STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315321	A. BUILDING _____ B. WING _____	C 03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT OLD BRIDGE, LLC	**6989 RT18 OLD BRIDGE, NJ 08857**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00174183, NJ00180900 Survey Date: 3/25/2025 TO 3/31/2025 Census: 130 Sample: 27 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 all medications were administered without error of 5% or more. During the medication administration observation performed on 3/26/25, the surveyor observed three (3) nurses administer medications to five (5) residents. There were 32 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 6.25 %. This deficient practice was identified for one (1) of five (5) residents, (Resident #79), that were administered medications by one (1) of three (3) nurses. The deficient practice was evidenced as follows:	F 759	The LPN who was involved in the cited deficient practice of Resident #79 was provided with a one-on-one re-education regarding med pass administration with emphasis on following parameters on [redacted] administration. In addition, the [redacted] completed a med pass competency to ensure knowledge and understanding of medication administration. Education and competency were given and completed on March 25, 2025. All residents who have a physician order	4/30/25

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

Electronically Signed | 04/22/2025

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

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F 759	Continued From page 1 On 3/26/25 at 8:10 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) preparing to administer the morning medications to Resident #79. LPN #1 stated that according to the electronic medication administration record (EMAR), the resident had a physician's order (PO) for NJ Exec Order 26.4b1 but had looked through the medication cart and could not find the resident's NJ Exec Order 26.4b1. LPN #1 stated that he would have to check the backup supply. LPN #1 then stated that he was going to administer the morning medications that were in the cart first. On 3/26/25 at 8:20 AM, the surveyor with the LPN #1, observed the resident in bed with a breakfast tray on the overbed table. The breakfast tray had an uncovered plate with part of an egg omelet remaining and an empty bowl with cereal residue. LPN #1 stated that the resident spoke another language but was able to understand that medications were being administered. The surveyor observed LPN #1 obtain a NJ Exec Order 26.4b1 from Resident #79. Then, the surveyor observed LPN #1 administer seven (7) oral medications that had been crushed and placed in applesauce to the resident. On 3/26/25 at 8:30 AM, the surveyor with LPN #1, went to the medication room on the unit to look for the backup supply of NJ Exec Order 26.4b1. LPN #1 was joined by the US FOIA (b)(6), and they were unable to find a backup supply of NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that she would go to another unit to find the backup supply of NJ Exec Order 26.4b1.	F 759	for insulin administration have the potential to be affected by the cited practice. An audit of all residents who have a physician order for insulin medication was completed for accuracy of medication administration times. No errors were found to be corrected. Inservice education for licensed nurses was initiated on March 25, 2025, by the Director of Nursing regarding administration of insulin medication with emphasis on following appropriate parameters. The same Inservice will be given during orientation for newly hired licensed nurses, annually, and as deemed necessary. This Inservice education will be given by the Director of Nursing and/or nurse designee. Medication administration competencies will be given to four nurses per week for four weeks and then monthly for 6 months covering all shifts with emphasis on following parameters for insulin administration. Any negative findings will be corrected immediately, through re-education by the director of nursing or nurse designee and or progressive disciplinary actions as appropriate. Monthly medication audits for all residents with a physician order for insulin medications will be conducted by the director of nursing or nurse designee for timing and cautionary accuracy for six months. Negative findings will be corrected immediately, and a one on one re-education for the nurse involved will be	

