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 _____	**03/06/2023**

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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 3/02/2023 and 3/06/2023 and Preferred Care at Old Bridge was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the 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 1988. The facility is divided into five (5) smoke zones. The facility has a Diesel Emergency Generators.	K 000		
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 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	K 321		3/7/23

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

Electronically Signed | 03/23/2023

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

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K 321	Continued From page 1 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 on 3/02/23 and 3/06/23, in the presence of facility management, 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 practiced was evidenced by the following: On 3/02/2023 (day one of survey), during the survey entrance at approximately 9:40 AM, a request was made to the Administrator (Admin.) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility is a single-story building with eighty-two (82) Resident sleeping rooms.	K 321	The Director of Maintenance ordered the self-closing hinges for the door in the medical record storage room and the kitchen storage room after the conclusion of our Life Safety Survey. Both self-closing hinges were installed on March 7, 2023. All residents have the potential to be affected by this deficient practice. The Director of Maintenance and Maintenance Assistant were in-serviced on March 7, 2023, regarding the regulation to have self-closing doors on all hazardous areas. The Director of Maintenance or designee will audit the doors to all hazardous areas to ensure they are all self-closing weekly for 1 month, and monthly for 3 months. Results of the audit will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not	

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K 321	Continued From page 2 Starting at approximately 9:57 AM on 3/02/23 and continued on 3/06/23, in the presence of the Admin. and DOM, a tour of the building was performed. During the two day tour of the facility, the surveyor observed the following hazardous areas that failed to have smoke resisting doors: 1) On 3/02/23 at approximately 10:18 AM, an inspection of the Medical records room was performed. During a closure test of the corridor door leading into the Medical Records storage room, the door did not self-close into its frame. The surveyor observed evidence of the doors automatic door closure had been removed. The surveyor observed multiple combustible paper medical records around the room. At this time, the surveyor recorded the measurements of the room. The room was 15 feet by 6 feet (90 square feet) which is larger than 50 square feet. 2) On 3/2/23 at approximately 11:08 AM, an inspection of the South Kitchen storage room was perform. During a closure test of the corridor door leading into the Kitchen storage room the door did not self-close. The surveyor observed the door had no means to self-close and the room was larger than 50 square feet.. The surveyor observed in the Kitchen storage room 44 cardboard boxes of briefs, 18 cardboard boxes of latex gloves and several combustible cardboard boxes.	K 321	within regulation, then the audit will be conducted for another 3 months.	

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K 321	Continued From page 3 The surveyor recorded the measurements of the room. The room was 25 feet by 17 feet (425 square feet) which is larger than 50 square feet. With these corridor doors not self-closing this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The Admin. and DOM confirmed the finding at the time of the observations. The Administrator was informed of the above findings at the survey exit on 3/06/23 at approximately 12:01 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 3/02/23 and 3/06/23, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being	K 521	The Electrical Company evaluated the exhaust system that was not functioning in the 2 bathrooms during our survey. Upon evaluation from the Electrical	3/31/23

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K 521	Continued From page 4 properly maintained for two (2) of 12 Resident bathroom exhaust systems, as per the National Fire Protection Association (NFPA) 90 A. This deficient practice was evidenced by the following: On 3/02/23 (day one of survey) during the survey entrance at approximately 9:40 AM, a request was made to the Administrator (Admin.) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility is a single-story building with eighty-two (82) Resident sleeping rooms. At approximately 9:57 AM on 3/02/23 and continued on 3/06/23, in the presence of the Admin. and DOM, a tour of the building was performed. During the building tour, the surveyor inspected twelve resident sleeping rooms. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in two 2 of 12 resident bathrooms in the following locations: On 3/06/2023, at approximately 9:58 AM, inside Resident room #205 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the Admin and DOM that the exhaust system did not function properly. This bathroom had no window with an	K 521	Company it was found that the motor needed to be replaced. The motor was replaced by Friday March 31, 2023. All residents have the potential to be affected by this deficient practice. The Director of Maintenance and Maintenance Assistant were in-serviced on March 7, 2023, regarding the regulation to have exhaust systems always working. The Director of Maintenance or designee will audit the functionality of the exhausts systems throughout the facility bi-monthly for 2 months, and monthly for 3 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, then the audit will be conducted for another 3 months.	

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K 521	Continued From page 5 area that would open. This bathroom would rely on mechanical ventilation. At approximately 10:01 AM, inside Resident room #203 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The Admin. and DOM confirmed the above findings at the time of observations. The Administrator was informed of the above findings at the survey exit on 3/06/23 at approximately 12:01 PM. NFPA 90 A. NJAC 8:39- 31.2 (e).	K 521		
K 911 SS=D	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 observations on 3/02/23 and 3/06/23, in the presence of facility management, it was determined that the facility failed to ensure that one (1) of 18 electrical outlets located next to a water source (with-in 6 feet) was equipped with safe and secured Ground-Fault Circuit Interrupter	K 911	The Director of Maintenance replaced the Ground-Fault Circuit Interrupter (GFCI) outlet on March 7, 2023, to ensure the electrical outlet met code standards. All residents have the potential to be	3/7/23

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K 911	Continued From page 6 (GFCI) protection. This deficient practice was evidenced by the following: On 3/02/23 (day one of survey) during the survey entrance at approximately 9:40 AM, a request was made to the Administrator (Admin.) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility is a single-story building with 82 Resident sleeping rooms. At approximately 9:57 AM on 3/02/23 and continued on 3/06/23, in the presence of the facility's Admin. and DOM, a tour of the building was performed. During the two day tour, the surveyor observed and tested eighteen (18) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: On 3/02/23 at approximately 10:45 AM, the surveyor observed inside Resident room #415 bathroom one (1) GFCI electrical outlet. When the surveyor tested the GFCI electrical outlet with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. The Admin. and DOM confirmed the finding at the time of observation. The Administrator was informed of the above finding at the survey exit on 3/06/23 at approximately 12:01 PM.	K 911	affected by this deficient practice. The Director of Maintenance and Maintenance Assistant were in-serviced on March 7, 2023, regarding the regulation to have all GFCI electrical outlets working to meet code requirements. The Director of Maintenance or designee will audit the GFCI outlets throughout the facility bi-monthly for 2 months, and monthly for 3 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, then the audit will be conducted for another 3 months.	

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K 911	Continued From page 7 NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 3/02/23 and 3/06/23, in the presence of the facility's Director of Maintenance (DOM), it was determined that the facility failed to functionally test electrical receptacles in resident rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. Maintenance and testing 6.3.3.2 Receptacle Testing in Patient Care Rooms.	K 914	The Director of Maintenance created a tickler file to ensure the testing is completed annually. The tickler file was created on March 7, 2023. There will be a second electrical inspection prior to December 31, 2023, since the electrical inspection completed on February 6, 2023, was for 2022.	3/7/23

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K 914	Continued From page 8 This deficient practice was evidenced by observations, documentation review and interview with the DOM, for all resident rooms by the following: During the survey entrance on 3/02/23 at approximately 9:40 AM, a request was made to the facility's Administrator and DOM to provide all mandatory inspections from 6/01/2021 up to 3/01/23 for review. On 3/02/23 at approximately 9:57 AM and continued on 3/06/23, a tour of the facility was conducted. During the two day tour, the surveyor inspected twelve (12) Resident sleeping rooms. The surveyor observed the electrical outlets inside the resident rooms were less than hospital grade electrical outlets. On 3/02/23 (day one of survey), the surveyor reviewed the facility's annual electric inspection report from the facility vendor dated 2/06/23. On that same day at approximately 1:29 PM, a request was made to the DOM to provide annual electrical inspections for the years 2021 and 2022. On 3/06/23 (day two of survey) at approximately 8:45 AM, a request was made to the DOM if he could provide the two (2021 and 2022) annual electrical inspections. At this time, the DOM told the surveyor that the 2021 electrical inspection had not been conducted and that the 2/06/23 electrical inspection was actually for the year 2022.	K 914	All residents have the potential to be affected by this deficient practice. The Director of Maintenance and Maintenance Assistant were in-serviced on March 7, 2023, regarding the regulation to have annual electrical inspections. The Director of Maintenance or designee will audit the electrical inspections bi-annually. Results of inspection audits will be reviewed at the quarterly quality assurance meeting. If there are areas of the audit that are not within regulation, then the audit will be conducted for another 2 quarters.	

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K 914	Continued From page 9 The DOM indicated resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The DOM confirmed the finding at the time of documentation review. The Administrator was informed of the above findings at the survey exit on 3/06/23 at approximately 12:01 PM. NJAC 8:39-31.2(e) 6.3.4 (NFPA 99)	K 914		
K 918 SS=E	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	K 918		3/10/23

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K 918	Continued From page 10 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new 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 3/02/23 and 3/06/23, in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for one (1) of one (1) emergency generators 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 by the following: On 3/02/23 (day one of survey) during the survey entrance at approximately 9:40 AM, a request was made to the Administrator (Admin.) and Director of Maintenance (DOM) if the facility had an Emergency Generator. The DOM told the surveyor, "yes we have one Emergency Generator that supplies emergency electrical power for the entire building." At approximately 9:57 AM on 3/02/23 and	K 918	The Director of Maintenance contacted our generator company to install a remote emergency stop button for the generator. This was installed on March 10, 2023. All residents have the potential to be affected by this deficient practice. The Director of Maintenance and Maintenance Assistant were in-serviced on March 7, 2023, regarding the regulation to have a remote emergency stop button on the generator. The Director of Maintenance or designee will audit the remote emergency stop button for the generator monthly for 3 months and quarterly thereafter. Results of the audit will be reviewed at the quarterly quality assurance meeting.	

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K 918	Continued From page 11 continued on 3/06/23, in the presence of the facility's Admin. and DOM, a tour of the building was performed. During the tour the surveyor observed the following: On 3/06/23 at approximately 9:54 AM, during an inspection outside of the building where the Emergency Generator was located, the surveyor observed that the emergency stop button was located on the housing of the generator. At this time, the surveyor asked the DOM, "Do you have a remote emergency stop button for the generator?" The DOM stated, "no." The Admin. and DOM confirmed the finding at the time of observation. The Administrator was informed of the above finding at the survey exit on 3/06/23 at approximately 12:01 PM. 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		

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	5/1/2023 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	K0321	03/07/2023	LSC	K0521	03/31/2023	LSC	K0911	03/07/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0914	03/07/2023	LSC	K0918	03/10/2023	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	
3/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO