STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 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		
F 000	INITIAL COMMENTS Survey Date: 2/10/23 Census: 46 Sample: 12 + 1 closed record 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 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		2/27/23

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

Electronically Signed | 02/21/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 623	Continued From page 1	F 623		

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 623	Continued From page 2	F 623		

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 623	Continued From page 3 Based on interview, record review and review of other pertinent facility documentation it was determined that the facility failed to notify the resident and/or the resident's representative in writing of the reason for transfer or discharge to the hospital and also send a copy to a representative of the Office of the State Long-Term Care Ombudsman for 2 of 2 residents reviewed for hospitalization, Residents #17 and Resident #24. This deficient practice was evidenced by the following: According to the Admission Record (AR) Resident #17 was admitted to the facility with the diagnoses which included but was not limited to NJ Exec Order 26.4b1 The surveyor reviewed the unplanned discharge Minimum Data Set (MDS-an assessment that facilitates a resident care) dated NJ Exec Order 26.4b1 which indicated that the resident was discharged to the hospital. The surveyor reviewed the New Jersey Universal Transfer form (NJUTF) dated NJ Exec Order 26.4b1, which indicated that Resident #17 was discharged to the hospital for a NJ Exec Order 26.4b1. The surveyor also reviewed the physician's order dated NJ Exec Order 26.4b1, that the resident was to be sent to the hospital's emergency room for evaluation of a NJ Exec Order 26.4b1. The facilities Hospitalization Tracking Record (HTR) indicated that Resident #17 was discharged to the hospital on NJ Exec Order 26.4b1 and returned on NJ Exec Order 26.4b1. The HTR also indicated that the residents responsible party (RP) was	F 623	I CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICICENT PRACTICE: The following corrective actions were immediately implemented: - Resident #17 and #24, the office of the State Long-Term Care Ombudsman was notified of their transfers to the hospital. - Resident #17, a transfer notification letter was mailed to the resident□s representative. - Resident #24 a transfer notification letter was mailed to the resident's representative. II IDENTIFICATION OF RESIDENTS WHO MAY HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: - All residents have the potential to be affected by the same deficient practice. III SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR - The Social Worker received education on the notification of transfer or discharge requirements to ensure the resident and the resident□s representative and the office of the State Long-Term Care Ombudsman will receive notification of transfers or discharge and the reason for the transfer or discharge. The Assistant Administrator and/or designee will monitor and review all transfer and discharge notifications every month for the next three months and then quarterly for six months. A monthly audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 623	Continued From page 4 notified by phone and not letter. The surveyor could not find any documentation in the resident's medical record that the RP or Office of the State Long-Term Care Ombudsman was notified about the resident's transfer to the hospital on [redacted]. The surveyor reviewed the medical records of Resident #24. Review of the AR reflected that the resident was admitted to the facility with diagnoses which included but was not limited to [redacted] Review of the NJUTF, dated [redacted], indicated the resident was transferred to the hospital. Review of Resident #24's "Progress Notes" revealed a [redacted] Nursing Notes that indicated the physician requested for the resident to be transferred to the hospital. Review of the MDS dated [redacted], indicated the resident had a discharge assessment with return anticipated. Review of the facility's HTR indicated that Resident #24 was discharged on [redacted] and revealed under the "Date of Letter Send to POA [power of attorney]" section that the representative was notified by phone. Review of Resident #24's medical record did not include a notification letter to the Office of the State Long-Term Care Ombudsman of the transfer to the hospital.	