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F 759	Continued From page 2 On 3/26/25 at 8:44 AM, the surveyor observed the [redacted] give a [redacted] of [redacted] to LPN #1. The [redacted] stated that she had retrieved the [redacted] from the backup supply on the Rehab unit. On 3/26/25 at 8:52 AM, the surveyor observed LPN #1 administer [redacted] to the [redacted] Resident #79. At that time, the breakfast tray was no longer observed in the room. On 3/26/25 at 8:53 AM, the surveyor interviewed LPN #1, at the medication cart, who stated that there were no other morning medications to administer to Resident #79. LPN #1 verified that the EMAR reflected a 9 AM time of administration for [redacted]. LPN #1 stated he had 1 hour before and 1 hour after to administer the medication and was on time. LPN #1 also verified that breakfast was usually delivered to the floor between 7:30 AM and 8:00 AM and that the resident had eaten breakfast before administering the [redacted]. (ERROR #1) LPN #1 could not speak to why the [redacted] had an administration time of 9 AM which would be after breakfast was finished. The surveyor reviewed the electronic medical record for Resident #79. A review of the resident's Admission Record reflected that the resident had diagnoses, which included but not limited to; [redacted]).	F 759	given by the director of nursing. The results of all audits will be submitted by the Director of Nursing to the QAPI committee who meets quarterly, to review and determine the frequency and necessity of future audits.	

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F 759	Continued From page 3	F 759		

A review of the most recent comprehensive quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [NJ Exec Order 26.4b], reflected the resident had a brief interview for mental status (BIMS) score of [NJ Exec Order 26.4b] out of 15, indicating that the resident had a [NJ Exec Order 26.4b1].

A review of the resident's Order Summary Report (OSR) reflected a PO with a start date of [NJ Exec Order 26.4b] for [NJ Exec Order 26.4b1] three times a day for DM call MD(physician) if [NJ Exec Order 26.4b1]."

A review of the EMAR reflected the same PO as the above OSR with a time of administration of 9 AM. Further review of the EMAR revealed that the PO was discontinued on [NJ Exec Order 26.4], after the medication administration observation and the same PO was entered on [NJ Exec Order 26.4] with different times of administration for 7:30 AM, 11:30 AM and 4:30 PM.

Further review of the EMAR, during reconciliation of the medications observed during the medication administration observation, revealed a PO dated [NJ Exec Order 26.4] for '[NJ Exec Order 26.4b1] in the morning for [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1], give after breakfast." The EMAR had a time of administration of 8:30 AM and was signed on [NJ Exec Order 26.4] as being administered by LPN #1.

A review of the resident's individualized Care Plan Report had a focus area of '[NJ Exec Order 26.4b1]

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F 759	Continued From page 4 [redacted] with an initiated date of [redacted] and interventions, which included but not limited to, '[redacted] medication as ordered by doctor. Monitor/document for side effects and effectiveness" and '[redacted] as ordered by doctor." On 3/26/25 at 11:36 AM, the surveyor interviewed LPN #1, who stated that he had changed the administration time of the [redacted] from 9 AM to 7:30 AM because that was "standard protocol." LPN #1 could not speak to the meaning of standard protocol. LPN #1 then verified that he had not administered the [redacted] during the medication administration observation because he had administered that [redacted] before the surveyor had joined him. LPN #1 then reviewed the PO for [redacted] and acknowledged that the PO indicated a time of administration of 8:30 AM with instructions to give after breakfast. LPN #1 was unable to speak to why he had administered the [redacted] before breakfast. (ERROR #2) On 3/26/25 at 1:49 PM, the surveyor interviewed the [redacted]) via telephone, who stated that he was the owner and could speak to any questions. The [redacted] stated that the time of administration of [redacted] should depend on the mealtime. The [redacted] added that the recommendation was that fast-acting insulins should be administered 15 minutes before eating a meal. On 3/27/25 at 8:10 AM, the surveyor interviewed the [redacted]), who stated [redacted] administration was coordinated according to the mealtimes of 7:30 AM, 11:30 AM and 4:30 AM. The [redacted] added that [redacted] administration could	F 759		

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F 759	Continued From page 5	F 759		

be dependent on [redacted] and [redacted]. The [redacted] also stated that Resident #79 had a specific time of administration for [redacted] at 9 AM because they were [redacted] and woke up between [redacted] and tended to eat breakfast [redacted]. The [redacted] also stated that physician's orders were to be followed. The [redacted] acknowledged the [redacted] supply for current orders should have an adequate supply on hand.

A review of an "Inservice Attendance Sheet" dated 3/3/25, provided by the [redacted] revealed the topic of the inservice was Resident #79 and the subject was [redacted]

There was no documentation from the physician reflecting the [redacted] be taken after breakfast and [redacted] administration to be administered after the meal.

On 3/27/25 at 10:17 AM, the surveyor interviewed the Certified Nursing Aide (CNA #1), who stated that she was familiar with the care of Resident #79 and had [redacted] the resident on the morning of [redacted] CNA #1 stated the resident was a [redacted] and she had to make sure that the resident ate in the morning. She stated the resident [redacted]. CNA #1 added that she brings the breakfast tray into the resident in the morning and the resident was able to indicate whether they were ready to eat breakfast. CNA #1 also stated that she remembered on [redacted] that the resident was up when she brought the tray in which she thought was after the breakfast trucks were usually delivered to the floor but was unsure of the exact time. CNA #1 added that she remembered the resident [redacted] and

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F 759	Continued From page 6	F 759		

approximately half of the egg omelet. CNA #1 stated that she does not tell the nurses when the resident was ready to eat but she tells the nurse the percentage the resident ate after they finished the meal.

On 3/27/25 at 12:29 PM, the surveyor interviewed LPN #2, who stated that she was the medication nurse for Resident #79 for the day. LPN #2 stated that she checked the resident's NJ Exec Order 26.4b1 before the resident ate breakfast and lunch and then administered the NJ Exec Order 26.4b1 because it was a NJ Exec Order 26.4b1 and should be administered right before a meal. LPN #2 added that the NJ Exec Order 26.4b1 was administered in the morning after the resident finished their breakfast. LPN #2 could not speak to why there was a time of administration of 9 AM indicated on the EMAR for the NJ Exec Order 26.4b1

A review of an unsigned "Medication Pass Observation" for LPN #1 provided by the US FOIA (b) that had been completed on 9/18/24, revealed that there was no observation of NJ Exec Order 3 administration observed during that med pass.

On 3/27/24 at 2:00 PM, the surveyor interviewed the US FOIA (b)(6) who stated the 9/18/24 "Medication Pass Observation" was completed by a nurse who no longer worked at the facility and that med passes were performed yearly for the nurses. The US FOIA (b) added that an inservice was performed immediately after the med pass with the nurse if there were any discrepancies noted.

A review of a "Med Pass Inservice" completed by the CP on NJ Exec Order 26.4b1 revealed an attendance sign in sheet that was not signed by LPN #1. The "Medication Pass Inservice" information sheets

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PREFERRED CARE AT OLD BRIDGE, LLC	**6989 RT18 OLD BRIDGE, NJ 08857**

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F 759	Continued From page 7	F 759		

that the CP reviewed during the inservice revealed that one of the five rights was "Right Time: Medication can be given 60 minutes before the time on MAR or 60 minutes after is considered correct, Exception medication to be given with regard to meals either AC (before meals) or PC (after meals) need to be given as such." In addition, another information sheet reviewed during the inservice "Medications Administration with Regards to Meals" revealed that NJ Exec Order 26.4b1 was to be administered before a meal.

On 3/31/25 at 10:41 AM, the survey team met with the US FOIA (b)(6) . The US FOIA (b) stated that she had spoken with the family representative and the physician, and both agreed that they were more concerned with the resident exhibiting NJ Exec Order 26.4b1 and wanted to make sure the resident had NJ Exec Order 26.4b1 . The US FOIA (b) acknowledged that the standard protocol for a NJ Exec Order 26.4b1 was to be administered prior to a meal and that the PO had not indicated different instructions for the time of administration.

A review of the facility policy dated as reviewed January 2025 for "Medication Administration" provided by the DON reflected "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." In addition, "Administer medication as ordered in accordance with manufacturer specifications."

A review of the facility policy dated as reviewed

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F 759	Continued From page 8 January 2024 for "Insulin Administration Policy" provided by the DON reflected "All insulin will be administered in accordance with physician's orders." In addition, "Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order." The policy also reflected, "For current insulin orders, an adequate supply of insulin will be maintained for each resident." The manufacturer specifications for NJ Ex Order 26.4(b)(1) revealed "Administer Insulin Lispro by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal or immediately after a meal." NJAC 8:39-11.2(b), 29.2(a)(d)	F 759		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315321 Y1	A. Building B. Wing Y2	5/7/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT OLD BRIDGE, LLC	6989 RT18 OLD BRIDGE, NJ 08857

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 F0759	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(f)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/30/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/31/2025	☐ YES ☐ NO

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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E 000	Initial Comments This facility is in Substantial compliance with Appendix Z Emergency Preparedness for all provider and supplier types Interpretive Guidance 483.73. Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 3/28/2025 and 3/31/2025 and Preferred Care at Old Bridge was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Preferred Care at Old Bridge is a single-story, Type V Un-Protected building that was built in January of 1988. The facility is divided into five (5) smoke zones. The facility 350 KW Diesel Emergency Generator powers 100% of the build per the Maintenance Director.	K 000		
K 211 SS=F	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	K 211		4/25/25

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

Electronically Signed | 04/22/2025

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K 211	Continued From page 1 by: Based on observations and interview on 03/28/2025 in the presence of the facility's US FOIA (b)(6)), it was determined that the facility failed to ensure exits were maintained free of obstructions and impediments for full and instant use in accordance with NFPA 101:2012 Edition, Section 7.1.10.1. for 2 of 2 exits observed. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:22 AM revealed that the main courtyard exit door #1 was equipped with a keyed lockset from the egress side. The device on the door could restrict emergency use of the exit. An observation at 11:26 AM revealed that the main courtyard exit door #2 was equipped with a keyed lockset from the egress side. The device on the door could restrict emergency use of the exit. In an interview at the time, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 03/31/2025 at 2:15 PM.	K 211	Director of Maintenance removed the bolt from the lock on March 28, 2025. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) were re-inserviced by the Administrator on March 28, 2025, regarding the regulation of ensuring exits are maintained free of obstruction and impediments for full and instant use. The Director of Maintenance or designee will audit all courtyard doors of the interior courtyards to ensure compliance weekly for one month, and monthly for three months. Results of the audit will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not within regulation, immediately correct the issue and provide one-to-one education.	
K 291 SS=F	NJAC 8:39-31.2(e) Emergency Lighting CFR(s): NFPA 101 Emergency Lighting	K 291		4/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315321	A. BUILDING 02 B. WING _____	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT OLD BRIDGE, LLC	6989 RT18 OLD BRIDGE, NJ 08857

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 2 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 observations and interview on 03/28/2025 in the presence of the facility's US FOIA (b)(6) [redacted]), it was determined that the facility failed to provide a battery backed-up emergency light above the emergency generator transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. and NFPA 99: 2012 Edition. This deficient practice was identified for 2 of 2 transfer switches in the healthcare facility, had the potential to affect all residents and was evidenced by the following: An observation at 8:10 AM revealed that the emergency generator transfer switch by the building was not provided with battery backed-up emergency lighting. An observation at 12:44 PM revealed that the emergency generator transfer switch next to the emergency generator was not provided with battery backed-up emergency lighting. In an interview at 1:18 PM, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference on 03/31/2025 at 2:15 PM. NJAC 8:39-31.2(e)	K 291	The Director of Maintenance ordered the backup battery emergency lighting on March 28, 2025, and installed the emergency lighting on April 11, 2025. Lighting was placed by the building and by the generator. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) [redacted] were re-inserviced by the Administrator on March 28, 2025, regarding the regulation of providing a battery backup emergency light above the emergency generator. The Director of Maintenance or designee will audit the emergency lighting to ensure compliance monthly for six months. Results of the audit will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not within regulation, immediately correct the issue and provide one-to-one education.	

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	315321	A. BUILDING **02** B. WING _____	**03/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT OLD BRIDGE, LLC	**6989 RT18** **OLD BRIDGE, NJ 08857**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 3 NFPA 99	K 291		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 03/28/2025 in the presence of the facility's US FOIA (b)(6) of	K 321	The Director of Maintenance installed self-closing hinges for the doors in the dietician storage room and library after the	4/25/25

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	315321	A. BUILDING 02 B. WING	03/31/2025

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PREFERRED CARE AT OLD BRIDGE, LLC	6989 RT18 OLD BRIDGE, NJ 08857

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K 321	Continued From page 4 US FOIA (b)(6)), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing 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 had the potential to affect all residents and was evidenced by the following: An observation at 9:04 AM revealed that the dietitian combustible storage room door was not self-closing or automatic- closing. An observation at 9:34 AM revealed that the library was being as a storage for combustibles. The room was greater than 50 square feet in size and required an automatic closing device installed on the door. An observation at 9:40 AM revealed that the medical records door had a gap at the bottom section of the door frame, when it was tested by the US FOIA (b) In an interview at 9:42 AM, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 03/31/2025 at 2:15 PM.	K 321	conclusion of our Life Safety Survey. Both self-closing hinges were installed on March 28, 2025. The gap on the medical records door gap was filled in on March 28, 2025. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) were re-inserviced by the Administrator on March 28, 2025, regarding the regulation to have self-closing doors and door gaps filled in throughout the facility for all smoke barrier doors. The Director of Maintenance or designee will audit five smoke barrier doors to ensure they are all self-closing and without any gaps weekly for one month, and monthly for three months. Results of the audit will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not within regulation, immediately correct the issue and provide one-to-one education.	
K 352 SS=F	NJAC 8:39-31.2(e) Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals	K 352		4/25/25

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K 352	Continued From page 5 Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 03/28/2025 in the presence of the facility's US FOIA (b)(6)), it was determined that the facility failed to maintain fire sprinkler heads free from loading from dust and debris in accordance with NFPA 25:2011. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 10:20 AM revealed that 2 of 4 fire sprinkler heads for the Rehab courtyard overhang were loaded with dust and debris. Observations in the kitchen at 11:51 AM revealed that 2 of 16 fire sprinkler heads were loaded with a large buildup of grease and dust. Observations in the laundry room at 12:15 PM revealed that 2 of 7 fire sprinkler heads were loaded with dust and lint. In an interview at 12:18 PM, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit	K 352	The Director of Maintenance completed cleaning were two sprinkler heads in the rehab courtyard overhang, two sprinklers heads in the laundry room, and two sprinkler heads in the kitchen on March 31, 2025. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) were re-inserviced by the Administrator on March 28, 2025, regarding the regulation of maintaining fire sprinkler heads free from loading of dust and debris. The Director of Maintenance or designee will audit five sprinkler heads monthly for six months. Results of the audit will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not within regulation, immediately correct the issue and provide one-to-one education.	

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K 352	Continued From page 6 conference on 03/31/2025 at 2:15 PM. NJAC 8:39-31.2(e) NFPA 25	K 352		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors 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.	K 363		4/25/25

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K 363	Continued From page 7 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 observations and interview on 03/28/2025 in the presence of the facility's US FOIA (b)(6) 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 was identified for 2 of 61 resident rooms observed, had the potential to affect 4 residents and was evidenced by the following: An observation at 8:44 AM revealed that the door for room 204 was not latching into its frame. An observation at 10:33 AM revealed that the door for room 120 had a gap along the top. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 03/31/2025 at 2:15 PM.	K 363	The Director of Maintenance completed fixing the gap at the top of room 120 and frame latch for room 204 on April 4, 2025. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) were re-inserviced by the Administrator on March 28, 2025, regarding the regulation of ensuring all corridor doors are able to resist the passage of smoke. The Director of Maintenance or designee will audit five corridor doors monthly for six months. Results of the audit will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not within regulation, immediately correct the issue and provide one-to-one education.	
K 761 SS=F	NJAC 8:39-31.1(c), 31.2(e) Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		4/25/25

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K 761	Continued From page 8 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 03/31/2025 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that the fire doors assemblies were inspected, tested and properly documented annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101:2012 Edition, Section 19.7.6, 8.3.3.1, NFPA 80, 2010 Edition, Section 5.2, 5.2.3. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review at 10:12 AM revealed that the required detailed annual fire/smoke doors test/inspection documentation was not provided by the U.S. FOIA In an interview at the time, the US FOIA (b)(6) confirmed the findings.	K 761	The Director of Maintenance completed inspecting all operational components of the doors in the facility and created an audit tool to routinely inspect all facility fire doors annually. This was completed on April 4, 2025. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) [redacted] were re-inserviced by the Administrator on March 31, 2025, regarding the regulation of annually inspect and test the operational components of the fire doors throughout the facility and maintaining the inspection documentation. The Director of Maintenance or designee will audit five fire door components weekly	

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K 761	Continued From page 9 The facility's[US FOIA (b)(6) [redacted] were notified of the deficient practice at Life Safety Code survey exit conference at 2:15 PM. N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 80	K 761	for one month and then quarterly for one year. Results of the audit will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not within regulation, immediately correct the issue and provide one-to-one education.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and	K 918		4/25/25

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K 918	Continued From page 10 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 documentation review and interview on 03/31/2025 in the presence of the facility's US FOIA (b)(6) it was determined that the facility failed to ensure that emergency generator was exercised for 4 continuous hours every 36-months in accordance with NFPA 99:2012 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review 11:45 AM revealed the generator was not tested at least once every 36 months, under load for a minimum of four continuous hours. No further document was provided regarding when it was last tested under load for a minimum of four continuous hours. In an interview at the time, the US FOIA (b)(6) confirmed the documentation review. The facility's US FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference at 2:15 PM. N.J.A.C 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	The Director of Maintenance scheduled and completed the 4-hour bank load test on April 8, 2025. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) were re-inserviced by the Administrator on March 31, 2025, regarding the regulation of ensuring the emergency generator was exercised for 4 continuous hours every 36 months. The Director of Maintenance or designee will audit all emergency generator bank load testing annually for three years. Results of the audit will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not within regulation, immediately correct the issue and provide one-to-one education.	
K 921 SS=D	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101	K 921		4/25/25

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K 921	Continued From page 11 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 03/28/2025 in the presence of the facility's US FOIA (b)(6) [redacted] it was determined that the facility failed to conduct maintenance of electrical equipment and maintain a record and log of all	K 921	The Director of Maintenance completed an electrical inspection of the refrigerator on March 28, 2025. An audit of all other electrical equipment was also completed on March 28, 2025 to ensure all had inspection stickers.	

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K 921	Continued From page 12 required tests, test results and repairs for all the patient care related electrical equipment (PCREE), in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect 2 residents and was evidenced by the following: An observation at 10:35 AM revealed resident room 220 had tabletop refrigerator with no safety inspection sticker or label that identified when it was inspected. An interview at that time, the US FOIA confirmed the finding and acknowledged that no label was provided. The facility's US FOIA (b)(6) were informed of the deficient practice on 03/31/2025 during the Life Safety Code exit conference at 2:15 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) were re-inserviced by the Administrator on March 28, 2025, regarding maintaining an electrical equipment record and logging of all required tests, results and repairs for all patient care related electrical equipment. The Director of Maintenance or designee will audit 5 pieces of electrical equipment in patient care areas monthly for six months. Results of the audit will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not within regulation, immediately correct the issue and provide one-to-one education.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315321 Y1	A. Building 02 - OLD BRIDGE 02 B. Wing Y2	5/7/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT OLD BRIDGE, LLC	6989 RT18 OLD BRIDGE, NJ 08857

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	04/25/2025	LSC K0291	04/25/2025	LSC K0321	04/25/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0352	04/25/2025	LSC K0363	04/25/2025	LSC K0761	04/25/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	04/25/2025	LSC K0921	04/25/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/31/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO