2: day shift: 12/12; evening shift: 12/15; day shift:12/18.

NA#3: evening shift: 12/12; night shifts: 12/13, 12/14; evening and night shift: 12/15; evening shift 12/16; evening & night shift: 12/17; evening shift: 12/18.

NA# 4: night shift: 12/12; day shifts: 12/13, 12/14, 12/18.

NA #5: day shifts: 12/12, 12/14, 12/15; evening shifts: 12/15, 12/16; day shifts: 12/18, 12/19.

NA# 6: evening shift: 12/13; evening & night shift: 12/14, 12/15; evening shift: 12/16; night shift:12/17; evening shifts: 12/18; evening and night shift: 12/19.

NA#7: evening shift: 12/12, 12/13; day and evening shift: 12/15; evening shifts: 12/17, 12/18.

NA# 8: evening shifts: 12/12, 12/14, 12/18, 12/19.

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F 728	Continued From page 25	F 728		

NA#9: day shifts: 12/12,12/13,12/14; evening shift 12/14; day and evening shift:12/15, 12/16; day shift 12/17/; day and evening shifts: 12/19.

NA# 10: day shift: 12/12, 12/13; day and evening shift: 12/15, 12/16, day shift 12/17, 12/18; night shift: 12/19.

NA# 11: evening and night shift: 12/13; day shift:12/15.

NA#12: day and evening shift: 12/13. Day shift: 12/15.

NA#13: day shift: 12/12, 12/13,12/16, 12/17; day and night shift: 12/19.

On 12/19/23 at 9:41 AM, during an interview with the Director of Nursing (DON) and the Assistant Director of Nursing/Infection Preventionist (ADON/IP), the ADON/IP stated that NAs must complete at least 16 hours of schooling to work as an NA and that they must compete the certification within 120 days from date of hire. She stated the reason was "they have to learn regulations of safe practice, stay in the scope of practice, and to makes sure when in building they are providing care within guidelines."

On 12/19/23 at 10:55 AM, the LPN/UM, on the 2nd floor, provided a staffing assignment sheet to the surveyor, NA #12 was listed on the assignment sheet as a CNA. The surveyor asked the LPN/UM about NA#12, the LPN/UM stated this was the first time she was working with her and "did not know anything about her."

On 12/19/23 at 11:00 AM, the surveyor interviewed NA#12, who was wearing her name

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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F 728	Continued From page 26 badge which had her name and CNA listed below it. The surveyor asked if she was a CNA and she stated "yes." The surveyor asked if she was a certified nursing aide and she stated "well I completed my school and took the skills test, I will take the written part in Ex Order 26. 4B1." She stated she started work about 3 weeks ago and they (Human Resources, HR) told me I had 120 days from my school completion date to take the test." On 12/19/23 at 11:10 AM, during a follow up interview with DON and ADON/IP, the DON stated that the UMs would know who the NA's are and would assign them a "buddy" CNA to go to for help. She then stated, "the UM should know the NA because they are considered to be on orientation and should be monitored." On 12/19/23 at 11:20 AM, during an interview with the LNHA and Registered Nurse/Vice President of Clinical Services (RN/VPCS), the LNHA verified that NAs should be certified within 120 days from date of hire. He stated, "he understands that tracking needs to be to done and that he started a tracking system." The LNHA confirmed at that time, that the NAs progress was not being tracked. The LNHA stated that the NAs all signed letters that they would obtain their certification within 120 days of completion of their schooling. On 12/19/23 at 11:40 AM, during an interview with NA#9, he stated he started working in Ex Order 26. 4B1 not sure of the exact date. He stated he "finished CNA school in Sept and finished up my skills test." The surveyor observed NA#9 was wearing a badge that identified him as a CNA but stated "he was working as a NA training to be a CNA." He state he was informed by the facility that "he	F 728		

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	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

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F 728 Continued From page 27
has to take his test by Ex Order 26. 4B1."

F 728

On 12/19/23 at 11:45 AM, during an interview with the surveyors, the LNHA stated that the HR Director (HRD) had been informed that NAs had to obtain certification within 120 days of completion of school. At that time, the LNHA confirmed that the certification must be obtained within 120 days from date of hire. He then confirmed again that the HRD was not tracking the NAs progress. The surveyor made the LNHA aware that 2 NAs (NA#12 and NA #9) that were currently working, were wearing name badges that listed them as CNAs. He stated that the purpose of badges with name and department "was to identify staff to residents, visitors, and other staff members for their scope of practice." The LNHA stated the "NA's would be taken off the schedule until they get their certification."

On 12/20/23 at 10:10 AM, during an interview with the HRD, the HRD stated that NAs must show proof of being in school, or completion of school, and that they need to complete at least 3 days of schooling before starting work at the facility. He further stated that, "I believe it is 16 hours but we require them to complete 3 days." He stated he had a system in place for tracking NAs progress, but he was unable to provide the tracking to the surveyor.

On 12/20/23 at 12:10 PM, the LNHA again confirmed that the HRD did not have a tracking system for the NAs until the LNHA emailed him one.

On 12/20/23 at 4:02 PM, the LNHA and the DON were made aware of the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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F 728	Continued From page 28 No additional information was provided to the survey team. N.J.A.C. 8:39-43.10	F 728		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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F 755	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a medication was administered according to physician orders and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in 1 (one) of 6 (six) residents (Resident #7) 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 restorative care, under the direction of a	F 755	1. A med error report was completed. The MD was notified regarding resident #7 no new order, give next dose as scheduled, monitor for any change in behavior. The nurse was re-educated in Medication Administration. 2. All residents have the potential to be affected. The Medication Administration Record of residents on the nurses assignment were checked and no additional errors were found. 3. Nurses were educated on Medication Administration. Facility policy was revised to include that the nurse must check the medications prior to administering. 4. The Director of Nursing or designee will complete 5 medication pass observations-one from each of the five units- monthly for three months. Findings will be reported to the Administrator and to the Quality Assurance committee which meets quarterly and as needed.	

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F 755	Continued From page 30 registered nurse or licensed or otherwise legally authorized physician or dentist." On 12/18/23 at 9:10 AM, during the medication administration observation, the surveyor observed a Licensed Practical Nurse (LPN) in the room of Resident #7. The surveyor observed the LPN checking the resident's identification bracelet and informing Resident #7 that she would be administering the resident's medications. The surveyor observed the resident in their bed and just finished eating breakfast. On 12/18/23 at 09:15 AM, the surveyor observed LPN preparing to administer (5) medications to Resident #7 which included one tablet of Ex Order 26. 4B1 one tablet of Ex Order 26. 4B1, two tablets Ex Order 26. 4B1, Ex Order 26. 4B1 and one tablet of Ex Order 26. 4B1. The surveyor observed the LPN put one tablet of Ex Order 26. 4B1, one tablet of Ex Order 26. 4B1 and 2 tablets of Ex Order 26. 4B1 into a medication cup for a total of 4 tablets. The surveyor then observed the LPN add Ex Order 26. 4B1 into a measuring cup. The surveyor did not observe the LPN add Ex Order 26. 4B1 into the medication cup. The surveyor then observed the nurse pour Ex Order of water into a cup. The surveyor checked the medication cup three more times which showed 4 tablets in the cup. The surveyor then observed the LPN administered the resident their medications. After administering Resident #7's medication the surveyor observed the LPN signed off the electronic medication administration record (EMAR) which included	F 755		

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	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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F 755	Continued From page 31 Ex Order 26. 4B1. At that time, the surveyor interviewed the LPN who refused to acknowledge that she omitted Ex Order 26. 4B1. 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 Ex Order 26. 4B1." A review of the Quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, reflected that the resident's Ex Order 26. 4B1 score was Ex Ord out of 15, which indicated that the resident was Ex Order 26. 4B1. A review of the Ex Order 26. 4B1 Medication Review Report (MRR) which revealed a physician order (PO) dated Ex Order 26. 4B1, for Ex Order 26. 4B1, give 1 tablet by mouth in the morning for Ex Order 26. 4B1. A review of the Ex Order 26. 4B1 electronic Medication Administration Record (eMAR) revealed an order dated Ex Order 26. 4B1, for Ex Order 26. 4B1, give 1 tablet by mouth in the morning for Ex Order 26. 4B1 and scheduled for 9:00 AM, and showed on 12/18/23 that Ex Order 26. 4B1 was documented as being administered.	F 755		

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	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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F 755	Continued From page 32 On 12/20/23 at 3:30 PM, the surveyor met with the Licensed Nursing Home Administrator, Director of Nursing (DON) and the Infection Preventionist and discussed the above findings. No further information was provided. A review of the facility's policy for "Medication Administration" dated 04/30/23, which was provided by the DON, revealed that they were no policy that assure that prepared medications should be double check prior to medication administration. NJAC 8:39-11.2 (b), 29.2 (d)	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		1/30/24

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	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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F 756	Continued From page 33 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of facility documentation, it was determined that the facility failed to respond to pharmacy consultant recommendations in a timely manner for 2 of 5 residents (Resident # 125 and #152) reviewed for unnecessary medications. This deficient practice was evidenced by the following: 1. During lunch observation on 12/12/23 at 1:04 PM, the surveyor observed resident #125 leaving the dining room, asking staff if he/she could leave the room. The NJ Exec. Order 26:4.b.1 unit clerk directed the resident to his/her room. According to the Admission Record (AR), Resident#125 was admitted to the facility with diagnoses that included but were not limited to: *Ex Order 26. 4B1*	F 756	1. The medication for resident #125 was discontinued by the MD. The recommendations for resident #152 were addressed. 2. All residents have the potential to be affected. No other issues were identified. 3. Pharmacy Consultant recommendations will be received by the unit managers and acted upon within 7 days. This process will be audited the Director of Nursing or designee. The unit managers were educated on the process of receiving and acting on pharmacy consultant recommendations. 4. The Director of Nursing or designee will audit pharmacy consultant recommendations of 5 residents (one from each unit) monthly for 3 months and then as needed, to verify if changes have been acted upon and/or documentation exists if not. Findings will be reported to	

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F 756	Continued From page 34 Ex Order 26. 4B1 . The annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, indicated that the facility assessed the resident's cognitive status using a Ex Order 26. 4B1 . The resident scored a Ex out of 15 which indicated that the resident had Ex Order 26. 4B1 . Further review of the Ex Order 26., revealed the resident was receiving Ex Order 26. 4B1 medications. A review of the electronic Medical Record (eMR) revealed a physician order (PO) dated Ex Order 26. 4B1 at 1600 (4:00 PM) for Ex Order 26. 4B1 , give 1 tablet by mouth every 8 hours as needed (PRN) for Ex Order 26. 4B1. This order did not include a duration for the prn medication. Further review of the physician orders revealed an order dated NJ Exec. Order 26:4 at 21:43, "Ex Order 26. 4B1, Give NJ Exec. Order 26:4.b.1 as needed for Ex Order 26. 4B1 for NJ Exec. Order 26:4.b." On 12/18/23 at 9:30 AM, the Director of Nursing (DON) provided the Consultant Pharmacist's Medication Regiment Review (CPMR) reports, which included the Medication Regimen Review (MRR), from 4/1/23. On 12/19/23 at 8:30 AM, a review of the CPMR for Resident #125 revealed the following: -MRR Priority Normal: dated NJ Exec. Order 26:4., "As per Federal Regulations all NJ Exec. Order 26:4.b.1 should be written for NJ Exec. Order 26:4.b. Please clarify Ex Order 26. 4B1	F 756	the Administrator and the Quality Assurance Committee which meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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F 756	Continued From page 35	F 756		

prn to NJ Exec. Order 26:4.b."

-MRR, Priority Normal: dated NJ Exec. Order 26:4.b. "We have noticed that the prn Ex Order 26. 4B1 has been renewed after NJ Exec. Order 26:4.b.1). The purpose of the NJ Exec. Order 26:4.b.1 for PRN NJ Exec. Order 26:4.b.1 medications is to place our resident's on safer alternatives to prevent NJ Exec. Order 26:4.b.1. Please have resident re-evaluated and their Ex Order 26. 4B1 and consider safer alternatives such as NJ Exec. Order 26:4.b.1t that can treat NJ Exec. Order 26:4.b.1, and other non-interventions."

-MRR, Priority High: dated NJ Exec. Order 26:4.b.1: "We have noticed that the prn Ex Order 26. 4B1 has been renewed after NJ Exec. Order 26:4.b.1). The purpose of the NJ Exec. Order 26:4.b.1 for PRN NJ Exec. Order 26:4.b.1 medications is to place our resident's on safer alternatives to prevent NJ Exec. Or Please have resident re-evaluated and their Ex Order 26. 4B1 and consider safer alternatives such as NJ Exec. Order 26:4.b.1, and other non-interventions."

A review of the Psychiatry Progress Note dated NJ Exec. Order 26:4.b. revealed "Monitored NJ Exec. Order 26:4.b.1: Ex Order 26. 4B1 q 8 hours prn for Ex Order 26. 4B1 ... Plan: 3. specify duration of Ex Order 26. 4B1 prn to NJ Exec. Order 26:4.b."

The facility failed to provide documented evidence that nursing or the physician addressed the pharmacy recommendations for Resident #125 from April 2023 to present.

On 12/19/23 at 9:41 AM, the surveyor interviewed the DON regarding the process for the pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 36 consultant recommendations. She stated that they come through email. The nurses on the floor were responsible to follow up with the physician to make sure that the pharmacist's recommendations were addressed. She also stated that "the unit managers should take the lead to make sure it was done." The DON stated that prn NJ Exec. Order 26:4.b.1 should only be written for NJ Exec. Order 26:4.b so that it can be reviewed as to what causes the NJ Exec. Order 26:4.b.1 On 12/19/23 at 9:50 AM, in the presence of the surveyor, the DON reviewed the eMR and confirmed that the original PO for Ex Order 26. 4B1 by PO (by mouth) q (every) 8 hours as needed for Ex Order 26. 4B1 was from NJ Exec. Order 26. She also confirmed that there was not a duration of NJ Exec. Order 26:4.b. The DON stated that there should be a duration so the resident could be re-evaluated to see if the medication was effective or if the medication should be titrated, increased or decreased. On 12/19/2023 at 10:40 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) of the NJ Exec. Order 26:4.b.1, who stated that the expectation of staff was to try and distract residents and to try non-pharmaceutical interventions before using medications to address behaviors. She then stated that the purpose was "to monitor behaviors and how often the behavior occurs to see they needed something (medication) standing." She stated that the pharmacy consultant recommendations came through emails that go to every floor and "we (nurses) are supposed to go through the recommendations, verify diagnoses, clarify orders with the Nurse Practitioner or physician with the pharmacist recommendations."	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	**303 ELM STREET PERTH AMBOY, NJ 08861**

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F 756	Continued From page 37 On 12/19/23 at 1:54 PM, during a telephone interview, the pharmacist consultant supervisor stated that the MRR's are emailed monthly to the facility, the DON, administrator, and to the unit manager. She then stated that "we do not send them directly to the physicians. The facility should fax it or give to the physician." She stated that the reason that Ex Order 26. 4B1 prn should have a NJ Exec. Order 26:4 duration was the "new regulation to make sure safe alternates are used before Ex Order 26. 4B1 are used. " On 12/20/23 at 4:02 PM, in the presence of the survey team, the above findings were presented to the Licensed Nursing Home Administrator (LNHA) and the DON. No additional information was provided. 2. On 12/13/23 at 12:37 PM, the surveyor observed resident #152 in the dining room for lunch. The resident was dressed and wearing a hat. According to the AR, Resident#152's was admitted to the facility with diagnoses that included but were not limited to: Ex Order 26. 4B1 . The MDS, dated NJ Exec. Order 26:4, indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored a Ex Ord out of 15, which indicated that the resident was Ex Order 26. 4B1. Further review of the MDS, revealed the resident was receiving Ex Order 26. 4B1 .	F 756		

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	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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F 756	Continued From page 38 On 12/19/23 at 11:48, a review of the CPMR revealed the following pharmacy consultant recommendations for Resident #152 that were not addressed until 11/23/23: MRR, Priority Normal: dated NJ Exec. Order 26:4.b. "Please clarify Ex Order 26. 4B1 PRN order to include degree of Ex Order 26." "Please clarify Ex Order 26. 4B1 order to include leaving Ex Order 26. 4 NJ Exec. Order 26:4.b.1 per day and remove." MRR, Priority Normal: dated NJ Exec. Order 26:4.: "The resident is on Ex Order 26. 4B1. Please do the monthly NJ Exec. Order 26:4.b.1. Include NJ Exec. Order 26:4.b.1]." MRR, Priority Normal: dated NJ Exec. Order 26:4.b.1: "Please clarify and space Ex Order 26. 4B1 evenly around the clock for around the clock pain coverage. Clarify to Ex Order 26. 4B1 q 8 hr Ex Order 26. 4B1." MRR, Priority High dated NJ Exec. Order 26:4.b.1 "Please clarify Ex Order 26. 4B1 PRN order to include degree of Ex Order 26." "Please clarify Ex Order 26. 4B1 order to include leaving Ex Order 26. 4 NJ Exec. Order 26:4.b.1 per day and remove." MRR, priority: Normal, dated NJ Exec. Order 26:4.b. "The resident's Ex Order 26. 4B1 was increased on NJ Exec. Order 26:4.1. Please be sure to NJ Exec. Order 26:4.b.1 in the nursing	F 756		

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F 756	Continued From page 39 notes and address NJ Exec. Order 26:4.b.1 notes." MRR, Priority: Normal, dated NJ Exec. Order 26:4: "Ex Order 26. 4B1 was used many times in July, there is no nursing note in the progress notes for the reason. Please review documentation with the nursing staff." MRR, Priority: Normal, dated NJ Exec. Order 26:4.b.1: "The resident is on Ex Order 26. 4B1. Please do the NJ Exec. Order 26:4.b.1 (if any), last Ex Order 26. 4B visit, None seen in [name redacted-EMR]."" MRR, Priority: Normal, dated NJ Exec. Order 26:4: "Ex Order 26. 4B1 was used many times in August, there is no nursing note in the progress notes for the reason. Please review documentation with the nursing staff." MRR, Priority: High dated NJ Exec. Order 26:4.b.1: "The resident is on Ex Order 26. 4B1. Please do the NJ Exec. Order 26:4.b.1 (if any), ;last Ex Order 26. 4B visit, None seen in chart. None seen in [name redacted-EMR]." MRR, Priority High dated NJ Exec. Order 26:4.b.1 "Please clarify Ex Order 26. 4B1 PRN order to include degree of Ex Order 2." MRR, Priority Normal, dated 1NJ Exec. Order 26:4. and NJ Exec. Order 26:4.b.1 "Resident has an order for Ex Order 26. 4B1	F 756		

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F 756	Continued From page 40 Ex Order 26. 4B1 to be applied once daily for NJ Exec. Order 26:4.b.1. Please be aware, the manufacturer recommends NJ Exec. Order 26:4.b.1 be applied for NJ Exec. Order 26:4.b.1 hours, and to be repeated for NJ Exec. Order 26:4.b.1 times daily. Please review this order with Physician." A review of PO revealed the following: NJ Exec. Order 26:4.b.1 at 19:05 (7:05 PM), Ex Order 26. 4B1 *NJ Exec. Order 26:4.b.1 mouth every 8 hours as needed for Ex Order 26, Discontinue on NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 at 19:05, Ex Order 26. 4B1 Give 1 capsule by mouth three times a day for Ex Order 26. 4B1, facility time code: 0900-1400-2100. -NJ Exec. Order 26:4.b.1 at 14:24 (2:24 PM), Ex Order 26. 4B1 Apply to Ex Order 26. 4B1 every day shift for Ex Order 26-discontinued NJ Exec. Order 26:4.b.1 -NJ Exec. Order 26:4.b.1 at 14:30 (2:30 PM), Ex Order 26. 4B1 Give 1 tablet by mouth in the evening for Ex Order 26. 4B1 NJ Exec. Order 26:4.b.1 at 13:41 (1:41 PM), Ex Order 26. 4B1 Give 1 tablet by mouth at bedtime for Ex Order 26. 4B1 NJ Exec. Order 26:4.b.1 at 15:00 (3:00 PM), Monitor/document/report PRN adverse reactions to Ex Order 26. 4B1: change in NJ Exec. Order 26:4.b.1	F 756		

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F 756	Continued From page 41 NJ Exec. Order 26:4.b.1 . NJ Exec. Order 26:4.b.1 at 12: 50 AM, Ex Order 26. 4B1 Apply to Ex Order 26. every shift for Ex Order 26 Remove and replace patch q shift for Ex Order 26 A Review NJ Exec. Order 26:4.b.1 Progress Notes provided by facility revealed the following: -Ex Order 26. 4B1 notes dated NJ Exec. Order 26: "Plan: 3. monitor and document NJ Exec. Order 26:4.b.1 notify Ex Order 26. 4B1 as indicated." A review of the Medication Administration Record (MAR) and Treatment Administration records (TAR) reviewed form Ex Order 26. 4B1 did not reveal NJ Exec. Order 26:4.b.1 ordered or documented. A review of the progress notes from April to NJ Exec. Order 26:4.b.1 did not reveal documentation for NJ Exec. Order 26:4.b.1 . On 12/20/23 at 4:02 PM, in the presence of the survey team, the above findings were presented to the LNHA and the DON. The facility failed to provide documented evidence that the physician addressed the pharmacy recommendations, NJ Exec. Order 26:4.b.1 documentation for Resident #152. On 12/21/23 at 10:11 AM, the surveyor interviewed the DON, who stated NJ Exec. Order 26:4.b.1 would be in the progress notes. She stated she will provide the NJ Exec. Order 26:4.b.1 for resident.	F 756		

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F 756	Continued From page 42 On 12/21/23 at 10:24 AM, the DON provided NJ Exec. Order 26:4.b.1 monitoring with a start date NJ Exec. Order 26:4.b.1 On 12/21/23 at 10:40 AM, the DON provided NJ Exec. Order 26:4.b.1 with a start date of NJ Exec. Order 26:4.b.1 She confirmed, at that time, that there was no NJ Exec. Order 26:4.b.1 documentation completed prior to that date. A review of the facility's policy, "Medication Review" revised April 2023 revealed: Procedure: 5. Facility should independently review each resident's medication regimen directly from the residents medical chart and with the Interdisciplinary Care Team members, resident or responsible party as needed. 6. Facility should ensure that the Facility Physicians/Prescribers are provided with copies of the MRRs. 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRRS and the Director of Nursing to act upon the recommendations contained within the MRR. For those issues that require Physician/Prescriber interventions, Facility should encourage Physician/prescriber to either (a) accept and act upon the recommendations contained within the MRR or (b) reject all or some the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. NJAC 8:39-29.3 (1)	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		1/30/24

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F 758	Continued From page 43 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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F 758	Continued From page 44 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to order an "as needed" (PRN) NJ Exec. Order 26:4.b.1 medication for a NJ Exec. Order 26 period for 1 of 5 residents (Resident #125) reviewed for unnecessary medications. This deficient practice was evidenced by the following: During lunch observation on 12/12/23 at 1:04 PM, the surveyor observed resident #125 leave the dining room, asking staff if he/she could leave the room. The NJ Exec. Order 26:4.b.1 unit clerk directed the resident to his/her room. According to the Admission Record, Resident#125's was admitted to the facility with diagnoses that included but were not limited to: Ex Order 26. 4B1 . The Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec. Order 26:4, indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a Ex out of 15 which	F 758	1. Resident #125 was evaluated, and the provider ordered prn Ex Order 26. 4B1 for 14 days and monitor behavior and re-evaluate. The medication has since been discontinued. 2. All residents receiving as needed psychotropic medications have the potential to be affected. After audit, no other residents were found to be affected. 3. Psychotropic medications will be audited to ensure they are limited to 14 days unless they are evaluated by the provider and the rationale for extending is documented. The nurses and unit managers were educated on as needed psychotropic medication ordering and documentation requirements. 4. The DON or designee will audit psychotropic medications of five residents (one per unit) monthly for 3 months and then as needed, to verify that proper ordering and documentation is in place. Findings of the audits will be reported to the Administrator and Quality Assurance committee which meets quarterly and as needed.	

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F 758	Continued From page 45 indicated that the resident had Ex Order 26. 4B1 . Further review of the MDS, revealed the resident was receiving Ex Order 26. 4B1 . A review of the Electronic Medical Record (EMR) revealed a physician order (PO) dated Ex Order 26. 4B1 at 1600 (4:00 PM) for Ex Order 26. 4B1 Tablet Ex Order 26. 4 , give 1 tablet by mouth every 8 hours as needed [PRN] for Ex Order 26. 4B1 . Further review of the physician orders revealed an order dated Ex Order 26. 4B1 at 21:43, "Ex Order 26. 4B1 Tablet Ex Order 26. 4 , Give 1 tablet by mouth every 8 hours as needed for Ex Order 26. 4B1 for NJ Exec. Order 26:4.b.1 A review of the April medication administration record (MARs) revealed the medication was administered as follows: NJ Exec. Order 26:4.b.1 . A review of the May MARs revealed the medication was administered as follows: NJ Exec. Order 26:4. at 10:32 AM. A review of the June MARs revealed the medication was not administered. A review of the July MARs revealed the medication was administered on NJ Exec. Order 26:4. at 17:17. A review of the August MARs revealed the medication was administered as follows: NJ Exec. Order 26:4. at 1721. A review of the September MARs revealed the	F 758		

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F 758	Continued From page 46 medication was administered as follows: NJ Exec. Order 26:4. [redacted] at 1531. A review of the October MARs revealed the medication was administered as follows: NJ Exec. Order 26:4. [redacted] t 1529. A review of the November MARs revealed the medication was administered as follows: NJ Exec. Order 26:4.b.1 [redacted] at 1622. A review of the December MARs revealed the medication was administered on NJ Exec. Order 26:4. at 0500. On 12/19/23 at 9:41 AM, the surveyor interviewed the Director of Nursing (DON), who stated that prn Ex Order 26. 4B1 should only be written for NJ Exec [redacted] so that it can be reviewed as to what causes the NJ Exec. Order 26:4.b.1 On 12/19/23 at 9:50 AM, in the presence of the surveyor, the DON reviewed the EMR and confirmed that the original PO for Ex Order 26. 4B1 by PO (by mouth) q (every) 8 hours as needed for Ex Order 26. 4B1 was from NJ Exec. Order 26. She also confirmed that there was not a duration of NJ Exec. Order 26:4.b. The DON stated that there should be a duration so the	F 758		

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F 758	Continued From page 47 resident could be re-evaluated to see if the medication was effective or if the medication should be titrated, increased or decreased. On 12/19/23 at 10:40 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) of the NJ Exec. Order 26:4.b.1, who stated that the expectation of staff was to try and distract residents and to try non-pharmaceutical interventions before using medications to address behaviors. She then stated that the purpose was "to monitor behaviors and how often the behavior occurs to see they needed something (medication) standing." On 12/19/23 at 1:54 PM, during a telephone interview, the pharmacist consultant supervisor stated that the reason that Ex Order 26. 4B1 prn should have a NJ Exec. Order 26:4 duration was the "new regulation to make sure safe alternates are used before Ex Order 26. 4B1 are used. " On 12/20/23 at 4:02 PM, in the presence of the survey team, the above findings were presented to the Licensed Nursing Home Administrator and the DON. No additional information was provided. A review of the facility's policy "Antipsychotropic Use" revised March 2023 revealed Procedure: 3. Any PRN psychotropic medication, excluding Antipsychotics, will be limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she will document their rational in the resident's medical record and indicate the duration for the PRN	F 758		

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F 758	Continued From page 48 order. 4. Any PRN antipsychotic medication will be limited to 14 days. If the attending physician or prescribing practitioner wishes to write a new order for PRN antipsychotic, he/she will evaluate the resident to determine if the new order for antipsychotic is appropriate. N.J.A.C 8:39-29.3 (d)	F 758		
F 761 SS=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 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:	F 761		1/30/24

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F 761

Continued From page 49

Based on observation, interview, and record review, it was determined that the facility failed to (a). properly label, store and dispose of medications in three (3) of seven (7) medication carts and in two (2) of three (3) medication storage room inspected, and b). failed to secure one (1) of three (3) narcotic lock boxes in 1 of 3 medication refrigerators inspected.

This deficient practice was evidenced by the following:
(a). On 12/19/23 at 10:20 AM, the surveyor inspected the 6th floor medication cart #1 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed a bottle of blood glucose test strips that was opened and had no opened date. The surveyor also observed a Basaglar insulin pen that was opened and dated but the resident's name on the vial did not match the resident's name that was on the medication bag that held the insulin pen.

At that time, the surveyor interviewed LPN#1, who stated that an opened bottle of blood glucose strips should have been dated. LPN#1 further stated that the Basaglar insulin pen should have been stored in a bag that contained the same resident's name as was on the insulin pen. She also stated that prior to administering any insulin via a vial or pen that she will always assure that the resident's name on the product matched the resident who was receiving the insulin.

On 12/19/23 at 10:40 AM, the surveyor inspected the 6th floor medication room refrigerator in the presence of LPN#1. The surveyor observed four bottles of Lorazepam (medication for anxiety) 2 mg (milligrams)/ml (milliliters) multi-dose injectable vials. The surveyor observed one vial

F 761

1. The Ex Order 26. 4B1 was put in the correct bag. Medications without dates or not labeled correctly were discarded and reordered. The lockbox was secured to the refrigerator.
2. All residents have the potential to be affected. Medication storage and fridges were checked, and no additional issues were identified.
3. The nurses and unit managers were educated on labeling and storage of drugs and biologicals.
4. The Director of Nursing or designee will audit 5 med carts (one per unit) weekly for one month and then 5 med carts monthly for 2 months. Findings will be submitted to the Administrator and the Quality Assurance committee which meets quarterly and as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 761	Continued From page 50	F 761		

of the Lorazepam 2mg/ml that was opened and not dated.

At that time, the surveyor interviewed LPN#1 who stated that a vial of multi-dose Lorazepam should have been dated once opened. She also stated that the resident was no longer on the medication and that the medication should have been removed from active medication stock.

On 12/19/23 at 10:45 AM, the surveyor inspected the 5th floor medication cart #2 in the presence of LPN#2. The surveyor observed an opened and undated vial of Lantus insulin.

On 12/19/23 at 10:50 AM, the surveyor inspected the 5th floor medication room in the presence of LPN#2. The surveyor observed a bottle of Vitamin B-12 house stock that had an expiration date of 6/2023.

At that time, the surveyor interviewed LPN#2 who stated that an opened vial of Lantus should have been dated and that an expired bottle of Vitamin B-12 should have been removed from active medication stock.

On 12/19/23 at 11:15 AM, the surveyor inspected the 2nd floor medication cart #3 in the presence of LPN#3. The surveyor observed an opened and undated bottle of blood glucose test strips.

At that time, the surveyor interviewed LPN #3 who stated that once a bottle of blood glucose test strips was opened that it should have been dated.

A review of the Manufacturer's Specifications for the following medications revealed the following:

F 761 | F 761

Continued From page 51

1. Blood glucose test strips once opened have an expiration date of 180-days.
2. Lorazepam 2mg/ml multi-dose injectable vial once opened have an expiration date of 28-days.
3. Lantus insulin vial once opened have opened have an expiration date of 28-days.

b). On 12/29/23 at 10:40 AM, the surveyor inspected the 6th floor medication room refrigerator in the presence of LPN#1. The surveyor observed a locked narcotic refrigerator that contained a narcotic lock box that was not affixed to the refrigerator. The surveyor was able to pull the whole shelf with the narcotic box out of the refrigerator. The narcotic box contained 4 Lorazepam multi-dose injectable vials.

At that time, the surveyor interviewed LPN#1 who acknowledge that the narcotic box inside the medication should have been affixed to the refrigerator.

On 12/30/23 at 3:30 PM, the surveyor discussed the above concerns with the administrative team which included the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) and the Infection Preventionist. There was no additional information provided.

A review of the facility's policy for Medication Administration that was dated 04/30/23 and provided by the DON that included the following:
" G. Prior to Medication Administration:
3. Check expiration date on medication label."

A review of the facility's policy for Storage of Controlled Medications that was dated 04/30/23 and provided by the DON included the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	**303 ELM STREET PERTH AMBOY, NJ 08861**

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F 761	Continued From page 52 "2. Schedule II through V medications and other medications subject to abuse or diversion are stored in either in a permanently affixed, double locked compartments separate from all other medications or in accordance with state regulations." "3. Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator and/or in accordance with state regulations and facility policy." "10. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed in accordance with facility policy and state regulations. Accountability records for discontinued controlled substances are maintained with the unused supply until it is destroyed or disposed of, and then stored for five years or as required by applicable law or regulation." NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 804		1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	**303 ELM STREET PERTH AMBOY, NJ 08861**

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F 804	Continued From page 53 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of hot foods served to the residents. This deficient practice was identified for two (2) of six (6) residents interviewed during the Resident Council meeting and confirmed during the lunchtime meal service on 12/20/23 for 1 of 5 nursing units tested for food temperatures by two surveyors and was evidenced by the following: On 12/14/23 at 11:00 AM, the surveyor met with six (6) residents for council meeting. Two out of six residents stated that food temperatures varied depending upon if they ate in the dining room or in their rooms; if they ate in their rooms, the food was cold. One of the two residents further stated that this was a recurrent complaint at resident council meetings. On 12/20/23 at 11:11 AM, the Registered Dietitian (RD) surveyor calibrated a state issued digital thermometer via the ice bath method to 32 degrees Fahrenheit (F) in the presence of the survey team. On 12/20/23 at 11:35 AM, the surveyor interviewed the evening cook in the presence of a second surveyor. He was setting up a five well steam table for lunch service on the fourth floor. He stated that it was working properly and that "it warms up quick." On 12/20/23 at 11:57 AM, the surveyor observed kitchen staff deliver hot food in a food warmer to the unit pantry. On 12/20/23 at 12:50 PM, the surveyor observed	F 804	1. The two test trays were replaced with new trays. 2. All residents have the potential to be affected. 3. The dietary staff and CNA were educated on acceptable food serving temperatures and passing trays promptly. The FSD or RD will do four test trays monthly. 4. The RD or designee will do one test tray weekly for 3 months, checking for proper temperatures, and then as needed. Finding will be submitted to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 804	Continued From page 54	F 804		

Continued From page 54

the last tray delivered to the residents. At that same time the evening cook joined the dietary aide who was plating food from the steam table in the fourth-floor unit pantry. The surveyor took the temperatures of the following items in the presence of both food service staff and a second surveyor:

Beef cubes teriyaki style: 122 degrees F
Mixed vegetables: 117 degrees F
Lo Mein noodles: 126 degrees F
Sausage: 110 degrees F
Puree beef: 123 degrees F
Puree vegetables: 113 degrees F
Mashed potatoes: 116 degrees F

On 12/20/23 at 12:52 PM, the surveyor interviewed the two food service staff members in the presence of a second surveyor. The evening cook stated that beef should have been at 140-145 degrees F at which time the dietary aide agreed.

On 12/20/23 at 1:20 PM, the surveyor interviewed the Food Service Director (FSD) in the presence of the survey team. He stated that food temperatures were checked before transport to the unit via warmer about five to ten minutes prior to service. The FSD further stated that to his knowledge all the steam tables were working properly. He stated, "their process should maintain food temperatures, food should stay hot." He also stated that he had not done test trays and had not taken food temperatures on that unit. In addition, the FSD stated that there have been issues about food being cold discussed in resident council meetings. He stated that the facility did not have plate warmers and that hot food temperatures "should be held at 165

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 804	Continued From page 55 degrees F." Review of an undated facility policy "Dining Services Food Temperatures," indicated that acceptable serving temperatures for the following items were: Meat, entrees > 140 degrees F, but preferably 160-175 degrees F Potatoes, pasta > 140 degrees F, but preferably 160-175 degrees F Vegetables > 140 degrees F, but preferably 160-175 degrees F The policy also included to "heat hot plates." NJAC 8:39-17.2(g), 17.4(e)	F 804		
F 812 SS=F	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	F 812		1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 812	Continued From page 56 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain kitchen sanitation in a manner intended to prevent the spread of food borne illness. This deficient practice was evidenced by the following: On 12/12/23 from 9:26 AM to 11:25 AM, the surveyor conducted a tour of the main kitchen in the presence the Food Service Director (FSD) and observed the following: At 10:11 AM, the surveyor observed a dish machine temperature log which was filled out for the afternoon (for lunch time). The FSD stated, "They signed this early, I don't know why." At 10:24 AM, the surveyor observed orzo pasta wrapped in clear plastic with a use by date of 12/3. This was stored on a metal rack in the dry storeroom. The FSD stated, "It's Orzo, maybe ten pounds" and stated, "I am not sure why they put it there" and he removed it from the storage room. The surveyor observed an opened five pounds (lbs) container of Honey with no open date. The FSD stated, "it should be good for seven days." At 11:00 AM, the surveyor observed several opened food items with no opened date or labels in the walk-in refrigerator as follows: -Seven hardboiled eggs in an opened clear package, with no opened date.	F 812	1. Unlabeled and improperly labeled items were discarded and replaced. The cutting boards have been replaced. The personal items were removed. The temperature logs and dish machine logs were corrected. 2. All residents have the potential to be affected. 3. The Food Service Director was educated on his job description and proper labeling / storage, and not having personal items near food storage and preparation areas, as well as dish machine logs, fridge / freezer temp logs. Staff were educated on proper labeling and storage, not having personal items near food storage and preparation areas, dish machine logs and fridge/freezer temp logs. 4. RD or designee will perform sanitation audits of the kitchen weekly for one month, and then monthly for two months and as needed. These rounds will include checking for proper labeling and storage, no personal items in food storage and preparation areas, dish machine logs and fridge/freezer temp logs. Findings will be submitted to the Administrator and Quality Assurance committee which meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 812 Continued From page 57

F 812

-An opened one-pint container of Mayonnaise, with no opened date.

-A 64 ounce (oz) opened gallon of Apple Juice, with no opened date.

-An opened bag of shredded Mozzarella cheese wrapped in the original packet, with no opened date. The FSD stated, "I am gonna throw it out. Majority of the food is good for seven days once its open."

-An opened eight oz container of sour cream dated 10/28, the FSD stated, "It's probably (the date) when it came it" and "It's probably somebody's personal sour cream."

-One 17 oz bottle of unopened black raspberry juice and one 17 oz bottle of unopened cranberry lime juice. The FSD stated, "It's somebody's personal juice because I don't order that."

-Two and a half lbs. opened [name redacted] Greek yogurt, without a lid, covered with clear plastic wrap and dated 11/26.

-Half four-inch pan with a half of a tomato wrapped in plastic wrap, not dated. The FSD stated, "I told them so many times to date things, but they don't listen."

-One gallon opened chunky Bleu cheese dressing, with no opened date.

-An opened one gallon of regular milk, with no opened date. The FSD stated, "It was probably opened today."

At 11:25 AM, the surveyor conducted a tour of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 812		F 812		

Continued From page 58
Indian kitchen prep room with the FSD and Indian Cook (IC) # 1 and observed the following:

-In the first white closet, there was a brownish yellow flaked snack stored in a small plastic container. The FSD stated, "it's personal food and should not be there." IC#1 identified them as corn flake snacks.

-In the black closet there was an opened five lbs. container of Cumin powder in it's original clear plastic bag packaging, with no opened date. The surveyor observed an unwrapped black immersion blender stored directly on the floor in the closet. IC #1 stated, "its clean because its not used." The FSD explained to IC#1 that the blender can not just sit on the floor unwrapped, once it is used, it should be cleaned and a bag placed over it.

-On top of the white reach in freezer there was a jacket in a large clear plastic bag . IC #1 stated, "it belongs to another staff." The FSD stated, "The jacket should not be in the kitchen, it should be in the locker."

-There was a pan on the top of the black closet. The FSD identified it as a "six-inch third pan" that contained four boxes of of hashbrown potatoes (4.2 oz) with a best date of 9/23.

-In a double door cabinet, under the prep table, there was an opened 32 oz bottle of lime juice, with no opened date.

-On the bottom shelf of a double door cabinet there were two pairs of eyeglasses next to the lentil containers. IC #1 stated, "they belong to IC #2 and the FSD stated, "They (the glasses)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 812 Continued From page 59 F 812

shouldn't be there."

-In the left top cabinet, there was an unidentified brown colored powder stored in a plastic container which had the name of a different manufactured item [name redacted]. The container had no label and no opened date. IC #1 stated, "It's amchoor powder (a spice made from dried green mangoes)."

-In the left top cabinet there was a closed clear plastic container with two small packets wrapped in plastic, IC#1 identified the packets as an opened four lbs packet of pearl tapioca, with no opened date and an opened four lbs packet of samo seeds (a type of rice/millet), with no opened date.

-A green cutting board that had multiple scratches/gouges and black, brown marks on it.

-In the single door white refrigerator was an opened four lbs container of [name redacted] natural dahi (whole milk yogurt), with no opened date. On the outside of the refrigerator, the surveyor observed the Freezer Temperature Log sheet and the Refrigerator Temperature Log sheet for Dec 2023.

Review of the Indian kitchen preparation room's log labelled "Freezer Temperature log" for December 2023 revealed that the temperatures were documented for the refrigerator temperatures and not the freezer temperatures from December 2 to 12th. The IC#1 stated that staff filled out the log incorrectly.

Review of the Indian kitchen preparation room's "Refrigerator Temperature log" for December

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 812	Continued From page 60	F 812		

2023 revealed the temperatures were not filled in for the AM or PM for December 2,3,4,5,6,7,8,9,10,11, and 12. The FSD stated, "I do not check temp logs in the Indian kitchen prep room as often as I should be." He then stated that the "temperature log sheets should be checked daily, and I didn't."

At 12:30 PM, in the main kitchen, the surveyor observed a metal rack with four shelves next to the pillar. The third shelf contained dry spices and other cooking ingredients. The surveyor identified the following:

-An opened one gallon container of red hot sauce, with no opened date.

-An opened 12 fluid (fl) oz glass bottle of red cooking wine, with no opened date.

-An opened 12 fl oz glass bottle of white cooking wine, with no opened date.

-Two 32 oz opened bottles of gravy mix, with no opened date.

Review of the undated facility policy "Record of Refrigeration Temperatures" included "a daily temperature record is to be kept of refrigerated items. It further included, "the refrigerator temperatures must be 41 degree or below."

Review of the undated facility policy "Food Storage" included "all products shall be dated upon receipt or when they are prepared." It also included the following:

- "Label and date all storage containers" as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 812	Continued From page 61	F 812		

1. The received date should already be on it.

2. Date opened.

3. Date the item expires.

Review of the undated facility job description for "Director of Food Services" included the following:

- "Perform administrative duties such as completing necessary forms, reports, evaluations, studies, etc., to assure control of equipment and supplies."

- "Inspect food storage rooms, utility/janitorial closets, etc., for upkeep and supply control."

- "Maintain a reference library of written material, laws, diet manuals, etc., necessary for complying with current standards and regulations and that will provide assistance in maintaining quality food service."

- "Make daily rounds to assure that dietary personnel are performing required duties and to assure that appropriate dietary procedures are being rendered to meet the needs of the facility."

- "Monitor dietary service personnel to assure that they are following established safety regulations in the use of equipment and supplies."

- "Ensure that all food storage rooms, preparation areas, etc., are maintained in a clean, safe, and sanitary manner."

- "Make weekly inspections of all dietary functions to assure that quality control measures are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 812	Continued From page 62 continually maintained." NJAC 8:39-17.2 (g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

(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 63 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observations, interviews, and review of facility documentation, it was determined that the facility failed to a.) ensure visitors follow appropriate infection control practices and	F 880	1. The family member, who had been previously educated, was asked not to visit. The resident□s family primary contact was spoken with and agreed with this course of action. Residents 217, 233 and 125 were monitored for signs and	

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	315180	A. BUILDING ______ B. WING ______	C 12/21/2023

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F 880	Continued From page 64 perform hand hygiene as indicated during dining observation for 1 of 5 units (2th-floor dining room), b.) appropriately discard soiled personal protective equipment (PPE) to prevent the potential spread of COVID-19 (a contagious disease caused by the virus SARS-CoV-2), c.) apply eye protection prior to entering a COVID-19 room and d:) change an N95 mask (a particulate-filtering facepiece respirator) upon exiting a COVID-19 room. This was observed on 1 of 5 units (4th-floor) during lunch pass. This deficient practice was evidenced as follows: 1. On 12/12/23 at 12:37 PM, the surveyor observed lunch in the dining room on the 2nd floor. The Licensed Practical Nurse/Unit Manager (LPN/UM) reviewed the lunch tickets, verified the residents diets, and filled the tray orders. Staff was observed distributing the trays. On 12/12/23 at 12:40 PM, the surveyor observed a woman, who the LPN/UM later identified as a family member/visitor (FM/V). The FM/V was observed encouraging Resident #217 to eat by putting the fork in the resident's hand and then walked over to Resident #233, touch their coffee cup and move their lunch tray out of the way. The FN/V then went back to Resident #217 and encouraged the resident to eat another fork full of food. The FN/V then went to resident #125 and removed their plate. The FN/V picked up a plastic lid from the ground and threw it away. The FN/V then went back to Resident #233, she placed her hand on the arm of the resident and then picked up and gave the resident their coffee mug. The FM/V did not perform hand hygiene during the above observations.	F 880	symptoms of infection- none were noted. The garbage can was emptied and moved to the inside of the room. The CNA was immediately re-educated on proper usage of PPE and assessed for exposure following current guidance. It was determined there was no exposure because of the short amount of time spent in the resident room without eye protection. 2. All residents have the potential to be affected. All residents on transmission based precautions were audited and no other issues were identified. 3. Staff were re-educated on infection control, including proper PPE and placement of trash bins for doffing PPE. Staff were educated on visitors and ensuring infection control policies are followed. 4. The DON or designee will audit 2 isolation rooms (if there are any) weekly for three months, checking for proper placement of trash bin, signage, and donning and doffing of PPE by staff entering the rooms. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	

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F 880	Continued From page 65 On 12/12/23 at 12:43 PM, the surveyor attempted to interview the woman, but she stated, "No English." On 12/12/23 at 12:46 PM, the LPN/UM identified the women as a FM/V. She stated "she shouldn't be touching people or their trays and she should sanitize her hands in between if she does." She then stated, "she (FM/V) encourages them (residents) to eat." The LPN/UM called the Assistant Director of Nursing/ Infection Preventionist (ADON/IP) who speaks Spanish to come speak to the FM/V. On 12/12/23 at 12:56 PM, the ADON/ IP spoke with FM/V to inform her that she cannot touch or assist the other residents. The ADON/IP stated that hands should be washed before handling food and after serving it. She then stated that family members should not be assisting other residents. On 12/12/23 at 3:16 PM, during an interview with the Director of Nursing (DON), she stated that hand hygiene should be performed between residents because you could infect others by touching one resident and then another. She stated "she spoke with the family of the resident and informed them that the visitor was not listening to the facility and that this was the second time they spoke to the FM/V." On 12/20/23 at 4:02 PM, in the presence of the survey team, the License Nursing Home Administrator (LNHA) and the DON were made aware of the above findings. No additional information was provided to the surveyor.	F 880		

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F 880	Continued From page 66 2. According to the Admission Record, Resident #27 was admitted to the facility with diagnoses that included but were not limited to; Ex Order 26. 4B1 . Review of Resident #27's Order Summary Report revealed an order for NJ Exec. Order 26:4.b.1 - Ex Order 26. 4B1 + every shift" dated NJ Exec. Order 26:4.b.1 and 'NJ Exec. Order 26:4.b.1 On 12/20/23 11:25 AM, the surveyors toured the 4th floor. The surveyors observed a white pedal garbage can (a touchless trash can that you open by stepping on the pedal with your foot to open the lid), with blue gowns overflowing from under the lid, to the right of the door frame of room NJ Exec. Order Signage for droplet precautions was noted at the door. On 12/20/23 at 11:37 AM, the surveyors interviewed the 4th floor Unit Manager (UM) who acknowledged that the gowns were overflowing and should not be because the gowns were contaminated and should be contained inside the garbage can. She further stated that the garbage can should be inside the room and not outside of it "to prevent the spread of infection." On 12/20/23 at 12:30 PM, the surveyors observed a Certified Nursing Aide (CNA) wearing an N95 mask, donn (put on) a blue gown and gloves, and bring a lunch tray into room NJ Exec. Ord The CNA did not	F 880		

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F 880	Continued From page 67	F 880		

put on eye protection before she entered the room. The CNA was observed exiting the room wearing only the N95. The surveyors interviewed the CNA, who acknowledged, that she should have worn eye protection and that she should have changed her N95 during the doffing (removing) process. She stated "I was only bringing in the tray." The surveyors observed the blue PPE bin that had face shields, surgical masks and N95 masks readily available.

On 12/20/23 at 3:48 PM, the LNHA and the DON were made aware of the above findings.

On 12/21/23 at 9:40 AM, the surveyor interviewed the ADON/ IP related to the above observation. She stated that the PPE garbage can should have been inside the room right by the door so staff can doff their PPE inside the room. She stated that this was to "contain the contaminated materials to prevent the spread of infection." The ADON/ IP further stated that the CNA should have applied a face shield or goggles before entering room [NJ Exec. O] and she should have removed the N95 prior to exiting the room. She then stated that once outside the room, staff should apply an Alcohol-Based Hand Rub and then apply a new N95.

A review of the facility's policy, "Hand Hygiene" revised April 2023, revealed Policy Explanation and Compliance Guidelines: 1. Hand Hygiene: a. during the delivery of patient care services, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surface.

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F 880	Continued From page 68 A review of the facility's policy, "Nutritional Services, review 8/9/2023, revealed Policy: All residents will be treated with dignity and respect at all times. A respectful, positive dining experience is essential to the residents' quality of life and helps to identify resident's needs and improve their overall nutritional status. Residents will be properly groomed and their needs attended to during the meal service. A review of the facility's policy "Infection Prevention and control Program/Outbreak Response Plan" revised April 2023 revealed "Adhere to Standard and Transmission-based Precautions including use of a facemask, gown, gloves, and eye protection for confirmed and suspected COVID-19 case(s)." ..."Limit only essential personnel to enter the room with appropriate PPE and respiratory protection. PPE includes: Gloves, Gown, Respiratory Protection: facemask, eye protection that covers both the front and side of the face." A review of the facility's policy, "Transmission-Based (isolation) Precautions," revised 4/2023, revealed Policy: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. Definitions: "Contact precautions" refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. "Droplet precautions" refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. 10. Droplet Precautions- f. Based upon the pathogen or clinical syndrome, if	F 880		

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F 880	Continued From page 69 there is a risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn. NJAC 8:39-19.4 (m)(n)	F 880		
F 922 SS=F	Procedures to Ensure Water Availability CFR(s): 483.90(i)(1) The facility must-- §483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the designated emergency supply of water needed for residents in the event of a loss of normal water supply. This deficient practice was evidenced by the following: On 12/12/23 at 11:00 AM, the surveyor met with facility Vice President of Operations, the Licensed Nursing Home Administrator (LNHA), the Director of Nursing and the Infection Preventionist for an entrance conference meeting. The facility was licensed for 250 beds and the facility census was 227 (the number of residents who currently resided at the facility). On 12/12/23 at 12:18 PM, the surveyor conducted a kitchen tour with the Food Service Director (FSD). The surveyor observed two pallets of water in the basement. The FSD stated that "it was enough water for 250 residents for three days." The FSD could not speak to the exact	F 922	1. Additional water was ordered and delivered. 2. All residents have the potential to be affected. 3. The FSD was educated on the Emergency Water requirements, policy, and his responsibility of ensuring an adequate supply is on hand. 4. The FSD or designee will audit the emergency water supply weekly for 3 months to ensure an adequate supply is on hand. Findings will be submitted to the Administrator and Quality Assurance committee which meets quarterly and as needed.	1/30/24

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F 922	Continued From page 70	F 922		

quantity that was there and stated he would get back to the surveyor with an exact count.

On 12/20/23 at 9:51 AM, the surveyor conducted a follow up kitchen tour with the FSD in the presence of a second surveyor. The surveyor observed four pallets of water stored in the basement hallway which equaled 864 gallons (216 gallons per pallet). One pallet of water had a best if used by date of May 21, 2022. The FSD acknowledged that the water should have been used before that date. In addition, he acknowledged that he ordered water after surveyor inquiry. The FSD stated "I got two pallets of water delivered on Monday" and pointed to the pallets of water stored to the left.

On 12/20/23 at 12:28 PM, the FSD acknowledged that he placed an order for water by phone, after surveyor inquiry, on 12/12/23 and received the water on 12/13/23 (an invoice was provided).

On 12/20/23 at 1:40 PM, the surveyor interviewed the FSD who stated that the facility was required to maintain emergency water in the amount of one (1) gallon per resident per day for three (3) days. He stated he would use the number of licensed beds (250) to calculate the maximum amount needed. He further stated that the administrator was ultimately responsible for emergency food and water "but it's my responsibility to order the emergency supplies and get them."

On 12/20/23 at 4:02 PM, the LNHA acknowledged the concern regarding the emergency water in the presence of the survey team.

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F 922	Continued From page 71	F 922		

Review of an undated facility policy "Dining Services: Instructions for Implementing Menu to be Used in the Event of a Disaster or Emergency," included that the facility should maintain an "adequate supply ... of emergency water: one (1) gallon drinking water per day per every resident and staff member on duty."

Review of the facility policy "Disaster Planning - Emergency Water Plan" revised April 2023, included "In the event of a loss of utilities, water may be unavailable, or if available, it may be contaminated and in need of purification. In either case, the facility will need to have an adequate supply of water on hand ... Recognizing that suppliers may be unable to deliver immediately, a three-day supply of water is recommended."

It also included that "A minimum of three (3) day supply of water should be available. The quantity of water that is needed can be determined by the following calculations: Drinking water 2 quarts (0.5 gallon) per person per day and All-purpose water 1 gallon per person per day." It further included, "Rotate or discard water according to the manufacturers expiration date on the container."

Review of a letter from a vendor regarding emergency water supply dated 11/1/23, included that "In the event of an emergency, [name redacted] will have water available to purchase for your facility not in excess of our supply."

NJAC 8:39-31.6 (n)

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	061209	A. BUILDING: ______ B. WING ______	C 12/21/2023

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S 000	Initial Comments Complaint #: NJ00168177, NJ00166739, NJ00166275, NJ00162234, NJ00160160, NJ00159698, NJ00156272 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C/O # NJ156272, NJ166739 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to a:) maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey, and b.) ensure that one administrative staff member and one direct care staff member employed at the facility completed the general training for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female	S 560	1. Efforts to hire staff are ongoing and contracts with additional staffing agencies were signed. Two employees will receive LGBTQ+ training as the designated facility representatives- All staff will received annual LGBTQ+ training- training will be provided by Healthcare Academy. 2. All residents have the potential to be affected. 3. The staffing coordinator and human resources director were re-educated on cna staffing ratio requirements. Additional staffing agencies are being utilized. The	2/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 01/16/24

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S 560	Continued From page 1	S 560		

biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program.

Findings include:

A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:
One Certified Nurse Aide (CNA) to every eight residents for the day shift.
One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and
One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.

1. For the 2 weeks of Complaint staffing from 07/10/2022 to 07/23/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-07/10/22 had 16 CNAs for 231 residents on the day shift, required at least 29 CNAs.
-07/11/22 had 18 CNAs for 230 residents on the day shift, required at least 29 CNAs.
-07/12/22 had 19 CNAs for 228 residents on the

facility is sponsoring students to attend a CNA course. The facility is actively recruiting new staff using online job platforms and local organizations and word of mouth and referral and sign on bonuses. Two employees were registered for LGBTQ+ training and the facility utilizes an education platform by which all staff will receive the annual training.
4. The Administrator or designee will audit the staffing ratios weekly for one month and as needed. Findings will be reported to the Quality Assurance committee which meets quarterly and as needed. The Administrator or designee will audit training records quarterly to ensure compliance with LGBTQ+ training requirements.

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S 560	Continued From page 2 day shift, required at least 28 CNAs. -07/13/22 had 23 CNAs for 228 residents on the day shift, required at least 28 CNAs. -07/14/22 had 21 CNAs for 228 residents on the day shift, required at least 28 CNAs. -07/15/22 had 21 CNAs for 228 residents on the day shift, required at least 28 CNAs. -07/16/22 had 16 CNAs for 228 residents on the day shift, required at least 28 CNAs. -07/17/22 had 13 CNAs for 228 residents on the day shift, required at least 28 CNAs. -07/18/22 had 22 CNAs for 228 residents on the day shift, required at least 28 CNAs. -07/19/22 had 17 CNAs for 228 residents on the day shift, required at least 28 CNAs. -07/20/22 had 18 CNAs for 230 residents on the day shift, required at least 29 CNAs. -07/21/22 had 18 CNAs for 230 residents on the day shift, required at least 29 CNAs. -07/22/22 had 21 CNAs for 230 residents on the day shift, required at least 29 CNAs. -07/23/22 had 19 CNAs for 230 residents on the day shift, required at least 29 CNAs. 2. For the 2 weeks of Complaint staffing from 02/12/2023 to 02/25/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -02/12/23 had 17 CNAs for 232 residents on the day shift, required at least 29 CNAs. -02/12/23 had 15 total staff for residents on the overnight shift, required at least 17 total staff. -02/13/23 had 26 CNAs for 232 residents on the day shift, required at least 29 CNAs. -02/14/23 had 18 CNAs for 232 residents on the day shift, required at least 29 CNAs. -02/15/23 had 25 CNAs for 231 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061209	A. BUILDING: ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION ANI	**303 ELM STREET PERTH AMBOY, NJ 08861**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 day shift, required at least 29 CNAs. -02/16/23 had 21 CNAs for 231 residents on the day shift, required at least 29 CNAs. -02/17/23 had 26 CNAs for 231 residents on the day shift, required at least 29 CNAs. -02/18/23 had 23 CNAs for 232 residents on the day shift, required at least 29 CNAs. -02/19/23 has 17 CNAs for 232 residents on the day shift, required at least 29 CNAs. -02/20/23 had 22 CNAs for 232 residents on the day shift, required at least 29 CNAs. -02/21/23 had 25 CNAs for 238 residents on the day shift, required at least 30 CNAs. -02/22/23 had 25 CNAs for 238 residents on the day shift, required at least 30 CNAs. -02/23/23 had 25 CNAs for 237 residents on the day shift, required at least 30 CNAs. -02/24/23 had 25 CNAs for 237 residents on the day shift, required at least 30 CNAs. -02/25/23 had 24 CNAs for 237 residents on the day shift, required at least 30 CNAs. 3. For the 2 weeks of staffing prior to survey from 11/26/2023 to 12/09/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 2 of 14 evening shifts, deficient in CNAs to total staff on 2 of 14 evening shifts, and deficient in total staff for residents on 9 of 14 overnight shifts as follows: -11/26/23 had 12 CNAs for 236 residents on the day shift, required at least 29 CNAs. -11/26/23 had 20 total staff for 236 residents on the evening shift, required at least 24 total staff. -11/26/23 had 9 CNAs to 20 total staff on the evening shift, required at least 10 CNAs. -11/26/23 had 12 total staff for 236 residents on the overnight shift, required at least 17 total staff.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061209	A. BUILDING: ___ B. WING ___	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION ANI	303 ELM STREET PERTH AMBOY, NJ 08861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 -11/27/23 had 10 CNAs for 232 residents on the day shift, required at least 29 total staff. -11/27/23 had 15 total staff for 232 residents on the overnight shift, required at least 17 total staff. -11/28/23 had 15 CNAs for 230 residents on the day shift, required at least 29 CNAs. -11/28/23 had 14 total staff for 230 residents on the overnight shift, required at least 16 total staff. -11/29/23 had 13 CNAs for 228 residents on the day shift, required at least 28 CNAs. -11/30/23 had 13 CNAs for 224 residents on the day shift, required at least 28 CNAs. -11/30/23 had 15 total staff for 224 residents on the overnight shift, required at least 16 total staff. -12/01/23 had 15 CNAs for 224 residents on the day shift, required at least 28 CNAs. -12/01/23 had 14 total staff for 224 residents on the overnight shift, required at least 16 total staff. -12/02/23 had 12 CNAs for 224 residents on the day shift, required at least 28 CNAs. -12/02/23 had 15 total staff for 224 residents on the overnight shift, required at least 16 total staff. -12/03/23 had 7 CNAs for 224 residents on the day shift, required at least 28 CNAs. -12/04/23 had 12 CNAs for 228 residents on the day shift, required at least 28 CNAs. -12/05/23 had 15 CNAs for 225 residents on the day shift, required at least 28 CNAs. -12/06/23 had 12 CNAs for 225 residents on the day shift, required at least 28 CNAs. -12/07/23 had 11 CNAs for 225 residents on the day shift, required at least 28 CNAs. -12/07/23 had 12 total staff for 225 residents on the overnight shift, required at least 16 total staff. -12/08/23 had 10 CNAs for 225 residents on the day shift, required at least 28 CNAs -12/08/23 had 12 total staff for 225 residents on the overnight shift, required at least 16 total staff. -12/09/23 had 15 CNAs for 228 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061209	A. BUILDING: ______ B. WING ______	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION ANI	**303 ELM STREET PERTH AMBOY, NJ 08861**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5	S 560		

day shift, required at least 28 CNAs.
-12/09/23 had 22 total staff for 228 residents on the evening shift, required at least 23 total staff.
-12/09/23 had 10 CNAs to 22 total staff on the evening shift, required at least 11 CNAs.
-12/09/23 had 11 total staff for 228 residents on the evening shift, required at least 16 total staff.

On 12/13/2023 at 8:24 AM the surveyor conducted an interview with the facility Staffing Coordinator (SC). The surveyor asked the SC if she was familiar with the minimum staffing requirements for nursing homes. The SC responded, "Yes, I am familiar with the minimum staffing requirements. The requirements are 1 CNA to 8 residents on 7-3, 1 CNA to 10 residents on 3-11, and 1 CNA to 14 residents on 11-7 shift." The surveyor then asked the facility SC if the facility consistently meets the minimum mandated staffing requirements. The SC replied, "We try to meet them as much as possible. We have a bunch of new hires to meet the ratios."

A review of the provided facility policy titled, "Nursing Services and Sufficient Staff" with a reviewed date of 07-2023 revealed under "Policy Explanation and Compliance Guidelines" that, "1. The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance New Jersey State guidelines with regards to staffing ratios for all licensed nurses and Certified Nurse Assistants."

B.) Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION ANI	303 ELM STREET PERTH AMBOY, NJ 08861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6	S 560		

and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C. 8:39 in future rulemaking.

Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities").

The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status.
Prohibited Actions
The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status:
1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility;
2. Denying a request by residents to share a room;
3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10(e)(5);
4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION ANI	**303 ELM STREET PERTH AMBOY, NJ 08861**

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S 560	Continued From page 7	S 560		

or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity;
5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice;
6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices;
7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations;
8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and
9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6).

Resident Records
Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident.

Confidentiality
The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident

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S 560	Continued From page 8 information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION ANI	**303 ELM STREET PERTH AMBOY, NJ 08861**

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S 560	Continued From page 9 to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities,	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 10 and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. During entrance conference on 12/12/2023 at 11:00 AM, the surveyor requested the certifications of the 2 staff members who were trained in LGBTQI+. On 12/13/23 at 11:28 AM the Licensed Nursing Home Administrator (LNHA) stated that the only person that was certified at the facility was the former LNHA and that "no one that was currently employed by the facility was certified." On 12/14/23 at 2:32 PM, during an interview with the surveyor, the Registered Nurse Vice President of Clinical Services (RN/VPCS) and the LNHA, the RN/VPCS confirmed that the facility did not have one administrative staff member and one direct care staff member that had received the LGBTQTI and HIV+ training currently employed by the facility. A review of the undated facility policy, "New Jersey Bill S2545" revealed: Policy: Establishes certain requirements concerning rights of lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, intersex, and HIV-positive residents of long-term care facilities. 6. a. Each long-term care facility shall ensure that the administrators and staff at the long-term care facility receive training, on at least a biennial basis. D. (1) Each long-term care facility shall designate two employees, including one employee representing management at the facility and one employee representing direct care staff at the facility to receive in p-person training ...which designated employees shall serve as points of contact for the facility regarding	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALAMEDA CENTER FOR REHABILITATION ANI	**303 ELM STREET PERTH AMBOY, NJ 08861**

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S 560	Continued From page 11 compliance with the provisions of this act and shall develop a general training plan for the facility. In the event a designated employee ceases to be employed by the facility, the facility shall designate another employee, who is representative of the employee group represented by the former designee ...serve as a point of contact for the facility regarding compliance with the provisions of this act.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315180	A. Building B. Wing	2/26/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

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) ID Prefix	Reg. #	LSC	DATE (Y5) Correction Completed
F0641	483.20(g)		01/30/2024
F0695	483.25(i)		01/30/2024
F0728	483.35(d)(1)-(3)		01/30/2024
F0755	483.45(a)(b)(1)-(3)		01/30/2024
F0756	483.45(c)(1)(2)(4)(5)		01/30/2024
F0758	483.45(c)(3)(e)(1)-(5)		01/30/2024
F0761	483.45(g)(h)(1)(2)		01/30/2024
F0804	483.60(d)(1)(2)		01/30/2024
F0812	483.60(i)(1)(2)		01/30/2024
F0880	483.80(a)(1)(2)(4)(e)(f)		01/30/2024
F0922	483.90(i)(1)		01/30/2024

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 12/21/2023

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315180		2/26/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

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ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix E0015 Reg. # 483.73(b)(1) LSC	Correction Completed 01/30/2024	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
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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
12/21/2023

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061209	A. Building B. Wing	2/26/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/09/2024	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
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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	
12/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061209 Y1	A. Building B. Wing Y2	2/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/21/2023	☐ 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
	315180	A. BUILDING **01** B. WING ___	**12/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	**303 ELM STREET** **PERTH AMBOY, NJ 08861**

(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 000	INITIAL COMMENTS Alameda Center for Rehabilitation and Healthcare is a six (6) story building with a Type 11 (222) protected non-combustible/limited combustible building construction, that was built in January 1, 1972. The facility is divided into 11 smoke zones. The building has a natural gas exterior generator 125 KW that does approximately 40% of the building. The fire suppression system utilizes an electric fire pump to support the system. The facility has three elevators. The facility has 250 licensed beds currently occuping 227. * The facility rents roof space to verizon for external antennas. Verizon installed an exterior natural gas generator on the facility grounds next to the building.	K 000		
K 161 SS=E	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 **I** (442), **I** (332), **II** (222) Any number of stories non-sprinklered and sprinklered 2 **II** (111) One story non-sprinklered Maximum 3 stories sprinklered	K 161		2/19/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 01/16/2024

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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K 161	Continued From page 1 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 12/19/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), a). it was determined that the facility failed to provide an acceptable construction type and wall-ceiling assembly in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1. and b).it was determined that the facility failed to provide an acceptable construction type and construction standards in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through 19.1.6.7, 19.3.1 and 8.6. This deficient practice was evidenced by the following:	K 161	1. Ceiling tiles were replaced. The facility has reached out to vendors to update the facility floor plans and provide fire rating to the beams. 2. All residents have the potential to be affected. Ceiling tiles were audited and addressed. 3. The Maintenance Director will make regular environmental rounds to check for missing ceiling tiles. The Administrator will audit the life safety book to ensure accurate floor plans are available. The maintenance director will do an annual check to ensure the steel beams are intact with fire retardant properties.	

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K 161	Continued From page 2 a). An interview was conducted at 09:45 AM, during the entrance conference with the MD and RPOD, who were unable to confirm the building construction type with the floor plans provided. The floor plans provided were evacuation routes, including basement floor plans that were not legible to read. The provided floor plans did not accurately identify smoke barrier walls, fire walls, shafts, hazardous areas and complete stairwell exits for the life safety code survey. The provided floor plans were identified as "Arista Care" and did not identify all specific floors and did not identify the basement accurately. b-1). At 11:22 AM, the surveyor, MD and RPOD, observed in the floor #4 dining room that an approximately 4' x 2' drop ceiling tile was missing, exposing unprotected steel beam and metal decking. b-2). At 11:45 AM, the surveyor, MD and RPOD, observed in the electrical room that an approximately 2' x 2' drop ceiling tile was missing, exposing unprotected steel beam and metal decking. b-3). At 12:18 PM, the surveyor, MD and RPOD, observed in the mechanical room that the ceiling was open and the steel beam and decking was observed to have no fire protection rating. 1. Exposed beams supporting floors and underside of metal deck not protected. 2. UL assembly, fire resistance rating for the composite metal deck and steel truss not known. 3a. The 6-story building requires Type II (222) construction.	K 161	4. The maintenance director or designee will make weekly environmental rounds to each unit checking for missing ceiling tiles weekly for one month and then monthly. The Administrator or designee will audit the Life Safety book monthly for 3 months and then as needed. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	

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K 161	Continued From page 3 3b. The 6-story building observed Type II (000) construction. The MD and RPOD confirmed the above observations and stated they were unaware the fire protection coating was missing on the beams and decking. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/21/23. NJAC 8:39-31.2(e)	K 161		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on interviews and documentation review on 12/19/23 and 12/20/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), a). it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. and b). it was determined that the facility failed to ensure fire doors were operating in optimal condition.This deficient practice was identified for seven (7) of seven (7) fire doors documented on the provided facility floor plans and was evidenced by the following:	K 211	1. Annual fire door inspection and log was implemented. Paint was removed from fire rating labels. The mechanical room frame strike plate was replaced and is now self-closing. The laundry room fire door handle was replaced. 2. All residents have the potential to be affected. 3. The maintenance director will make regular environmental rounds to check that fire doors are labeled correctly, doors that need to be self-closing are functioning properly, and strike plates and	2/19/24

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K 211	Continued From page 4 a). On 12/19/23 at approximately 9:45 AM, the surveyor asked the MD to provide the annual testing requirements for fire door assemblies. The MD provided a fire door log dated: 01/01/23, that indicated the inspection elements for each door were marked: GOOD and no other detail of each fire door assembly was applyed to the inspection form in accordance with NFPA 80 and NFPA 105 Standard for Smoke Doors Assemblies and other Opening Protectives. The MD indicated the annual inspection of the fire door components on the log were not specified as per NFPA 80 Standard for fire doors and other opening protectives. He stated he was unaware of the requirements of the inspection report. b-1). On 12/20/23 from 09:30 AM to approximately 12:45 PM, the surveyor, MD and RPOD observed fire doors with painted labels. The MD stated the facility painter was let go for unforeseen circumstances earlier in the year. b-2). At 10:50 AM, the surveyor, MD and RPOD observed that the mechanical room fire door was missing its frame strike plate, and not self-closing with latching in the closed position. b-3). At 11:07 AM, the surveyor, MD and RPOD observed in the laundry room that the fire door was missing its door handle. The MD and RPOD both confirmed the findings during the observations stated above. The Administrator was informed of the finding's at the Life Safety Code Exit Conference on 12/21/23.	K 211	door handles are in place. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	

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K 211	Continued From page 5 NJAC 8:39-31.1(c), 31.2(e) NFPA 80 and 105: Standard for fire doors assemblies and other opening protectives NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a	K 222		2/19/24

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K 222	Continued From page 6 complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/20/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide exit doors and gates in the means of egress readily accessible and free of all	K 222	1. The code to the door was provided to all staff and is posted inside the Rehab Director□s office. The courtyard gate lock key is being placed in a lockbox that all staff will have the code for. 2. All residents have the potential to be	

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K 222	Continued From page 7 obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was identified for 2 of 10 exit/egress doors and gates observed and was evidenced by the following. 1). At 11:15 AM, the surveyor, MD and RPOD observed a keypad at the rehabilitation exit/egress door. An interview was conducted at that time and it was determined, that all staff did not know the code to the door. 2). At 11:27 AM, the surveyor, MD and RPOD observed in the smoking area courtyard, that the exit gate was provided with special locking arrangements. The gate was chained and locked with a pad lock. An interview at that time, confirmed that all staff did not have keys to unlock the gate. The Administrator was notified of the findings at the Life Safety Code Exit Conference on 12/21/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	affected. 3. The maintenance director will make regular environmental rounds to check that staff are aware of the door codes and no egress doors are locked in a way that violates code. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.	K 225		2/19/24

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K 225	Continued From page 8 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 12/20/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD),it was determined that the facility failed to provide stairwell identification with the requirements of NFPA 101, 2012 Edition, Section 7.2.2.5.4.1 existing stairs serving five or more stories shall comply with 7.2.2.5.4.1(A) through 7.2.2.5.4.1(M). This deficient practice was evidenced for 4 of 4 stairwells observed by the following: On 12/20/23 from approximately 09:45 AM to approximately 01:45 PM, the surveyor, MD, and RPOD observed in stairwells identified as stairwells: West, South, North and Main and/or Center that each landing was not provided with any stairway identification indicating floor level. An interview with the MD and RPOR, during the observations, both indicated that currently from the interior stairwell, you could not determine what stairwell and floor you were on in the event of an emergency of non-emergencey evacuation. A review of the facility provided lay-out identified the facility is a six-story (6) building with four (4) exit stairwells (South, West, South, North and Main and/or Center stairwell), that Resident, Staff and Visitors would use in the event of an emergency to exit the building.	K 225	1. Stairwell identification will be put into place on each landing. 2. All residents have the potential to be affected. 3. The maintenance director will make regular environmental rounds to check that identification is in place on each stairwell landing. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	

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K 225	Continued From page 9 The Administrator was informed of the findings at the Life Safety Code exit conference on 12/21/23. NJAC 8:39 31.2 (e) NFPA 101, 2012 Edition, Section 7.2.2.5.4.1 existing stairs serving five or more stories shall comply with 7.2.2.5.4.1(A) through 7.2.2.5.4.1(M)	K 225		
K 281 SS=E	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 observation and interviews conducted on 12/20/23 in the presence of facility Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 4 of 12 occupied access areas observed and was evidenced by the following: 1). At 09:48 AM, the surveyor, in the presence of the MD and RPOD, observed in the 4th floor elevator corridor that the means of egress had no lighting when the wall switch was in the off position.	K 281	1. An electrician was hired to wire the lights so that emergency egress routes remain illuminated even if the light switch is in the off position. The 4th floor dining room exit signed was removed from the light switch and will always remain illuminated. Lights to the emergency egress route will remain on even if the light switch is in the off position. 2. All residents have the potential to be affected. 3. The maintenance director will make regular environmental rounds to check that emergency egress routes are illuminated and that emergency exit signs are illuminated. 4. The maintenance director or designee will make weekly environmental rounds to	2/19/24

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K 281	Continued From page 10 2). At 10:18 AM the surveyor, in the presence of the MD and RPOD, observed in the 4th floor dining room that the exit sign was illuminated by a wall light switch, when the switch was in the off position the means of egress had no lighting and illuminated exit sign. The areas were not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. 3). At 11:50 AM, the surveyor, in the presence of the MD and RPOD, observed in the physical therapy gym and kitchen, that the outside exit/egress areas were observed to be single bulb emergency lighting fixures. The MD and RPOD both confirmed the finding's at the time of observations. The Administrator was informed of these findings at the Life Safety Code survey exit conference on 12/21/23. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	each unit for one month and then monthly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	
K 291 SS=E	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 and interview on 12/20/23,	K 291	1. A battery backup emergency light will	2/19/24

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K 291	Continued From page 11 in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide a battery backup emergency light above the electric fire pump transfer switch independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 19.2.9.1.- 7.9.1 (general). This deficient practice was identified for 1 of 2 transfer switches observed and was evidenced by the following: At 11:48 AM, the surveyor, in the presence of the MD and RPOD, observed one (1) fire pump transfer switch in the ground floor fire pump room. The fire pump room observed was not provided with any emergency lighting independent of the building's electrical system and emergency generator. The MD and RPOD confirmed the findings at the time of the observation. The Administrator was informed of the findings at the Life Safety Code exit on 12/21/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	be installed above the electric fire pump transfer switch- the light is independent of the facility electrical system and emergency generator. 2. All residents have the potential to be affected. 3. The maintenance director will make regular environmental rounds to check that the emergency backup light is in place at the fire pump transfer switch. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	
K 321 SS=E	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	K 321		2/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING 01 B. WING	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	**303 ELM STREET** **PERTH AMBOY, NJ 08861**

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K 321	Continued From page 12 separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/20/23, in the presence of the Maintenace Director (MD) and the Regional Plant Operations Director (RPOD), 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, Section 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 was identified in five (5) of nine (9) hazardous storage areas in the facility, and was evidenced by the following:	K 321	1. The kitchen door in the HR corridor was made self-closing and latching. The storage room door by the bathroom was made self-closing and latching. The soiled utility room (4th floor) door was made self-latching, and tape was removed from the strike plate. The Rehabilitation storage room door was closed and made self-closing and latching. The Mechanical Equipment room door will be replaced. 2. All residents have the potential to be affected. 3. Staff were educated on not propping doors open or putting any materials into the strike plate that would prevent the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ____________	**12/21/2023**

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K 321	Continued From page 13 -The kitchen door in the HR corridor was not self-closing and latching. -The storage room door by the bathroom was not self-closing and latching. -The soiled utility room (4th floor) door was not latching as paper and tape were stuffed into the strike plate. -The Rehabilitation storage room door was propped open and was not self-closing and latching. -The Mechanical equipment room door had a transfer grill that opened to the exit/egress corridor. The MD and RPOD both confirmed the findings, during the observations. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 12/21/23. NJAC 8:39-31.2(e)	K 321	doors from locking. The maintenance director will make regular environmental rounds to check that self-closing doors are in place and functioning and that doors are not being propped open or prevented from latching. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	
K 324 SS=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	K 324		2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

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K 324	Continued From page 14 * 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, on 12/20/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that 1 of 1 kitchen ansul system inspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10. The deficient practice was evidenced by the following: On 12/20/23 at 11:27 AM, the surveyor, MD and RPOD observed in the kitchen, that the monthly inspection tag to the ansul fire suppression system, lacked documentation of monthly "quick check" or inspection as required by NFPA 96. The observation of the ansul monthly inspection tag indicated the last inspection was documented: 10/22/23.	K 324	1. The monthly inspection for the ansul system was completed and documented. 2. All residents have the potential to be affected. 3. The maintenance director will make regular environmental rounds to check that the monthly ansul system inspection is documented. The Maintenance Director and Maintenance Staff were educated on the need for the monthly inspection and documentation. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING 01 B. WING ______	12/21/2023

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K 324	Continued From page 15 At that time, the surveyor interviewed the MD, who confirmed that the ansul monthly inspection tag was not completed since 10/22/23. The Administrator was informed of the finding at the Life Safety Code exit conference on 12/21/23. NJAC 8:39-31.2(e) NFPA 96 and NFPA 10.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 12/19/23 and 12/20/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure: a.) that their fire alarm system annunciator panel was in normal mode as per NFPA 70 and 72. and b.) smoke detection sensitivity testing were completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The deficient practice was identified for 2 of 2 inspection reports and was evidenced by the following:	K 345	1. The fire panel was repaired and is no longer in trouble mode. Smoke detection sensitivity tests are scheduled to be conducted. 2. All residents have the potential to be affected. 3. The maintenance director and maintenance staff were educated on the need for immediate response when the fire alarm panel displays trouble. The maintenance director will make regular environmental rounds to check that the fire panel system is normal. The maintenance director will audit the life	2/19/24

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	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

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K 345	Continued From page 16 a). On 12/19/23 and 12/20/23 at 9:15 AM, on both days, the surveyor, MD and RPOD observed the fire alarm annunciator panels were in trouble mode indicating: The " TROUBLE : notif basement 1st floor LG0051CM34:0027 12/06/23". Trouble signals and their restoration to normal was not completed within 200 seconds. Fire Watch for the fire alarm system impairment was not undertaken. Twenty four hour "Monitoring Report" was not provided. The MD and RPOD both stated and confirmed that all the fire alarm annunciator panels were in trouble mode. The MD indicated he called the facility fire alarm vendor on 12/19/23 but the vendor would not respond until late 12/20/23, no further documentation was provided. b). On 12/19/23 at 9:48 AM, the surveyor, MD and RPOD confirmed that no fire alarm smoke detector sensitivity report was provided in the Life Safety Code Inspection book. The last semi-annual fire alarm inspection report's were dated: 11/03/23 and 05/08/23, and did not indicate when the last smoke detector sensitivity test was conducted in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The MD and RPOD were interviewed during the document review, where they stated currently, that no smoke detector sensitivity report was performed and they could not provide any documentation on when it was last conducted.	K 345	safety book to ensure the smoke sensitivity tests are up-to-date as required. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. The maintenance director will audit the life safety book quarterly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING 01 B. WING	12/21/2023

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K 345	Continued From page 17 The Administrator was informed of the findings at the Life Safety Code Exit conference on 12/21/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345		
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 12/19/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure a testing and maintenance of battery-operated smoke detectors in resident rooms, in an existing structure. This deficient practice was evidenced for 55 of 55 observed battery-operated smoke detectors observed in resident rooms and evidenced by the following: The MD stated that resident rooms had battery operated smoke detectors, but could not provide a monthly testing log A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance and testing document, for the testing of the detectors for battery replacement (including the make,	K 347	1. The maintenance director compiled a list of battery-operated smoke detectors in the facility which includes make, model, installation date, type of battery, and replacement date. 2. All residents have the potential to be affected. 3. The maintenance director or designee will audit the list of battery-operated smoke detectors to ensure preventative maintenance such as battery changes are being done timely. 4. The maintenance director or designee will audit the list of battery-operated smoke detectors monthly for 3 months and quarterly after. Findings will be reported to the Administrator and Quality Assurance committee which meets quarterly and as needed.	2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 347	Continued From page 18 model, installation date, type of battery and replacement date). The Administrator was informed of the findings at the Life Safety Code exit conference on 12/21/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 12/20/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide	K 351	1. Vendor was contracted to change the sprinkler heads. 2. All residents have the potential to be affected. 3. The maintenance director will make	2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

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K 351	Continued From page 19 complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment and install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The quick-response sprinklers shall not be mixed with any standard-response within a compartment as per NFPA 13. This deficient practice was evidenced for 1 of 1 compartments as follows: At 11:15 AM, the surveyor, MD and RPOD observed in the facility laundry room that fusible link type fire sprinkler heads(4) were installed with quick response (2) and standard response heads (2). The Administrator was informed of the finding's at the Life Safety Code exit conference on 12/21/23. NJAC 8:39-31.2(e) NFPA 13	K 351	regular environmental rounds to ensure proper sprinkler heads are in place. The maintenance director was educated on the requirement for uniform sprinkler heads. 4. The maintenance director will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and Quality Assurance committee which meets quarterly and as needed.	
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 _______________	K 353		2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING 01 B. WING ______	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

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K 353	Continued From page 20 b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/19/23, 12/20/23 & 12/21/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to A). maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25, B). to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated as evidenced by the following: in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1, and C). to ensure the fire pump was in optimal condition as per NFPA 20. These deficient practices was identified for and evidenced by the following: A-1). On 12/20/23 at 12:10 PM, the surveyor, MD and RPOD observed in the fire pump room that 13 of 13 fire sprinkler heads were green with oxidation and/or corrosion. A-2). On 12/20/23 at 12:28 PM, the surveyor, MD and RPOD observed in the laundry room compartment, that different types of fire sprinkler	K 353	1. The vendor was contracted to replace the 13 sprinkler heads in the fire pump room. The vendor was contracted to install uniform sprinkler heads in the laundry room compartment. A new escutcheon plate was installed at the fire sprinkler in the employee break room. A new ceiling tile was installed in the floor #2 med room. A new escutcheon plate was installed at the fire sprinkler in the medical records storage closet. All missing ceiling tiles were replaced. The vendor is scheduled to complete work quoted on the annual fire pump inspection dated 7/28/23. The water on the floor was removed and the fire pump corrosion was corrected. 2. All residents have the potential to be affected. 3. The maintenance director will make regular environmental rounds to ensure that the sprinkler system is good condition, plates are in place, and there are no missing or damaged ceiling tiles. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING 01 B. WING	12/21/2023

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K 353	Continued From page 21 heads were installed: (4) fusible link type, (2) quick response and (2) standard response. The MD and RPOD confirmed the findings during the observations. B-1). On 12/20/23 at 09:18 AM, the surveyor, MD and RPOD, observed in the employee break room by resident room 219 that the fire sprinkler escutcheon plate was missing. B-2). On 12/20/23 at 09:20 AM, the surveyor, MD and RPOD, observed in the floor #2 med room that 1 of 1 fire sprinkler heads had an approximately 2" opening around the sprinkler head due to an oversized ceiling tile cut. B-3). On 12/20/23 at 12:41 PM, the surveyor, MD and RPOD, observed in the medical records storage closet that 1 of 1 fire sprinkler escutcheon plates was missing. B-4). On 12/20/23 from 09:30 AM to approximately 12:45 PM, the surveyor, MD and RPOD observed missing and/or ceiling tiles not properly installed in the following locations of the facility: -Medical records storage approximately 2' x 2' ceiling opening. -4th floor dining room approximately 4' x 2' ceiling opening. -4th floor janitors closet: ceiling tile not in place. -Kitchen approximately 2' x 2' ceiling opening. -IT closet approximately 2' x 2' ceiling opening. -3rd floor recreation room approximately 1" hole in the ceiling tile. -Fire sprinkler room and pump room, missing ceiling tiles.	K 353	committee which meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING 01 B. WING ______	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 22	K 353		

An interview was conducted with the MD and RPOD, where both stated and confirmed the above findings.

C). On 12/19/23 at 09:45 AM, the surveyor reviewed all related documentation for the electric fire pump. The annual fire pump inspection from the facility vendor dated 07/28/23, indicated deficiencies noted: work order #168544.

A copy of an unsigned proposal Quote #110223 CPS job: repack Peerless was provided by the MD on 12/19/23 at 9:50 AM, the document was dated 11/06/23 and included the following:

* it was noted the unsigned quote was good for 30 days. The document date of 11/06/23 and the date the MD provided the document to the surveyor on 12/19/23, indicated the quote has expired.

Repack and replace bearings on existing Peerless 4ABF-10 fire pump to consist of:

Dissemble casing
Remove old packing and clean out internal area
Inspect impeller and inside housing
Install new packing
Install new case gasket
Reassemble casing
Reinstall packing glands and new gland bolt assemblies
Install new bearings

On 12/20/23 at 11:15 AM, the surveyor, MD and RPOD observed in the fire pump room, that the electric pump was surrounded by water on the floor. The electric motor connection to the fire

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ________	**12/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	**303 ELM STREET** **PERTH AMBOY, NJ 08861**

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K 353	Continued From page 23 pump had a heavy rust condition along with corrosion. The MD and RPOD both indicated the electric fire pump had a heavy rust condition, along with corrosion and was observed to be surrounded by water on the floor. The Administrator was informed of the finding's at the Life Safety Code exit conference on 12/21/23. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25 NFPA 20: fire pump requirements	K 353		
K 363 SS=E	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	K 363		2/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

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K 363	Continued From page 24 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/20/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring complete bedroom door and closet closure for confinement of smoke/fire products was identified in seven (7) of 25 resident rooms and closet doors observed and was evidenced by the following: During the building tour on 12/20/23 from 9:15 AM to 01:45 PM, the surveyor, in the presence of the MD and RPOD, toured the facility and observed the following compromised RR doors and closet doors in the following areas:	K 363	1. The doors are being adjusted or replaced. 2. All residents have the potential to be affected. 3. The maintenance director will make regular environmental rounds to ensure doors close and latch properly so that they will resist the passage of smoke as required. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and Quality Assurance committee which meets quarterly and as needed.	

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	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

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K 363	Continued From page 25 RR 215: top of door to the frame 1/2" opening RR 317: top of door to the frame 1/2" opening RR 318: top of door to the frame 1/2" opening RR 412: door will not close into its frame. RR 611: door will not latch into its frame RR 615: door will not latch into its frame Linen closet: door will not close into its frame as the door was rubbing onto the floor. At the time of observations, the surveyor interviewed the MD and RPOD, who both confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/21/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall,	K 531		2/19/24

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	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

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K 531	Continued From page 26 firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and record review on 12/19/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed A). to ensure that there was documented evidence that all existing elevators; having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key.19.5.3, 9.4.2, 9.4.3) and B). to maintain elevator emergency communication for 2 of 3 passenger elevator telephones tested, in accordance with ASME/ANSI A17.3. as follows: A). At 10:30 AM, the surveyor reviewed all LSC documentation provided by the MD. The monthly testing of the firefighters Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 was not provided. An interview was conducted with the MD and RPOD, during the record review. They confirmed	K 531	1. Firefighters monthly service log for the 3 elevators was implemented. The elevator service company has been contracted to repair the alarm push buttons and emergency communication telephone. 2. All residents have the potential to be affected. 3. The maintenance director will audit regularly audit the log for the firefighters monthly service of the elevators. The maintenance director and maintenance staff were educated on the monthly service log. The maintenance director will regularly check the alarm push buttons and emergency communication telephones to ensure they are working. 4. The maintenance director or designee will make weekly environmental rounds for one month and then monthly- these rounds will include checking the alarm push buttons and emergency telephone communications. The maintenance director or designee will audit the monthly firefighter service log quarterly. Findings will be submitted to the Administrator and Quality Assurance committee which meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ___	**12/21/2023**

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ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	**303 ELM STREET** **PERTH AMBOY, NJ 08861**

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K 531	Continued From page 27 there was no current firefighter's monthly service log for 3 of 3 elevator devices. B). 1. At 10:45 AM, the surveyor, MD and RPOD observed that the alarm push button in elevator #1, did not activate any alarms and the emergency communication telephone, when activated, attempted to dial a number, but then cut off from doing so. 2. At 12:50 PM, the surveyor, MD and RPOD observed that the alarm push button in elevator #2, did not activate any alarms and the emergency communication telephone, when activated, went to a busy signal only. The Maintenance Director and Regional Plant Operations Director both confirmed that the alarm push button and emergency communication telephones for elevators #1 and #2 did not work during the above observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/21/23. * This deficiency was cited during the 11/03/21 & 11/01/2019 Re-Certification survey's. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3 & 9.4.3 Fire Fighters Emergency Operations: 9.4.3.2	K 531		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room,	K 741		2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

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K 741	Continued From page 28 ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/20/23, in the presence of the Maintenance Director (MD) and the tRegional Plant Operations Director (RPOD), it was determined that the facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. for 1 of 1 smoking areas as follows: At 11:55 AM, the surveyor, MD and RPOD observed in the smoking area that the oasis style ashtrays were provided for cigarette buts only, the area was observed to not have an approved ash tray or a self-closing covered metal container for	K 741	1. Self-closing covered metal containers were purchased for the disposal of cigarette butts. 2. All residents have the potential to be affected. 3. The maintenance director will make regular environmental rounds to ensure proper containers for disposing of cigarette butts are in place. 4. The maintenance director or designee will make weekly environmental rounds for one month to include the smoking area and then monthly. Findings will be reported to the Administrator and Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

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K 741	Continued From page 29 the disposal of cigarette butts and ashes. The finding's were verified by the RPOD and MD, at the time of the observation. The Administrator was informed of the finding's at the Life Safety Code exit conference on 12/21/23. NJAC 8:39-31.2(e) NFPA 101 2012 edition Life Safety Code 19.7.4* (5) Smoking NFPA 101 2012 edition Life Safety Code 19.7.4* (6) Smoking	K 741	Assurance committee which meets quarterly and as needed.	
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 12/20/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure portable electric heaters were not used with a heating element exceeding 212 degrees Fahrenheit (100 degrees Celsius). This deficient practice was evidenced for 1 of 1 portable electric heater's and was evidenced by the following: At 11:45 AM, the surveyor, MD and RPOD observed in the unoccupied central supply office that (1) portable electric heater was plugged into	K 781	1. The portable space heaters and power strip were removed. 2. All residents have the potential to be affected. 3. The staff were educated about not using portable space heaters. The maintenance director will make regular environmental rounds to ensure portable space heaters are not being used. 4. The maintenance director or designee will make weekly environment rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and Quality Assurance	2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 781	Continued From page 30 a multi-outlet power strip. The multi-outlet power strip was then plugged into a duplex wall outlet. The facility did not provide a policy and procedure for the safe operating temperatures of heaters in the facility. The MD confirmed the portable electric heater was plugged into a multi-outlet power strip and indicated that the heater should not be used in the facility at any time. The Administrator was informed of the findings at the Life Safety Code exit on 12/21/23. No further information was provided. NJAC 8:39-31.2(e) NFPA 101 2012 edition Life Safety Code 19.7.8 (1) & (2) Portable Space-Heating Devices	K 781	committee which meets quarterly and as needed.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 12/19/23 and 12/20/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to A). demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition	K 911	1. A reliability letter has been requested from the natural gas provider. The electrical panel has been secured and locked. 2. All residents have the potential to be affected. 3. The maintenance director will make	2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING 01 B. WING ______	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 911	Continued From page 31 Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. for one (1) of one (1) generators, B). maintain the required clearance around electrical panels, guarding of live parts of electrical equipment and controls with unlocked panels in resident accessible areas in accordance with NFPA 101, 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas was by the following: 1). At 9:30 AM, the surveyor, MD and RPOD, reviewed all the facility's generator documentation. The facility currently has one (1) exterior 150 KW (kilowatt) natural gas generator. The MD and RPOD, could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The MD and RPOD, both confirmed there was no	K 911	regular environmental rounds to ensure electrical panels are locked and secure. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and Quality Assurance committee which meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING 01 B. WING ___	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

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K 911	Continued From page 32 reliability letter available from the natural gas provider for the 150 KW natural gas generator for the facility to present to the surveyor. No additional information was received. 2). At 9:30 AM, the surveyor observed that the floor #1 corridor electrical panel LP-16 outside the conference room, was unlocked. There was no guarding of live parts or arc-flash hazard warning signs on the panel. An interview was conducted with the MD during the observation, he varified the LP-16 electrical panel was open and did not have a locking feature. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/21/23. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911		
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 912		2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ______	**12/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	**303 ELM STREET** **PERTH AMBOY, NJ 08861**

(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 912	Continued From page 33 Based on interview and record review on 12/20/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to maintain electrical outlets in accordance with NFPA 99 for ground tension. This deficient practice was evidenced for 1 of 43 resident room duplex wall outlets by the following: At 10:00 AM, the surveyor, MD and RPOD observed in resident room 422 that the resident concentrator (in operation) was taped to the duplex wall outlet. The plug was taped to the wall outlet due to the outlet not having any tension to hold on to the plug. An interview was conducted with the MD and RPOD, who both confirmed that the resident concentrator plug was taped to the duplex wall outlet, due to the outlet not having any tension and the outlet needed to be replaced. The Administrator was informed of the finding at the Life Safety Code exit conference on 12/21/23. *The facility could not provide the last annual receptable testing report required by NFPA 99 NJAC 8:39-31.2(e) NFPA 99	K 912	1. The tape was removed and the outlet was replaced. 2. All residents have the potential to be affected. All outlets have been audited. 3. Staff were educated about not using tape to secure outlets and notifying maintenance of any issues with outlets. The maintenance director will make regular environmental rounds to ensure outlets are in good working order. 4. The maintenance director or designee will make weekly environmental rounds to each unit for one month and then monthly. Findings will be reported to the Administrator and Quality Assurance committee which meets quarterly and as needed.	
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	K 914		2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING **01** B. WING ___	**12/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 914	Continued From page 34 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 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 observations, interview and documentation review on 12/19/23, in the presence of the Regional Director (RD) and the Maintenance Director (MD), 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 90 of 90 resident rooms observed by the following: At 9:45 AM, while reviewing documentation provided by the Maintenance Director, the surveyor observed that no annual electrical inspection was performed for the facilities, non-hospital grade outlets in resident room's for polarity, grounding and tension.	K 914	1. Annual functional testing of electrical receptacles in residents rooms for grounding, polarity, and blade tension is being implemented. 2. All residents have the potential to be affected. 3. The maintenance director or designee will audit the life safety book to ensure outlet testing is completed at least anually. 4. The maintenance director or designee will audit the life safety book monthly for 3 months and then quarterly. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315180	A. BUILDING 01 B. WING ______	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

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K 914	Continued From page 35 The MD and RPOD both confirmed that the facility had non-hospital outlets installed in resident rooms, but could not provide any documentation indicating the annual inspection was being performed. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/21/23. NJAC 8:39-31.2(e) NFPA 99	K 914		
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	K 918		2/19/24

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K 918	Continued From page 36 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/21/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure a remote manual stop station for one of one outside natural gas 150 KW generators, providing emergency power to approximately 40% of Health Care facility, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 1 of 1 generators by the following: At 10:40 AM, the surveyor, MD and RPOD, observed the exterior 150 KW (kilowatt) natural gas generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location. An interview was conducted during the time of the observation with the MD and RPOD, who both stated and confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current	K 918	1. Verizon and the facility generator company will install remote manual stop stations. 2. All residents have the potential to be affected. 3. The generator company, Verizon, and facility staff were educated on the requirement for remote manual stop stations for the generators and will install them. 4. The maintenance director or designee will conduct environmental rounds weekly for one month and then quarterly to include the generator sites. Findings will be reported to the Administrator and the Quality Assurance committee which meets quarterly and as needed.	

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	315180	A. BUILDING **01** B. WING ____________	**12/21/2023**

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K 918	Continued From page 37 generator in service. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/21/23. * It was noted that Verizon was utilitizing space on the facility's property for a natural gas generator. The generator was observed next to the building and to not have a remote push/stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current generator in service. The MD indicated he would call Verizon to inform them of the NFPA 110 requirement. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920		2/19/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 920	Continued From page 38 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/20/23, in the presence of the Maintenance Director (MD), and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard and was identified in two (2) of six (6) areas observed and was evidenced by the following: At 10:33 AM, the surveyor, MD and RPOD observed in the Central Supply room, that a white multi-outlet power strip was being used to power an electric space heater and microwave. The first plug of the power strip by the on/off switch was observed to have an overheated outlet. The MD and RPOD both confirmed the finding's, during the observations. The Administrator was informed of the findings at	K 920	1. The one power strip was removed and the employee was educated on not using power strips. 2. All residents have the potential to be affected. 3. The maintenance director or designee will make regular environmental rounds to ensure power strips are not in use. 4. The maintenance director or designee will conduct environmental rounds weekly for one month and then monthly. Findings will be reported to the Administrator and Quality Assurance committee.	

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K 920	Continued From page 39 the Life Safety Code Exit Conference on 12/21/23. NJAC 8:39-31.2(e)	K 920		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with	K 923		2/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 923	Continued From page 40 integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 12/20/23 and 12/21/23, in the presence of the Maintenance Director (MD) and the Regional Plant Operations Director (RPOD), it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 9 of 115 portable oxygen cylinders observed and was evidenced by the following: 1). On 12/20/23 at 9:15 AM, the surveyor, MD and RPOD, observed in the floor-2 oxygen storage room that two (2) of fifteen (15) portable oxygen cylinders were freestanding and not secured from tipping, rupture and damage. 2). On 12/20/23 at 11:00 AM, the surveyor, MD and RPOD, observed in the outside oxygen storage shed that seven (7) of one-hundred (100) portable oxygen cylinders were freestanding and not secured from tipping, rupture and damage. An interview was conducted with the MD and RPOD, during the observations, they both stated that the portable oxygen cylinder's observed, must be secured from tipping, rupture and damage at all times in the facility. The Administrator was informed of the finding's at	K 923	1. The oxygen tanks were secured and staff educated. 2. All residents have the potential to be affected. 3. The maintenance director or designee will make regular environmental rounds to ensure oxygen tanks are secured and stored correctly. 4. The maintenance director or designee will make weekly environmental rounds for one month and then monthly. Findings will be reported to the Administrator and Quality Assurance committee which meets quarterly and as needed.	

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K 923	Continued From page 41 the Life Safety Code exit conference on 12/21/23. NJAC 8:39-31.2(e) NFPA 99	K 923		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315180	A. Building 01 - MAIN BUILDING 01 B. Wing	2/26/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE	303 ELM STREET PERTH AMBOY, NJ 08861

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0161	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0211	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0222	Correction Completed 02/19/2024
ID Prefix Reg. # NFPA 101 LSC K0225	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0291	Correction Completed 02/19/2024
ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 02/24/2024	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 02/19/2024
ID Prefix Reg. # NFPA 101 LSC K0347	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 02/19/2024
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 02/24/2024	ID Prefix Reg. # NFPA 101 LSC K0531	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0741	Correction Completed 02/19/2024

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

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

POST-CERTIFICATION REVISIT REPORT

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315180	A. Building 01 - MAIN BUILDING 01 B. Wing	2/26/2024

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0781	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0912	Correction Completed 02/19/2024
ID Prefix Reg. # NFPA 101 LSC K0914	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 02/19/2024	ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 02/19/2024
ID Prefix Reg. # NFPA 101 LSC K0923	Correction Completed 02/19/2024				

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
12/21/2023

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