F 623	will be conducted to ensure compliance and will be provided to the Administrator. IV MONTORING OF CORRECTIVE ACTIONS: - A Performance improvement Plan (PIP) report and audit results will be reported quarterly to the Quality Assurance and Performance Improvement (QAPI) Committee to assure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 623	Continued From page 5 On 02/09/23 at 12:32, the surveyors interviewed the Administrator who confirmed that the facility did not inform the Office of the State Long-Term Care Ombudsman or the RP in writing regarding Resident #17 and Resident #24's unplanned discharges to the hospital. The Administrator explained that the process for notifying the Ombudsman and RP regarding the written notice for discharge was not yet explained to the new Social Worker, (SW) so the SW did not know that it was her responsibility to complete the notifications in writing of discharge to the Ombudsman and RP. NJAC 8:39-5.3; 5.4	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		2/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 625	Continued From page 6 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and review of the medical record and other facility documentation, it was determined that the facility failed to provide a bed-hold and return policy to a resident representative. This deficient practice was identified for Resident #17 and #24, 2 of 2 residents reviewed for transfer and was evidenced by the following: 1.) According to the Admission Record (AR) Resident #17 was admitted to the facility with diagnoses which included but were not limited to [redacted]. The surveyor reviewed the unplanned discharge Minimum Data Set (MDS-an assessment that facilitates a resident care) dated [redacted] which indicated that the resident was discharged to the hospital with return to the facility anticipated. The surveyor reviewed the New Jersey Universal Transfer form (NJUTF) dated [redacted], which indicated that Resident #17 was discharged to the hospital for a [redacted].	F 625	I CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICICENT PRACTICE: The following corrective actions were immediately implemented: - Resident #17, a notification of the bed-hold and return policy was provided to resident #17□s representative. - Resident #24, a notification of the bed-hold and return policy was provided to resident #24□s representative II IDENTIFICATION OF RESIDENTS WHO MAY HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: - All residents have the potential to be affected by the same deficient practice. III SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR - The Social Worker received education on the notification of the bed-hold policy to ensure the notification is provided in writing to the resident and/or the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 625	Continued From page 7 Review of Resident #17's medical record did not include a notification letter to the residents and/or their representatives with the facility's notice of bed-hold policy. 2. The surveyor reviewed the medical records of Resident #24. Review of the AR reflected that the resident was admitted to the facility with diagnoses which included but not limited to[redacted] Review of the NJUTF dated [redacted], indicated the resident was transferred to the hospital. Review of Resident #24's "Progress Notes" revealed a [redacted] Nursing Notes that indicated the physician requested for the resident to be transferred to the hospital. Review of the MDS dated [redacted] indicated the resident had a discharge assessment with return anticipated. Review of Resident #24's medical record did not include a notification letter to the residents and/or their representatives with the facility's notice of bed-hold policy. On 02/09/23 at 12:32, the surveyors interviewed the Administrator who confirmed that the facility did not inform the RP in writing regarding the facility's notice of bed-hold policy. The Administrator explained that the process for notifying the RP regarding the bed hold policy in	F 625	resident's representative before or upon transfer. - The Assistant Administrator and/or designee will monitor and review all bed-hold notifications that occur in a monthly basis. An audit of bed-hold notifications will be conducted monthly for the next three months and then quarterly for six months IV MONTORING OF CORRECTIVE ACTIONS: - A Performance improvement Plan (PIP) report and results of the monthly audits will be reported quarterly to the Quality Assurance and Performance Improvement (QAPI) Committee to assure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 625	Continued From page 8 writing was not yet explained to the new Social Worker (SW) so the SW did not know that it was her responsibility to complete the notifications of bed hold to the RP. NJAC 8:39-5.3	F 625		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner designed to prevent foodborne illness. This deficient practice was evidenced by the following:	F 812	I CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The following corrective actions were immediately implemented: -The two (2) gluten free pasta packages opened and undated were immediately	2/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 9 On 02/03/23 10:57 AM, the surveyor, in the presence of the Food Service Director (FSD), observed the following during the kitchen tour: 1. In the spice cabinet, an opened and undated package of gluten free pasta was stored on a shelf. The surveyor observed a second opened and undated package of gluten free pasta wrapped in plastic stored on a shelf. When interviewed, the FSD stated the packages of gluten free pasta should have been dated when opened. The surveyor further observed signage posted on the door of the spice cabinet that indicated all items must have an open date on them. 2. In the walk-in refrigerator, a bin containing raw chicken and chicken blood was stored on a slant on top of second pan containing raw chicken. The surveyor further observed that some of the chicken blood had spilled onto the floor of the walk-in refrigerator. When interviewed, the FSD stated the bin containing the raw chicken should not have been stored on a slant and that she would get the blood on the floor cleaned up. 3. In the walk-in refrigerator, an unopened box containing 50 chocolate Mighty Shakes (MS), dated 01/16/23, was stored on a multitiered shelf. When interviewed, FSD stated the date on the box was the receiving date and not the pull date. The FSD added that the box may have been pulled last Thursday. 4. Two bins containing plastic lids were stored on a shelf. The plastic lids were open and exposed. When interviewed, the FSD stated the lids were not supposed to be in the bin and that they should be stored in plastic and in a drawer.	F 812	discarded. -The unopened box containing (50) Mighty Shakes (MS) was immediately discarded. -The plastic lids that were open and exposed were discarded. -The meat preparation refrigerator was emptied out and completely cleaned including the floor. -The mixer□s plastic cover was immediately discarded, and the mixer□s bowl was cleaned and sanitized. II IDENTIFICATION OF RESIDENTS WHO MAY HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: -All residents have the potential to be affected by the same deficient practice. All Dining Services staff were in-serviced on the regulations and facility□s policies on the following: - Properly handling and storage of potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses. -Maintaining equipment and kitchen areas in a manner to prevent the spread of food borne illnesses. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR - Food Service Director or designee will conduct Kitchen Observation Audits weekly times (1) month; then monthly thereafter x (6) months. Emphasis will be made on proper handling and storage of food and maintaining equipment and kitchen areas	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(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 10 5. The surveyor observed that the mixer was covered in plastic. The FSD stated the mixer had been cleaned and sanitized. Upon inspection, the surveyor observed white chunky unknown substance on the edging of the pot. When interviewed, the FDS stated that it should not be stored in that manner and removed the pot to be cleaned. Review of the facility's "Labeling and Dating Food Items and Shelf Life," revised 05/01/2019, indicated that "All food items must be covered, labeled, dated, and properly stored for a length of time to keep the food safe." The policy revealed that food items would be labeled with the open date once opened for use. The policy further revealed, under dry storage, that any opened products should be placed in seamless plastic, glass containers with tight-fitting lids, or Ziploc bags. Review of the facility's "Food Receiving and Storage" policy, revised July 2014, revealed that uncooked and raw animal products would be stored separately in drip-proof containers. NJAC 8:38-17.2 (g)	F 812	in a clean and sanitary manner. Any issues identified in the audits will be rectified immediately. IV MONITORING OF CORRECTIVE ACTIONS: Finding will be submitted to the QAPI Committee quarterly and will be incorporated in the Facility QAPI program for on-going compliance.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061223	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

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

Electronically Signed | 02/21/23

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)
315318	A. Building B. Wing	3/3/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

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 F0623 Reg. # 483.15(c)(3)-(6)(8) LSC	Correction Completed 02/27/2023	ID Prefix F0625 Reg. # 483.15(d)(1)(2) LSC	Correction Completed 02/27/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 02/27/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/10/2023	☐ 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
	315318	A. BUILDING **02** B. WING _____	**02/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	**1-3 ST JOSEPH'S TERRACE** **WOODBRIDGE, NJ 07095**

(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 1/08/2023 and St Joseph's Home AL & NC 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. St Joseph's Home AL & NC is a Two-story, Type I Fire Resistant building that was built in January 1992. The facility is divided into 5 smoke zones. The facility has a diesel generator.	K 000		
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 02/08/23 and in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency light above one (1) of one (1) emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 02/08/23, during the survey entrance at 9:07	K 291	1 CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE A licensed electrician installed a battery backup emergency light on February 9, 2023 (Battery-operated-(90) minutes) across and above the emergency generator's transfer switch. This battery backup emergency light is independent of the building's electrical system and the emergency generator and in compliance with the NJAC and NFPA codes.	2/27/23

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

Electronically Signed | 02/21/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING **02** B. WING _____	**02/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	**1-3 ST JOSEPH'S TERRACE** **WOODBRIDGE, NJ 07095**

(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 1 AM, a request was made to the Administrator (Admin) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. The surveyor also asked if the facility had an emergency generator. The Admin told the surveyor yes, we have an emergency generator. Starting at approximately 10:13 AM, in the presence of the Admin and MS, a tour of the building was conducted. Along the tour, at approximately 11:50 AM, an inspection of the emergency generator's transfer switch was performed. The surveyor observed no evidence of a battery back up emergency light in the area for the generator transfer switch. At that time, the surveyor asked the MS, "Do you have a battery back up emergency light for the transfer switch?" The MS pointed to the fluorescent light that was hanging in the room and said to the surveyor the light was tied into the emergency generator. The facility did not provide a battery back-up emergency light independent of the emergency generator as required. The Admin and MS confirmed the finding at the time of observation. The Admin and Assistant Admin were informed of the deficiency at the Life Safety Code exit on 02/08/23 at approximately 1:30 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	II IDENTIFICATION OF RESIDENTS WHO MAY HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the same deficient practice. All other areas were assessed and found that there are emergency lighting, battery operated devices in places. III SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance staff received education on battery backup emergency light across and above the emergency generator's transfer switch, and The NJCA and NFPA codes. The Maintenance staff will conduct monthly inspections to monitor and test the battery backup emergency light across and above the emergency generator's transfer switch, to ensure that the emergency light is in safe and working order. Findings will be reported to the Administrator. IV MONITORING OF CORRECTIVE ACTIONS: Maintenance staff will conduct tests of all emergency lighting monthly for six (6) consecutive months. A report will be presented to the Quality Assurance and Performance Improvement committee at the quarterly meetings to ensure on-going compliance.	
K 293 SS=D	Exit Signage	K 293		2/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING **02** B. WING _____	**02/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	**1-3 ST JOSEPH'S TERRACE** **WOODBRIDGE, NJ 07095**

(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 293	Continued From page 2 CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 02/08/23 and in the presence of facility management, it was determined that the facility failed to provide 3 illuminated exit signs to clearly identify the exit access path to an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction	K 293	1 CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE A licensed electrician installed three (3) illuminated exit signs were installed to clearly identify the exit paths to the exits discharge doors in compliance with the NJCA and NFPA Life Safety Codes. II IDENTIFICATION OF RESIDENTS WHO MAY HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the same deficient practice. The Maintenance Staff was educated on the NJCA and NFPA codes. The Maintenance Staff and/or designee will monitor and conduct monthly inspections by checking all exit signs in the building to ensure that exit signs are in safe and working order. Findings will be reported to the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING **02** B. WING _____	**02/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	**1-3 ST JOSEPH'S TERRACE** **WOODBRIDGE, NJ 07095**

(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 293	Continued From page 3 Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 02/08/23, during the survey entrance at 9:07 AM, a request was made to the Administrator (Admin) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a two story building with 5 smoke zones. The first floor had three (3) smoke zones with 14 Resident sleeping rooms. The second floor had two (2) smoke zones with 16 Resident sleeping rooms. Starting at approximately 10:13 AM, in the presence of the facility's Admin and MS, a tour of	K 293	III SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Maintenance staff will conduct monthly audits for six months to monitor and assure that Exit signs are in working order. The results of the audits will be reported to the Fire & Safety Committee at the quarterly meetings. IV MONITORING OF CORRECTIVE ACTIONS: A Performance Improvement Plan (PIP) report and the results of the audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee at the quarterly meetings to ensure on-going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING **02** B. WING _____	**02/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	**1-3 ST JOSEPH'S TERRACE** **WOODBRIDGE, NJ 07095**

(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 293	Continued From page 4 the building was conducted. Along the tour the surveyor observed three (3) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations: 1) At approximately 10:16 AM, on the second floor next to resident room #26, the surveyor observed no evidence of an illuminated exit sign in the area above the corridor double smoke doors. With the activation of the fire alarm system, this would allow the magnetic hold open devices to release and the smoke doors would close into their frame. You would not be able to see the illuminated exit sign at the end of the corridor (next to resident room #18) which identified the stairway exit. A review of an evacuation diagram posted in the area identified you would need to pass through the double smoke doors as the primary and or secondary exit access route to reach an exit. 2) At approximately 10:17 AM, on the second floor next to resident room #25 the surveyor observed no evidence of an illuminated exit sign in the area above the corridor double smoke doors. With the activation of the fire alarm system, this would allow the magnetic hold open devices to release and the smoke doors would close into their frame. You would not be able to see the illuminated exit sign near the Chapel which identified the direction to the stairway exit. A review of an evacuation diagram posted in the area identified you would need to pass through the double smoke doors as the primary and or secondary exit access route to reach an exit.	K 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING **02** B. WING _____	**02/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	**1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095**

(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 293	Continued From page 5 3) At approximately 11:25 AM, on the first floor (while standing in the corridor next to resident room #4) the surveyor observed no evidence of an illuminated exit sign with a directional arrow at the end of the corridor to identify the exit access which leads you to the lobby area exit discharge door. A review of an evacuation diagram posted in the area identified this is the primary and or secondary exit access route to reach an exit discharge door. The Admin and MS confirmed the finding at the time of observation. The Admin and Assistant Admin were informed of the deficiency at the Life Safety Code exit on 02/08/23 at approximately 1:30 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control	K 341		2/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING **02** B. WING _____	**02/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	**1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095**

(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 341	Continued From page 6 unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 02/08/23, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 02/08/23, during the survey entrance at 9:07 AM, a request was made to the Administrator (Admin) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a two story building with an outside enclosed center court yard located with-in the facility. During a tour of the building at 11:33 AM, with the	K 341	1 CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICICENT PRACTICE An audio and visual alarm was installed in the enclosed courtyard to notify resident, staff and visitors of an activation of the buildings fire alarm system in compliance with the NJAC and NFPA Life Safety Codes. II IDENTIFICATION OF RESIDENTS WHO MAY HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the same deficient practice. The Maintenance Staff was educated on the NJAC and NFPA codes. III SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance Staff and/or designee will monitor and test the fire alarm and visual lighting during monthly fire drills for six months to ensure that visual and audio	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315318	A. BUILDING **02** B. WING _____	**02/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	**1-3 ST JOSEPH'S TERRACE** **WOODBRIDGE, NJ 07095**

(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 341	Continued From page 7 Admin and MS, an inspection of the outside enclosed (surrounded by the building) courtyard was performed. The surveyor observed no evidence of an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the buildings fire alarm system. The Admin and MS confirmed the finding at the time of observation. The Admin and Assistant Admin were informed of the deficiency at the Life Safety Code exit on 02/08/23 at approximately 1:30 PM. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	alarms are in safe and working order. Maintenance staff will conduct monthly audits and results will be reported to the Administrator and Fire & Safety Committee at the quarterly meetings. IV MONITORING OF CORRECTIVE ACTIONS: A Performance Improvement Plan (PIP) report and results of the audits will be presented to the Quality Assurance and Performance Improvement (QAPI) committee at the quarterly meetings to ensure on-going compliance.	

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
315318 (Y1)	A. Building 02 - ST JOSEPH SENIOR HOME B. Wing (Y2)	3/3/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S HOME AL & NC, INC	1-3 ST JOSEPH'S TERRACE WOODBRIDGE, NJ 07095

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 K0291	Correction Completed 02/27/2023	ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 02/27/2023	ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 02/27/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/10/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO