STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD TINTON FALLS, NJ 07753**

(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 #: NJ171444 Survey Date: 10/8/24 Census: 73 Sample: 18 + 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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		11/19/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/31/2024

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

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain residents' living environment in a clean, comfortable, homelike manner. This deficient practice was identified on 1 of 2 nursing units reviewed for environment (300 unit), and was evidenced by the following: 1. On 10/1/23 at 12:24 PM, during initial tour of the facility, the surveyor entered onto a ramp that led to the 300 nursing unit, and observed the following: 1. The handrail on right side of wall going up the ramp had three areas where it was not connected to itself, which left a gap in the system where the metal framing was exposed. This presented a safety hazard for residents that were unsteady on their feet.	F 584	The handrail on the ramp going to the 300 unit was repaired to not have any gaps. The peeling wallpaper on the 300 unit was repaired to not be peeling anymore. The threshold that connects the ramp to the 300 nursing unit corridor had the missing tiles filled in and was made even. The hole in the wall by the doorframe to the 300 unit was repaired and the crumbling debris has been cleaned. The split by the corner seam in the wall of the vestibule entrance to the 300 unit was cleaned out from the debris and was repaired. The hole in the soffit on the right side of the 300 nursing unit has been closed. The threshold by the doorways of room 301 and 303 were made to be even with the hallway floor.	

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F 584	Continued From page 2 2. The wallpaper was peeling and bubbling throughout the entire entrance to the 300 nursing unit. 3. The threshold that connected the ramp to the 300 nursing unit corridor had tile removed, missing and uneven elevations in areas presenting a tripping hazard. 4. The entrance to 300 nursing unit's doorframe had a hole in the wall by the doorframe. and around the hole was white crumbling debris. On 10/3/23 at 12:02 PM, the surveyor toured the 300 nursing unit, and entered hallway vestibule entrance and observed the following: 1. To the left side of hall at two joining walls, there was a split in the wallpaper along the corner seam from the floor to approximately four feet. The area behind the wallpaper was black and had white dust debris. 2. On the right side of the 300 nursing unit hallway, there was an interior soffit enclosure that had a rectangular cutout hole that exposed the interior of the soffit. On 10/7/24 at 12:00 PM, the surveyor observed on the 300 nursing unit in Resident Room #301, the doorway threshold had cracked and sunken tiles, which caused the entryway into the room to be uneven. On 10/7/24 at 12:00 PM, the surveyor observed on the 300 nursing unit in Resident Room #303, the doorway threshold had cracked tiles that were lifted and created a lip to the entrance of the room.	F 584	The substance on the floor at the entrance of Room 309 was removed and the floor was repaired so that it is level with the rest of the floor. The missing and broken tiles in the bathroom of Room 309 was replaced. The substance in the bathroom of Room 309 has been removed. All residents have the potential to be affected by this cited practice. Staff have been in-serviced by the Administrator to report any area in the building which may require repair due to safety concerns or for not being comfortable or homelike. Staff have been in-serviced by the Administrator to report any area in the building which may require cleaning. Housekeeping staff have been in-serviced by the Director of Housekeeping on the proper method of cleaning rooms with special focus on ensuring that all areas with substances on them are cleaned properly. The U.S. FOIA (b) (6) was in-serviced by the Administrator to ensure that all areas that require repair due to possible safety concerns or for not being comfortable or homelike are addressed timely and appropriately to ensure that the residents have a safe, clean, comfortable and homelike environment. The Administrator or designee will do facility rounds will pay special attention to areas which may need extra cleaning or for areas that may need to be repaired	

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F 584	Continued From page 3 On 10/7/24 at 12:37 PM, the surveyor interviewed with U.S. FOIA (b)(6)), who stated that housekeeping staff was responsible for mopping and cleaning the floors. The U.S. FOIA (b) stated that the U.S. FOIA (b)(6)) and upper management were responsible for changing the tiles and flooring. On 10/7/24 at 1:15 PM, the surveyor and the U.S. FOIA (b)(6) toured the 300 nursing unit, and the surveyor showed the U.S. FOIA (b)(6) the identified concerns. The U.S. FOIA (b)(6) acknowledged he was aware of the identified concerns, and he stated that the facility planned to remodel the nursing unit, but there was no definitive date. The U.S. FOIA (b)(6) acknowledged that the residents could cut their hands on the handrail or trip on the elevated thresholds or missing tiles. The U.S. FOIA (b)(6) confirmed the flooring presented an issue with "safety" and was a "tripping hazard." The U.S. FOIA (b)(6) was unavailable for an interview during survey. 2. On 10/1/24 at 9:40 AM, during the initial tour of the facility, the surveyor observed Resident Room #309. On immediate entrance into the room, the surveyor noted a thick buildup of a brown substance on the floor. There was also a twelve-inch by twelve-inch (12" x 12") tile that was sunken down on the right side adjoining to another tile which was unleveled that created a tripping hazard. The crack in the sunken down tile, between the two tiles had a dark brown substance. The surveyor then entered the	F 584	due to not being a safe, clean, comfortable and homelike environment. This will be done twice weekly for the next 4 weeks and then twice a month for the next 4 months. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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F 584	Continued From page 4	F 584		

bathroom in Resident Room #309. On entrance to the bathroom, the surveyor noted a small tile that was missing the corner edge creating a small hole. In front of the toilet there was a loose tile, and around the base of the toilet towards the front was a dark brown substance.

When exiting the bathroom, the surveyor noted an area in the corner by the hinged side of the bathroom door, an area of a grayish brown substance on the floor and in the corner by the door jamb was a black and white substance on the floor and on the door jamb.

On 10/7/24 at 12:25 PM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the process for cleaning resident rooms. The U.S. FOIA (b) stated that the "worst" rooms were cleaned first, and the housekeepers had a "daily focus". The U.S. FOIA (b) stated that the floors were mopped daily or twice daily, and that the 300 nursing unit had one housekeeper and one porter (cleaned equipment and emptied trash).

On 10/7/24 at 12:50 PM, the surveyor reviewed a room checklist provided by the U.S. FOIA (b), and Resident Room #309 was marked as "unsatisfactory." The checklist was dated 10/7/24, after surveyor inquiry.

On 10/8/24 at 11:00 AM, the surveyor requested from the U.S. FOIA (b)(6)) a clean homelike environment policy.

On 10/8/24 at 12:10 PM, the surveyor reviewed the maintenance request logs provided by the facility. On 9/19/24, there was a maintenance request submitted for water leaking in a bathroom. The room number was not identified

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F 584	Continued From page 5 on the log, and the details written by maintenance were that there were no leaks, and the floor was just dirty. No additional information was provided. A review of the undated facility's "Maintenance Service" policy included...1. the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at tall times. 2. functions of the maintenance personnel include but are not limited to a. maintaining the building in compliance with the current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards. 3. the Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner...8. maintenance is responsible for maintaining the following records/reports ...a. inspection of the building, b. work order requests, c. maintenance schedules... NJAC 8:39-31.4(a)	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		11/19/24

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F 657	Continued From page 6 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to revise an individual comprehensive care plan for a resident with a NJ Exec Order 26.4b1 at the facility. This deficient practice was identified for 1 of 1 resident reviewed for [redacted] (Resident #53), and was evidenced by the following: On 10/1/24 at 10:17 AM, during the initial tour of the facility, the surveyor observed Resident #53 in bed with blankets over their head. On 10/2/24 at 11:30 AM, the surveyor observed Resident #53 in bed. Resident #53 told the surveyor that they liked to stay in bed and they ate meals in their room. The surveyor asked the resident if they had any NJ Exec Order 26.4b1 and the resident said yes, but did not say if they were	F 657	The Care Plan for Resident #53 was updated to address the [redacted] that occurred on [redacted] All residents have the potential to be affected by this practice. The Unit managers reviewed the Care Plans for residents that had a fall in the past 90 days to ensure that their care plans have been updated as needed. Incidents are reviewed at the daily clinical meeting by the interdisciplinary care team. The Unit Managers or designees will then update the Resident Care Plans with the interventions that have been implemented. The Incident reports will not be finalized until the Care Plans have been updated.	

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F 657	Continued From page 7 every injured [redacted]. The surveyor observed [redacted]. On 10/2/24 at 12:15 PM, the surveyor reviewed the medical record for Resident #53. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses which included but not limited to; [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] revealed the resident had a Brief Interview of Mental Status (BIMS) score of [redacted]; meaning the resident was [redacted]. A review of Section [redacted] for [redacted]. On 10/3/24 at 10:56 AM, the surveyor reviewed incidents and accidents which indicated that Resident #53 had a [redacted]. The resident was [redacted] by the staff. The resident told staff that they [redacted] Staff documented that [redacted]; and [redacted] were initiated; and the resident's family and physician were notified. On 10/7/24 at 10:19 AM, the surveyor reviewed the resident's individualized comprehensive care plan (ICCP) which included a focus area dated	F 657	The Unit Managers along with all Licensed nurses have been in-serviced by the Director of Nursing on the requirement to ensure that all Resident Care Plans are updated following an incident. The Director of Nursing or Designee will audit 2 incidents per week for 4 weeks then 3 incidents per month for 3 months to ensure that resident care plans have been updated post incident as required. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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F 657	Continued From page 8 NJ Ex Order 26.4(b) and revised NJ Ex Order 26.4(b), that the resident was at NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 [redacted] Interventions included to leave call bell within reach; ensure the resident was wearing appropriate footwear; keep pathways clear; and physical and occupational therapy to evaluate and treat as needed. The ICCP did not include the NJ Exec O [redacted], and was not revised following the NJ Exec [redacted] On 10/7/24 at 12:08 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) regarding the facility's NJ Exec Order 26.4b1 process. The U.S. FOIA (b)(6) said if a resident's NJ Exec was unwitnessed, NJ Ex Order 26.4(b)(1) were started, a NJ Ex Order 26.4(b)(1) evaluation was ordered if appropriate, and then we meet as a team to add interventions. The U.S. FOIA (b)(6) said the ICCP was revised with new interventions to implement. The surveyor asked the U.S. FOIA (b)(6) to review Resident #53's ICCP, and verify if the ICCP was revised after the resident's NJ Exec in NJ Exec Order 26.4b1 The U.S. FOIA (b)(6) confirmed the ICCP was not updated after the NJ Exec Order 26.4b1 On 10/8/24 at 11:00 AM, the U.S. FOIA (b)(6) [redacted], in the presence of the Acting U.S. FOIA (b)(6) [redacted] and survey team, acknowledged Resident #53's ICCP was not updated post U.S. FO until surveyor inquiry. A review of the facility's "Care Planning" policy dated revised April 2024, included that care plan development, renewal and revision will be based upon results of the resident assessment...when a problem, goal, approach or target date is added, changed or resolved it is indicated in the care plan...	F 657		

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F 657	Continued From page 9 NJAC 8:39-27.1(a)	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who NJ Exec Order 26.4b1 was assessed for safety. The deficient practice was identified for 1 of 5 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #25), and was evidenced by the following: On 10/1/24 at 10:28 AM, during initial tour of the facility, the surveyor observed Resident #25 in their room watching television. Resident #25 stated that they were NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted]. The resident also stated that the activities staff held on to theirNJ Exec Order 26.4b1. On 10/1/24 at 12:26 PM, the surveyor reviewed the medical record for Resident #25. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses including but not limited to; NJ Exec Order 26.4b1 [redacted]	F 689	A NJ Exec Order 26.4b1 for Resident #25 was completed. All Residents that smoke have the potential to be affected by this practice. A review of all smoking residents was completed by the Activity Director to ensure that their smoking assessments are up to date. All residents that smoke will have a smoking assessment completed by the Director of Activities or designee upon admission and then quarterly and annually as well at any significant change of condition. TheU.S. FOIA (b) (6) along with the interdisciplinary care team will be in-serviced by the Director of Nursing on the requirement of completing smoking assessments when they are due. The Unit Managers or designees will audit 2 smoking residents per week for 4 weeks	11/19/24

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F 689	Continued From page 10 NJ Exec Order 26.4b1 . A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2, indicated the resident had a brief interview for mental status score of NJ Exec Order 26.4b1 indicating a NJ Exec Order 26.4b1. A further review in Section J "Health Conditions" reflected the resident was a NJ Exec Order 26.4b1. A review of the individualized comprehensive care plan (ICCP) included a focus area dated NJ Exec Order 26.4, that the resident was NJ Exec Order 26.4b1. Interventions included that the resident required supervision NJ Exec Order 26.4b1; will be assessed quarterly for NJ Exec Order 26.4b1; instruct the resident about NJ Exec Order 26.4b risks and hazards and about NJ Exec Order 26.4b that are available; instruct the resident about the facility policy on NJ Exec Order 26.4b locations, times, and safety concerns; have NJ Exec Order 26.4b supplies stored with the activity department; observe the resident's clothing and NJ Ex Ord for signs of NJ Exec Order 26.4b1; the facility NJ Exec Order 26.4b contract has been reviewed with the resident and they have signed it; and to notify the charge nurse immediately if it was suspected that the resident had violated the facility's NJ Exec Order 26.4b policy. A review of the NJ Ex Order 26.4(b)(1 Safety Screen, located in the electronic medical record (eMR). revealed the most recent NJ Ex Order 26.4(b)(safety screen was completed on NJ Ex Order 26.4(b)(1 The NJ Ex Order 26.4(b)(1 Safety Screen indicated that the resident was NJ Ex Order 26.4(b)(1) and could NJ Ex Order 26.4 safely with supervision. A review of the resident's "NJ Ex Order 26.4(b)(1 Contract" was signed by the resident on NJ Ex Order 26.4(b)(1.	F 689	then monthly for 3 months to ensure that resident that smoke have had their smoking assessments completed when they were due. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 On 10/7/24 at 12:14 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that residents were assessed upon admission, quarterly, annually, and if there was a significant change for NJ Exec Order 26.4b which included safety. The U.S. FO stated that Resident #25 was a NJ Ex Order 26.4(and provided the surveyor with the most recent NJ Ex Order 26.4(b)(Safety Screen dated NJ Ex Order 26.4(. The U.S. FOIA stated that there should have been a smoking assessment completed the first week of September, and they could not speak to why there was no NJ Ex Order 26.4(b)(Safety Screen completed. The U.S. FOIA stated the importance of completing a NJ Ex Order 26.4(b)(Safety Screen was for the safety of the resident, and to determine if there were any changes such as needing a NJ Exec Order 26.4b1. On 10/7/24 at 1:35 PM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated NJ Ex Order 26.4(b)(Safety Screenings should be completed upon admission. The U.S. FOIA (b)(6 could not speak to when NJ Ex Order 26.4(b)(Safety Screenings should be completed other than upon admission. On 10/8/24 at 11:00 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) and survey team, stated that the NJ Ex Order 26.4(b)(Safety Screenings were completed quarterly, or if there was a significant change. The U.S. FOIA (b)(6 also stated that the NJ Ex Order 26.4(b)(Safety Screening was due when the facility was changing Activities Directors, and we "missed" the September screening. The U.S. FOIA (b)(further stated that Resident #25's NJ Ex Order 26.4(b)(Safety Screening was completed on NJ Ex Order 26.4(, after it was brought to our attention. The U.S. FOIA (b)(acknowledge a NJ Ex Order 26.4(b)(Safety Screening should have been completed in September.	F 689		

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	315414	A. BUILDING _____ B. WING _____	C 10/08/2024

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F 689	Continued From page 12 A review of the facility's "Resident Smoking Policy" dated revised 8/30/23, included the resident will be evaluated upon admission, re-admission, and quarterly or upon any significant change to a residents physical or cognitive status...	F 689		
F 695 SS=D	NJAC 8:39-27.1(a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documentation, it was determined that the facility failed to label, date, and initial a resident's[NJ Exec Order 26.4b1]. This deficient practice was identified in 1 of 1 residents reviewed for [NJ Ex Order 26.4(b)(1)] (Resident #49), and was evidenced by the following: On 10/1/24 at 10:07 AM, during initial tour of the facility, Resident #49 approached the surveyor in the main dining room on the second floor. During the observation, the resident had a [NJ Exec Order 26.4b1] [redacted] The [NJ Exec Order 2] that supplied the [NJ Exec Order 26] that went from the resident to the tank	F 695	The [NJ Exec Order 26.4b1] for Resident #49 was changed, labeled and dated and placed in a plastic bag when not in use. All residents receiving Oxygen have the potential to be affected by this practice. The Unit Managers checked the Oxygen tubing of residents on oxygen to ensure that their tubing has been dated and is still within the date. Nursing staff have been in-serviced by the Director of Nursing on the requirement for changing oxygen tubing weekly and	11/19/24

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F 695	Continued From page 13 did not have a date. The surveyor then entered the resident's room with the resident, and the resident had an NJ Exec Order 26.4b1 [redacted]) in the room. The concentrator had NJ Exec Order 26.4b1 that went from the NJ Exec Order 26.4b1 and into a bag. The resident told surveyor that they wore that when in bed. On 10/1/24 at 10:37 AM, the surveyor observed Resident #49 in the bed. The resident was being administered NJ Exec Order 26.4b1 [redacted]. The resident's NJ Exec Order 26.4b1 was not dated. On 10/1/24 at 11:20 AM, the surveyor reviewed the medical record for Resident #49. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with medical diagnoses that included but not limited to; NJ Exec Order 26 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order [redacted], revealed the resident had a Brief Interview of Mental Status (BIMS) score of NJ Exec Order 26.4b1 meaning the resident was NJ Exec Order 26.4b1. A further review revealed the resident NJ Exec Order 26.4b1. A review of the physician's orders (PO) included the following POs: A PO dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 when NJ Exec Order 26 was in use every twenty-four hours as	F 695	ensuring that the tubing is labeled and dated and placed in a plastic bag when not in use. The Unit Managers or designees will audit 2 residents on oxygen per week for 4 weeks then monthly for 3 months to ensure that their oxygen tubing is labeled and dated and in a bag when not in use. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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F 695	Continued From page 14 needed. To apply NJ Exec Order 26.4b1) at NJ Exec Order 26.4b1 as needed every NJ Exec Order 26.4b1 A PO dated NJ Exec Order 26.4b1, for the staff to change the NJ Exec Order 26.4b1 weekly and date the NJ Exec Order 2 and NJ Ex Or every night shift on Sunday. A review of the individual comprehensive care plan (ICCP) included a focus area dated NJ Exec Order 2 and revised NJ Exec Order 26.4, that the resident was able to apply the NJ Exec Order 26.4b1 when needed. Interventions included to change the NJ Exec Order 26 On 10/3/24 at 1:00 PM, the surveyor observed Resident #49 NJ Exec Order 26.4b under the supervision of the activities staff. The resident removed the NJ Exec Order 26 prior to going outside to NJ Exec Order 26 and the NJ Exec Order 26 remained in the building. Resident #49 went back into building and reapplied the NJ Exec Order 26. The surveyor observed that the NJ Ex Order 26 was not dated. On 10/7/24 at 12:16 PM, the surveyor interviewed the U.S. FOIA (b)(6) regarding . The U.S. FOIA (b)(6) stated that NJ Exec Order 26.4b1 was changed every Sunday night and the NJ Exec Order 2 was dated. The surveyor informed the U.S. FOIA (b)(6) that on the surveyor observed that Resident #49's NJ Exec Order 26.4b1 was not dated. The U.S. FOIA (b)(6) could not speak to why the NJ Exec Order was not dated. On 10/7/24 at 2:01 PM, the surveyor informed the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6)) about	F 695		

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F 695	Continued From page 15 the multiple observations of Resident #49's NJ Exec Order 26.4b1 not dated. No additional information was provided. A review of the facility's "Oxygen Administration" policy dated revised 7/10/23, included...staff were to date and initial tubing and humidifiers when changing each week...	F 695		
F 812 SS=F	NJAC 8:39-27.1(a) 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 pertinent facility documents, it was determined that the facility failed to a.) discard potentially	F 812	The bread boxes that were left directly on the ground were removed from the ground and the bread company was notified not	11/19/24

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F 812	Continued From page 16 hazardous foods past their date of expiration; b.) ensure potentially hazardous foods were stored at least six inches from the floor; c.) maintain multiuse food-contact surface cutting boards in a manner to prevent microbial growth; d.) maintain kitchen and storage areas in a sanitary manner; and e.) perform hand hygiene to prevent food borne illness. This deficient practice was evidenced by the following: Upon arrival to the facility on 10/1/24 at 8:45 AM, the surveyor observed eight boxes of bread that were delivered and placed directly on the ground in the parking lot. The bread boxes were stacked in two piles with two boxes directly on the pavement. On 10/1/24 at 8:50 AM, the surveyor accompanied by the U.S. FOIA (b)(6) exited the facility and observed the bread delivery on the ground. The U.S. FOIA (b)(6) confirmed food should not be stored directly on the ground. On 10/1/24 at 10:07 AM, the surveyor observed the U.S. FOIA (b)(6)) enter the kitchen, and the U.S. FOIA stated he had just come from the stock room and hung up his coat. The surveyor interviewed the U.S. FOIA, who stated that the bread company always delivered the bread and placed it directly on the ground in the parking lot outside the building. The U.S. FOIA stated that it was acceptable for the bread to be stored on the ground since the bread was in a box. At that time, the surveyor and U.S. FOIA began a tour of the kitchen. The surveyor observed no hand hygiene from the U.S. FOIA (b) after returning to the kitchen from the stock room and hanging up his	F 812	to leave the delivery directly on the ground. The U.S. FOIA (b) (6) was in-serviced on the proper technique and when to perform hand hygiene by the Infection Preventionist. The Bug Trap was cleaned out from the dead bugs. The expired egg salad was discarded. The expired Macaroni salad was discarded. The cottage cheese that was not dated was discarded. The microwave oven was cleaned out. The cutting boards that were pitted and dented were replaced. The 2 dented cans were discarded. The vinyl strips in the walk-in freezer were replaced. The 2 freezer chests were cleaned from the accumulated ice. The dry food storage room was cleaned and the tiles were repaired. The Japanese bread crumbs was discarded. The cracked white condiment bottle was discarded. All residents have the potential to be affected by this cited practice. The U.S. FOIA (b) (6) was in-serviced on the proper technique and when to perform hand hygiene by the Infection Preventionist. The Administrator in-serviced the FSD along with the dietary staff on the following: - To label and date all opened food items	

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F 812	Continued From page 17 coat. The [redacted] began to open the reach-in refrigerator, when the surveyor asked the [redacted] if he had just left the kitchen and hung up his personal jacket, was there anything he needed to do. The [redacted] acknowledged he should have performed hand hygiene. The [redacted] proceeded to perform hand hygiene using soap and water, lathering outside the flow of running water for twenty seconds, then used a paper towel to dry his hands. The [redacted] then obtained a clean paper towel to turn the sink faucet off, then used that paper towel to continue to dry his hands. The [redacted] then dropped the paper towel on the floor, picked it, disposed of it in the trash receptacle, and proceeded on the tour. The surveyor asked the [redacted] if he used the paper towel that he turned the faucet off with to dry his hands and then dropped it on the floor and picked it up, were his hands still clean? The [redacted] acknowledged he needed to perform hand hygiene again because his hands were considered dirty. On 10/1/24 at 10:18 AM, the surveyor and the [redacted] toured the kitchen and observed the following: 1. In the kitchen on the wall directly next to the reach-in refrigerator, a light powered bug trap. The bottom of the bug trap had over twenty dead bugs, and the area was opened, exposing the dead bugs to the kitchen area. The [redacted] acknowledged that the trap needed to be cleaned. 2. In the reach-in refrigerator, a container of egg salad with a use by date of 9/29/24. The [redacted] confirmed it needed to be discarded. 3. In the reach-in refrigerator, a container of	F 812	and to ensure that they are discarded by the use by date. - To clean out the bug trap as needed. - To ensure that all equipment is clean and in proper working condition and is not compromised in any way. - To ensure that all dented cans are kept separately and are either discarded or returned to the supplier. - To ensure that the freezers are cleaned as needed and do not have accumulated ice buildup in them. - To notify maintenance if any of the plastic strips on the walk-in freezer are missing or need to be replaced. - To ensure that the food storage areas are clean and the food is kept off the floor and to discard any food or other items that may have become compromised. The infection preventionist will observe 2 dietary employees to ensure that they are performing proper hand hygiene as required The Administrator/designee will check the kitchen for the following: - that all opened food items is labeled and dated and that they are discarded by the use by date. - that the bug trap is cleaned out as needed. - that all equipment is clean and in proper working condition and is not compromised in any way. - that all dented cans are kept separately and are either discarded or returned to the supplier. - that the freezers are cleaned and do not have accumulated ice buildup in them.	

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F 812	Continued From page 18 macaroni salad with a use by date of 9/22/24. The [U.S. FOIA] confirmed it needed to be discarded. 4. In the reach-in refrigerator, a one-pound opened container of cottage cheese with no opened date and an expiration date of 11/18/24. The [U.S. FOIA] stated the kitchen used cottage cheese for thirty days. At that time, the surveyor showed the [U.S. FOIA] the cottage cheese packaging which indicated use within seven days of opening. 5. The inside of the microwave had caked on debris on the roof and sides as well as the plate. The [U.S. FOIA] acknowledged it needed to be cleaned. 6. On a drying rack, one large green cutting board deeply pitted and discolored. The [U.S. FOIA] stated the grooves caused cross-contamination and led to bacterial growth. The [U.S. FOIA] acknowledged it should be discarded. 7. In dry storage on the active can rack, one six-pound twelve-ounce (oz) can of vegetarian bean and sauce and one six-pound twelve-ounce can of red kidney beans, both dented. 8. In the walk-in freezer, the vinyl strip curtains located in the entrance to the freezer were missing three strips on the outer sides of the doorway. These curtains protected the inside of the freezer from outside dust particles as well as kept the cold air from escaping the freezer when the door was opened. The [U.S. FOIA] acknowledged the vinyl strips maintained temperature and prevented dust particles from entering the freezer. 9. On a storage rack in the kitchen, one large brown, one large yellow, one large white, one	F 812	- that none of the plastic strips on the walk-in freezer are missing or need to be replaced. - that the food storage areas are clean and the food is kept off the floor and there is no food or other items that may have become compromised. These reviews will be done weekly for the first 4 weeks and then monthly for 3 months. The results of these audits will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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F 812	Continued From page 19 large blue, and one large red cutting boards all pitted and discolored. The [N.J. Exec C.] stated he usually changed the cutting boards every eight to nine months, and acknowledged these cutting boards were ready to be replaced. 10. Outside the kitchen, freezer chest #2 had a build-up of ice accumulation around the sides. The [U.S. FOIA] stated the ice affects the temperature, and the facility cleaned every six months. 11. Outside the kitchen, freezer chest #1 had a build-up of ice accumulation along the sides. On 10/1/24 at 10:30 AM, the surveyor and [U.S. FOIA] toured a food storage room located in the 200-unit hallway and observed the following: 12. The storage room floor was soiled with black colored build-up and the tiles were coming up. The [U.S. FOIA] stated that there was a "flood" in the room that past summer, so the flooring came up. When the surveyor questioned about the flood, the [U.S. FOIA] stated it was not a flood, the air conditioner (AC) was running all summer so there was condensation on the floor. 13. Directly on the soiled floor was a box of corn flakes cereal and the emergency water. The [U.S. FOIA] acknowledged the cereal and water should not be stored directly on the floor. 14. Directly on the soiled floor was a twenty-five pound of Japanese breadcrumbs. The bottom of the bag had a discolored brownish area that appeared to be discoloration from sitting on liquid. The bottom of the bag was also ripped, had bugs flying around it, and patches of a green fur-like substance that the [U.S. FOIA] identified as "mold". The	F 812		

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F 812	Continued From page 20 U.S. FOIA acknowledged that the breadcrumbs were not store appropriately and needed to be discarded. 15. On a storage rack, a white condiment bottle pump that was caked on with brownish/black substance. The U.S. FOIA stated it needed to be discarded. On 10/8/24 at 11:00 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) and survey team, acknowledged the concerns. A review of the undated facility provided "Stock Room Storage Policy" included...boxes must be stored six inches above the [floor]... A review of the undated facility provided "Refrigerator Storage Policy and Procedure" included...check for out dated food. If any discard. A review of the facility provided "Infection Control Policy Procedures 2020" included Handwashing/Hand Hygiene...1. vigorously lather hands with soap and water creating friction to all surfaces, for a minimum of 20 seconds [...] 2. rinse hands thoroughly under running water [...] 3. dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel 4. discard towels into trash...	F 812		
F 814 SS=E	NJAC 8:39-17.2(g) Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse	F 814		11/19/24

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F 814	Continued From page 21 properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to properly dispose and maintain waste in garbage dumpster areas. This deficient practice was identified for 1 of 1 garbage disposal areas, and the facility was previously cited for this during their last standard survey on 9/1/23. The evidence was as follows: On 10/1/24 at 10:46 AM, the surveyor and the U.S. FOIA (b)(6) toured the facility's outside garbage disposal area and observed the following: 1. The cardboard dumpster had no lid and garbage debris was around it. The U.S. FOIA (b) stated the facility was trying to get the company to replace the lid. 2. The other three dumpsters had paper and food waste around it. 3. A storage container in the area had food and paper debris, wooden boards, and an unidentifiable large object around it. 4. The wooded area along the dumpster area had trash including food product, paper waste, broken wooden boards, and a mattress. 5. The fence along the inside of the garbage area had three pallets leaning against it, and the fence along the outside had an accumulation of both intact and broken pallets as well as other debris surrounding it. The fence itself was dirty and	F 814	The lid on the cardboard dumpster was repaired. The entire area around the dumpsters in the garbage area was cleaned up and trash has been disposed of properly. All residents have the potential to be affected by this cited practice. Housekeeping and Dietary staff were in-serviced by the Administrator to ensure that all trash is disposed of properly. The Maintenance and Housekeeping Directors will ensure on their daily rounds that the trash area does not have any debris out of the dumpsters. The Administrator/designee will check the garbage area to ensure that all trash is placed inside the dumpsters and the lids are closed and that there is no debris around the dumpsters. This will be done weekly for 4 weeks and then monthly for 3 months. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 22	F 814		

falling down. The [redacted] stated that someone came to pick up the pallets, but he did not know when. They had not come for the pallets in a "minute."

At the time of the observation, the surveyor interviewed the [redacted] who stated housekeeping staff maintained the garbage area, and it was important to maintain the area because of the woods and "what comes out." The [redacted] acknowledged that the area needed to be cleaned.

On 10/7/24 at 12:25 PM, the surveyor interviewed the [redacted], who stated both housekeeping and the kitchen maintained the garbage area. The [redacted] stated the day the surveyor identified the debris, housekeeping staff cleaned the area. The [redacted] stated that they tried to clean the area daily but sometimes forgot. The [redacted] stated that the guys who made deliveries threw the pallets by the fence and have been like that for a while; at least two or three months. The [redacted] stated it was important to maintain the garbage area, so no one got hurt or it did not attract rodents, and the [redacted] acknowledged the condition was unacceptable during the surveyor's observation.

On 10/8/24 at 11:00 AM, the [redacted] in the presence of the [redacted]) and survey team, stated all the surveyor's concerns were addressed.

No additional information was provided.

A review of the facility's "Housekeeping - Outdoor Trash Area" policy dated revised April 2024, included our nursing home is committed to

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	315414	A. BUILDING _____ B. WING _____	C 10/08/2024

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F 814	Continued From page 23 maintaining a clean, safe, and hygienic environment for our residents, staff, and visitors...housekeeping staff are responsible for regularly cleaning and maintaining the outdoor trash area...the maintenance team will ensure the trash bins are in good condition and are adequately covered to prevent odors and pests. They will promptly repair or replace any damaged bins or equipment in the outdoor trash area. All staff members are expected to dispose of waste properly by placing it in designated trash bins. No littering is allowed in or around trash area...housekeeping staff will perform routine checks to ensure that the outdoor trash area is free of litter and debris. Any litter found in the vicinity will be promptly cleaned up to maintain a neat appearance...	F 814		
F 880 SS=D	NJAC 8:39-19.3(a); 19.7(a)(b) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		11/19/24

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F 880	Continued From page 24 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 25 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to use appropriate hand hygiene and proper disinfection while providing [redacted] to a resident. The deficient practice was observed for 1 of 1 residents reviewed for [redacted] (Resident #8), and was evidenced by the following: On 10/1/24 at 10:40 AM, during initial tour of the facility, the surveyor observed Resident #8 sleeping in their bed. The surveyor observed the resident [redacted]. On 10/2/24 at 10:08 AM, the surveyor reviewed the medical record for Resident #8. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses including but not limited to; [redacted]	F 880	The LPN that didn't perform proper hand hygiene was in-serviced by the infection preventionist on the requirement of when to perform along with the proper technique of performing hand hygiene. All residents have the potential to be affected by this cited practice. All staff have been in-serviced by the infection preventionist on the requirement of when and how to perform to perform hand hygiene. The infection preventionist or designee will observe 2 incidents that require hand hygiene to ensure that it is done as required weekly for 4 weeks then monthly for 4 months. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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F 880	Continued From page 26 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] indicated the resident had a brief interview for mental status score of [redacted] indicating a NJ Ex Order 26.4(b)(1) [redacted]. A further review in Section NJ Ex Order 26.4(b)(1) reflected the resident had NJ Exec Order 26.4b1 [redacted] A review of the individualized comprehensive care plan (ICCP) included a focus area dated [redacted], that the resident had a potential for NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) [redacted] related to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) In NJ Ex Order 26.4(b)(1), the resident returned from the hospital with a NJ Exec Order 26.4b1 [redacted] Interventions included to monitor the resident for NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b) consultation as indicated for NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1) [redacted] while in bed; weekly treatment documentation to include measurement of each NJ Ex Orde of the NJ Ex Order 26.4(b)(1) [redacted], type of NJ Ex Order 26 and NJ Ex Order 26.4(b)(1)), and any other notable changes or observations; NJ Exec Order 26 consult as indicated; NJ Exec Order 26.4b1 as per physician orders. A review of the Physician Order Summary Report reflected the following physician's orders (PO):with a start date of [redacted] A PO dated NJ Ex Order 26.4(b), for NJ Exec Order 26.4b1 [redacted]; apply to NJ Exec Or [redacted] every day shift for NJ Exec Order 26.4b1 First cleanse with NJ Exec Order 26.4b1; apply NJ Exec Order 26.4b1 to base of the NJ Exec Order 2; leave open to air; and change daily.	F 880		

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F 880	Continued From page 27 A PO dated NJ Exec Order 26.4b1 apply t NJ Exec Ord First cleanse with NJ Exec Order 26.4b1; apply NJ Exec Order 26.4b1 to base of the NJ Exec Order 26 leave open to air,; and change daily. A PO dated NJ Exec Order 26.4, for NJ Exec Order 26.4b1 ; apply to NJ Exec Order 26.4b1 every day and evening shift for NJ Exec Order 26 care. First NJ Ex Order 26.4(b) with NJ Exec Order 26.4b1; apply NJ Ex Ord prep to NJ Exec Order 26.4b1 NJ Exec Order 2); apply NJ Exec Order 26 moistened fluffed gauze to base of NJ Exec Order 26 secure with dry gauze and lightly rolled gauze; change twice a day (BID) and as needed NJ Exec Order 26.4b1 . On NJ Ex Order 26.4(b) at 9:33 AM, the surveyor obtained verbal permission from Resident #8 to observe their NJ Exec Order 2 care. The surveyor observed the U.S. FOIA (b)(6) began to perform NJ Exec Order 26.4b1 The U.S. FOIA (b) performed hand hygiene prior to donning (apply) gloves and gown at the start of the NJ Exec Order 26.4b1 The U.S. FOIA (b) removed the old dressing and disposed of it in the trash receptacle. The U.S. FOIA then doffed (removed) their gloves, and without performing hand hygiene, donned a new pair of gloves and cleansed the NJ Exec Order 26.4b1 External Solution using a NJ Ex Order 26.4(b)(1) . The U.S. FOIA then cleansed the right dorsal foot NJ Exec Order 26 with NJ Exec Order 26.4b1 using a NJ Ex Order 26.4(b)(1). The U.S. FOIA then doffed her gloves and without performing hand hygiene, donned a new pair of gloves and cleansed the NJ Exec Order 26.4b with NJ Exec Order 26.4b1 applied NJ Ex Ord , applied NJ Ex Order 26.4(b)(1) with NJ Exec Order 26.4 and NJ Ex Order 26.4(b)(1) to the NJ Exec Order 26.4 . The U.S. FOIA then removed her gloves, and without	F 880		

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F 880	Continued From page 28	F 880		

performing hand hygiene donned a new pair of gloves and dated the [NJ Ex Order 26.4(b)(] on the [U.S. FOIA (b)(6)]. The [U.S. FOIA] then removed both gloves once the [NJ Exec Order 26.4b1] treatment was completed and performed hand hygiene.

On 10/7/24 at 10:00 AM, the surveyor interviewed the [U.S. FOIA (b)] in the presence of the [U.S. FOIA (b)(6)], who stated that hand hygiene should have been completed in between each glove change. The [U.S. FOIA] then acknowledged that they should have used alcohol-based hand rub or washed their hands using soap and water in between glove changes. The [U.S. FOIA (b)] acknowledge that they did not complete hand hygiene in between the glove changes during [NJ Exec Order 26] care. The [U.S. FOIA (b)(6)] confirmed that hand hygiene should have been performed in between glove changes.

On 10/7/24 at 1:32 PM, the surveyor asked the [U.S. FOIA (b)(6)]) what their expectations were for staff for hand hygiene while performing [NJ Exec Order 26] care, and the [U.S. FOIA (b)(6)] stated for the staff to do it properly. The [U.S. FOIA (b)(6)] stated staff were to wash their hands prior to [NJ Exec Order 26] care, anytime they removed their gloves, and when [NJ Exec Order 2] care was finished.

On 10/8/24 at 11:00 AM, the [U.S. FOIA (b)(6)]) in the presence of the [U.S. FOIA (b)(6)] and survey team, stated that the facility had began inservicing staff on handwashing. The [U.S. FOIA (b)(] acknowledge handwashing should be completed in between glove changes.

A review of the facility's "Infection Control Policy Procedures 2020" included Handwashing/Hand Hygiene...hand hygiene is the final step after removing and disposing of personal protective

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F 880	Continued From page 29 equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections... NJAC 8:39-19.4(a)	F 880		

New Jersey Department of Health

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 7 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	The facility will schedule the nursing units as per state guidelines. This will be accomplished by offering extra shifts to current staff when needed and by using nursing agencies. All residents have the potential to be affected by this cited practice. However, no care issues were identified on the shifts that were deficient The staffing coordinator was in serviced by the Administrator on the required staffing ratio for staff to resident as mandated by the state of New Jersey for each shift.	11/19/24

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

Electronically Signed | 10/31/24

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During entrance conference on 10/1/24 at 11:00 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and the Acting Director of Nursing Acting (ADON) how the facility's staff was, and the LNHA stated that staffing was fair; that the facility did not always meet minimum requirements. The LNHA stated that the facility occasionally used Agency staff but relied mainly on their staff. At that time, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 9/15/24 to 9/28/24. For the two weeks of staffing prior to survey from 9/15/24 to 9/28/24, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: 9/15/24 had 7 CNAs for 73 residents on the day shift, required at least 9 CNAs. 9/16/24 had 8 CNAS for 73 residents on the day	S 560	Sign on and referral bonuses are in place to ensure the facility is adequately staffed. The facility advertises on job sites and other venues to recruit more staff. The facility has recently started using another temporary staffing agency as well. The Administrator/designee will review the daily staffing sheets to ensure that the minimum staff to resident ratio is met. This review will be done weekly for 4 weeks and then monthly for 3 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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S 560	Continued From page 2 shift, required at least 9 CNAs. 9/19/24 had 8 CNAS for 73 residents on the day shift, required at least 9 CNAs. 9/20/24 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. 9/21/24 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. 9/22/24 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. 9/24/24 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced	S1405		11/19/24

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S1405	Continued From page 3 by: Based on interview, and review of other facility documentation, it was determined that the facility failed to ensure that employees received a health examination by a physician, an advanced practice nurse, or a licensed physician assistant within two weeks prior to the first day of employment or upon employment. This deficient practice was identified for 4 of 5 employee files reviewed (Employee # 1, #3, #4, and #5), and was evidenced by the following: During entrance conference on 10/1/24 at 11:00 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Acting Director of Nursing (ADON) to provide the survey team with a list of employees newly hired since last standard survey. On 10/7/24 at 8:48 AM, the surveyor requested from the LNHA to provide five selected newly hired employees' health files. On 10/1/24 at 1:30 PM, the surveyor reviewed the employee files which revealed the following: Employee #1, a Certified Nursing Aide (CNA), was hired on [NJ Exec Order 264], the Employee Physical form was not dated. Employee #3, an Activities Director, was hired on [NJ Exec Order 264], there was no Employee Physical form. Employee #4, a Licensed Practical Nurse, was hired on [NJ Exec Order 26] there was no Employee Physical form. Employee #5, a CNA, was hired on [U.S. FOIA (b)(6)]; the Employee Physical form had no date.	S1405	Employees #3, #4, and #5 are no longer employed by the facility. Employee #1 had an employee physical done by a physician. All residents have the potential to be affected by this practice. A review will be done of the employee health records that were hired within the last year to ensure that they documentation of their employee physical is on file. Any employee that was found not to have had their employee physical Done will be required to be examined by a physician, APN or NP. The Human Resource manager will notify the Director of Nursing and/or infection preventionist or designee of any new potential hire with their projected start date. The Director of Nursing /Infection preventionist will ensure the prospective employee has proof a being examined by a physician, APN or NP within the 2 weeks prior to the date of hire. Otherwise, the prospective employee will be assessed by an RN and then will be examined by a physician, APN or NP within 30 days of hire. The Director of Nursing or designee will audit all new hires to ensure that employee physicals were Done within the required timeframe. This review will be Done weekly for 4 weeks and then monthly for 3 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further	

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S1405	Continued From page 4 On 10/7/24 at 2:11 PM, the surveyor interviewed the LNHA and ADON regarding the facility's hiring practices. The LNHA stated that the Director of Nursing (DON), who was currently out of the facility of leave, was responsible for obtaining all new hires physicals. The LNHA stated that the employee should have a physical upon hire, or if there was a Registered Nurse (RN) assessment upon hire, the physician or advanced practice nurse needed to complete the physical within thirty days. The surveyor requested additional information for the four employees. On 10/8/24 at 11:00 AM, the LNHA in the presence of the ADON and survey team, acknowledged that the physicals for Employee #1 and Employee #5 had no date and the forms should have been dated, and the facility could not locate a physical for Employee #3. The LNHA provided an Employee Physical form for Employee #4 dated 9/13/23, with a hire date of 9/5/23. The LNHA confirmed the facility did not have a RN assessment upon hire, and the physical should have been completed upon hire. A review of the facility's "Employee Medical Records" policy dated revised April 2024, did not include obtaining employee physicals upon hire.	S1405	recommendations based on the results of this audit.	
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative	S1410		11/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061310	A. BUILDING: _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATIC	524 WARDELL ROAD TINTON FALLS, NJ 07753

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S1410	Continued From page 5 two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to a.) perform a NJ Ex Order 26.4(b)(1) [redacted]) as required for new employees hired for NJ Ex Order 26.4(b)(1) for [redacted] and [redacted] screening; and b.) ensure the second step was administered one to three weeks after a negative first step. This deficient practice was identified for 3 of 5 employee files (Employee #3, #4, and #5) reviewed, and was evidenced by the following: During entrance conference on 10/1/24 at 11:00 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Acting Director of Nursing (ADON) to provide the survey	S1410	Employees #3, #4, and #5 are no longer employed by the facility. All residents have the potential to be affected by this practice. A review was Done of employee health records that were hired within the last year to ensure that they have had a 2 step PPD's upon hire. Any employee that was found not to have had their 2 step PPD completed was administered a new series of the 2 step PPD. The Human Resource manager will notify the Director of Nursing and/or infection preventionist or designee of any new potential hire with their projected start	

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S1410	Continued From page 6 team with a list of employees newly hired since last standard survey. On 10/7/24 at 8:48 AM, the surveyor requested from the LNHA to provide five selected newly hired employees' health files. On 10/1/24 at 1:30 PM, the surveyor reviewed the employee files which revealed the following: Employee #3, an Activities Director, was hired on [redacted], the first step of the [redacted] was administered NJ Ex Order 26.4(b)(1) after hire on [redacted], with the results read on [redacted]. The second step of the [redacted] was administered four weeks later on 8/15/24, with the results read on [redacted]. Employee #4, a Licensed Practical Nurse, was hired on [redacted], the first step of the [redacted] was administered on [redacted] with the negative results read on [redacted]. There was no documented second step administered. Employee #5, a CNA, was hired on [redacted]; the first step of the [redacted] was administered on [redacted], with the negative results read on [redacted]. There was no documented second step administered. On 10/7/24 at 2:11 PM, the surveyor interviewed the LNHA and ADON regarding the facility's hiring practices. The LNHA stated that the Director of Nursing (DON), who was currently out of the facility of leave, was responsible for ensuring all newly hired employees received a two-step [redacted]. The LNHA stated that the employee received the first step upon hire, and the second step was received two weeks later. The surveyor requested additional information for the three employees.	S1410	date. The Director of Nursing/Infection preventionist will ensure that if the prospective employee does not have proof of a prior PPD within the past year that they cannot start to work until the 1st PPD is administered and read and will schedule a date for the 2nd PPD to be completed within 1 to 3 weeks after the 1st step was administered. The Director of Nursing or designee will audit all new hires to ensure that the PPD's have been administered timely. This review will be Done weekly for 4 weeks and then monthly for 3 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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S1410	Continued From page 7 On 10/8/24 at 11:00 AM, the LNHA in the presence of the ADON and survey team, confirmed the facility had no additional information regarding the three employees missing [redacted]. The LNHA could not speak to why the [redacted] for Employee #3 was not started until July if they were hired in April. A review of the facility's "Employee TB Testing" policy dated revised April 2024, included all employees will be screened for TB upon hire... The policy does not include the length of time between administering step one and step two.	S1410		
S2340	8:39-31.6(n) Mandatory Physical Environment (n) The facility shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain their three-day supply of food to ensure food items were within expiration dates. This deficient practice has the potential to affect all residents, and was evidenced by the following: On 10/1/24 at 10:30 AM, the surveyor accompanied by the Food Service Director (FSD) observed the facility's three-three day emergency food supply. The surveyor observed the following food items were expired:	S2340	The instant potatoes and vanilla pudding in the emergency food area was discarded. All residents have the potential to be affected by this cited practice. The Food Service Director was educated by the Administrator on the requirement to ensure that the 3-day emergency food items are not expired. The Administrator/designee will check the	11/19/24

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S2340	Continued From page 8 A case of granola bars with an expiration date of 3/15/24. A case of six 6/5-12 ounce (oz) cans of instant potatoes with a use by date of 1/22/2020. A case of vanilla pudding marked delivered 11/10/22. The packaging did not include an expiration date. At the time of the observation, the surveyor interviewed the FSD, who stated that he checked the emergency food supply every five to six months to for expired food. The surveyor asked how long the vanilla pudding was good for, and the FSD was unsure. The surveyor requested a copy of the manufacturer's shelf life for the product. On 10/7/24 at 11:00 AM, the FSD provided the surveyor with the product specifications from the manufacturer for the vanilla pudding, but it did not include shelf life. On 10/8/24, at 11:00 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Acting Director of Nursing (ADON and survey team, acknowledged these concerns. A review of the facility's "Emergency Preparedness Plan" dated updated 6/17/24, included [the facility] shall maintain at least a three day supply of staple foods and a two day supply of perishable goods stored onsite at all times... A review of the undated facility provided "Stock Room Storage Policy" included...every two weeks staff take inventory check for items and check for expired dates to be removed from stock.	S2340	emergency food storage area monthly for 6 months. to ensure that they are not expired. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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
315414 Y1	A. Building B. Wing Y2	12/5/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

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 F0584	Correction	ID Prefix F0657	Correction	ID Prefix F0689	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	11/19/2024	LSC	11/19/2024	LSC	11/19/2024
ID Prefix F0695	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	11/19/2024	LSC	11/19/2024	LSC	11/19/2024
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/19/2024	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	
10/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061310 Y1	A. Building B. Wing Y2	12/5/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1405	Correction	ID Prefix S1410	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. # 8:39-19.5(b)(1)	Completed
LSC	11/19/2024	LSC	11/19/2024	LSC	11/19/2024
ID Prefix S2340	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-31.6(n)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/19/2024	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	
10/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING **01** B. WING _____	**10/08/2024**

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ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 10/03/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 10/03/24, and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Aster Creek Nursing and Rehabilitation Center is a two-story building with a partial basement that was constructed in the 1990's. It is composed of Type III construction and is divided into thirteen smoke compartments. The diesel generator powers 50% of the building. The number of occupied beds was 73 out of 100. During the LSC survey, a finding which constituted Immediate Jeopardy (IJ) was identified for K 353. The facility's failure to maintain their automatic fire sprinkler system to ensure there was a reliable water source and was functional posed a likelihood of serious and immediate threat to the safety and well-being of all 73 residents, staff, and visitors in the facility.	K 000		

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

Electronically Signed | 11/01/2024

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

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K 000	Continued From page 1 This deficient practice resulted in an Immediate Jeopardy (IJ) situation. On 10/03/2024 at 11:45 AM, the surveyor observed that the storage tank (pool), serving as the primary water supply to the fire sprinkler system, had a thick layer of debris that had the potential to obstruct the sprinkler piping and prevent it from functioning as designed during a fire emergency. On 10/04/24 at 2:56 PM, the Administrative staff was notified of the Immediate Jeopardy by telephone. The facility submitted an acceptable Removal Plan (RP) on 10/07/2024 at 4:25 PM. The acceptable Removal Plan indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including; the facility began fire watch on 10/03/24 at 6:30 PM, around the clock, and on 10/07/24 at 2:30 PM, the fire watch included the entire building by a designated staff member; staff was in-serviced on fire watch policy; a licensed electrician verified the fire pump was connected to the emergency generator; pool will be cleaned out of debris; and the facility will convert fire sprinkler to city water continuing a fire watch until completed. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey and determined the IJ for K 353 was removed as of 10/08/2024.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101	K 161		11/27/24

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K 161	Continued From page 2 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of	K 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 161	Continued From page 3 approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain their construction type as required by NFPA 101 Life Safety Code (2012 Edition), Section 19.1.6.1. This deficient practice had the potential to affect all 73 residents. Findings include: Observations on 10/03/24 at 12:30 PM of the generator room revealed a four-foot by three-foot section of the ceiling missing. The wood framing and the structure above was exposed. An interview with the U.S. FOIA (b)(6) at the time of the observation confirmed the finding and revealed the facility was aware of the missing ceiling. An observation on 10/03/24 at 3:40 PM of the Elevator Lobby on the Second Floor revealed a six-inch by eight-inch gap in the ceiling. An observation on 10/03/24 at 4:00 PM of the Information Technology (IT) Room, located within the Administration Area on the First Floor, revealed exposed wood framing above the missing ceiling tile. Interviews with the U.S. FOIA (b)(6) at the time of the observations confirmed the findings and revealed the facility was not aware that the wood framing needed to be protected from fire by fire-resistant materials. NJAC 8:39-31.1(c), 31.2(e)	K 161	The ceiling in the generator room has been repaired. The gap in the ceiling of the elevator lobby on the second floor has been repaired. The ceiling tiles in the IT room within the administrative area were replaced. All residents have the potential to be affected by this cited deficiency. A review was done throughout the facility to identify any other areas in the ceiling which may be missing. The Administrator educated the U.S. FOIA (b) (6) on the requirement to ensure that there are no openings in the ceiling. Staff was in-serviced by the Administrator to report any openings in the ceiling in the maintenance book. The Administrator will do rounds throughout the facility to ensure that there are no openings in the ceiling. This will be done weekly for 4 weeks and then monthly for 3 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

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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 by: Based on observations and interviews, the facility failed to ensure the means of egress was maintained to be free of all obstructions as required by NFPA 101 Life Safety Code (2012 Edition) Chapter 7. This deficient practice had the potential to affect staff and 35 residents. Findings include: An observation on 10/03/24 at 3:04 PM of the designated exit from the Dining Room revealed the stairway was less than 36-inches in width due to a permanently installed barrier at the top of the stairs. An interview with the U.S. FOIA (b)(6) at the time of the observation revealed the facility installed the barrier to prevent wheelchairs from going down the stairs and the Elevator was to be used as the exit for people in wheelchairs. An observation on 10/03/24 at 3:58 PM of the designated exit door, located in Physical Therapy, revealed a picnic table blocking the exit. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the finding	K 211	The barrier at the top of the stairway by the designated exit of the dining room was changed to a lightweight barrier made from PVC piping that will be able to be removed easily and will allow free access of the required width in case of emergency. This barrier has always been in place by the stairwell to prevent residents in wheelchairs from rolling down the stairs. Staff and Residents were in-serviced on how to remove it in case of an emergency and signs stating the same were be placed on the barrier. The picnic table that was blocking the exit door of Physical Therapy was moved to ensure proper egress and a clear passageway to a public way in case of an emergency. All residents have the potential to be affected by this cited deficiency. All exit discharge ways from the facility have been inspected to ensure that there are no obstructions and that there is a clear passage leading to a public way. The Administrator educated the	11/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING **01** B. WING _____	**10/08/2024**

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K 211	Continued From page 5 and stated the facility was unaware the exit was blocked. NJAC 8:39-31.1(c), 31.2(e)	K 211	U.S. FOIA (b) (6) on the requirement of ensuring that all emergency exits have proper egress and a clear passageway to a public way. The Maintenance Director or designee will Check all emergency exits weekly for 4 weeks and then monthly for 3 months to ensure that there are no obstructions and that there is clear passage leading to a public way. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	
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	K 321		11/20/24

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K 321	Continued From page 6 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to separate hazardous areas from other parts of the facility in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 8.4. This deficient practice had the potential to affect staff and 30 residents. Findings include: Observations on 10/03/24 at 12:27 PM of the Maintenance Shop revealed a three-inch gap at the top of the door when closed which would allow smoke to pass through to the corridor. Additionally, the ceiling also had an eight-inch overcut around the pipe penetration from the Kitchen above. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was unaware the door was not smoke tight and the ceiling penetration was unsealed. An observation on 10/03/24 at 12:29 PM of the Laundry Room revealed the door separating it from the exit stairwell did not close in the door	K 321	The gap at the top of the door of the maintenance shop was closed. The overcut around the pipe penetration in the maintenance shop from the kitchen was closed. The 3 inch overcut around the duct penetration by the laundry stairwell has been closed. The door of the laundry room was repaired and now closes properly. Self-closing devices have been installed in rooms 201 and 202. All residents have the potential to be affected by this cited deficiency. The Maintenance Director or designee will check the building for any penetrations or openings and will have them repaired if any are found. The Administrator in-serviced the U.S. FOIA (b) (6) to ensure that there are no penetrations or openings in doors and that doors that require to have self-closers have them installed.	

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K 321	Continued From page 7 frame when released from the hold-open device, leaving a five-inch gap. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the finding and stated the facility was unaware the door was not self-closing. An observation on 10/03/24 at 12:33 PM of the stairwell by the Laundry Room revealed a three-inch overcut around a duct penetration. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the finding and stated the facility was unaware of the unsealed opening in the stairwell. Observations on 10/03/24 at 3:15 PM revealed Rooms 201 and 202 had been converted into combustible storage rooms. Self-closing devices were not installed on the door. The rooms were in a corridor designated as an exit from the Dining Room. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was not aware door closers were missing from the storage rooms.	K 321	The Maintenance Director or designee will audit there are no penetrations and that there are no gaps in doors and that all doors that require self-closers have one installed. This will be done will be done weekly for the first 4 weeks and then monthly for the next 3 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	
K 324 SS=F	NJAC 8:39-31.2(e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K 324		11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING 01 B. WING _____	10/08/2024

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K 324	Continued From page 8 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the hood system in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition). The deficient practice had the potential to affect All residents. Findings include: A review of the facility's documentation of the inspection and testing of the fire suppression system in the Kitchen, provided by the facility revealed semi-annual tests and inspections were not conducted. According to the documentation, the hood system was cleaned on 02/20/23 and	K 324	The missing hood inspection documentation was located and placed in the inspection logbook. The hole in the hood system by the filters was repaired. All residents have the potential to be affected by this cited deficiency. The Administrator educated the U.S. FOIA (b) (6) on the importance of keeping the inspection logbooks in order and ensuring that all required inspection reports are in it. The Maintenance Director will inspect the	

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K 324	Continued From page 9 02/27/24 by a company contracted by the facility. An inspection tag on the fire suppression system indicated it was most recently inspected in September of 2024 by a licensed inspection vendor; however, documentation of this report was not provided during the survey. This documentation was requested on 10/03/24 at 8:30 AM, 1:40 PM, and 3:00 PM. During an interview on 10/03/24 at 6:15 PM, the U.S. FOIA (b)(6) confirmed the finding and stated the facility was unable to locate the missing documentation. An observation on 10/03/24 at 3:17 PM of the hood system, located in the Kitchen above the cooking equipment, revealed a three-inch diameter hole by the filters, allowing a space for grease to get through. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the finding and revealed the facility was unaware of the gaps in the hood system. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324	hood monthly to ensure that there are no holes in it. The Administrator will check the maintenance logbooks monthly to ensure that all required documentation is in it and is in order. This will be done monthly for 6 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		11/26/24

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K 345	Continued From page 10 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 9.6.1.3 and NFPA 72 (2010) Section 14.4.5. This deficient practice had the potential to affect all 73 residents. Findings include: A review of the facility's "Fire Alarm Annual Inspection Reports" for the previous two years provided by the facility revealed sensitivity testing of the smoke detectors was not conducted. Documentation of the sensitivity testing of the smoke detectors was requested on 10/03/24 at 8:30 AM and 3:00 PM but was not provided by the facility during the survey. According to the "Fire Alarm Inspection and Testing Form," dated 02/28/24, the facility had 144 smoke detectors in the facility. During an interview on 10/03/24 at 6:10 PM, the U.S. FOIA (b)(6) confirmed the finding and revealed the facility was unable to locate the missing documentation. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 345	The fire alarm company will conduct a sensitivity testing on the smoke detectors. All residents have the potential to be affected by this cited deficiency. The Administrator educated the U.S. FOIA (b) (6) to ensure that he is aware of the requirement that the smoke detectors have a sensitivity testing performed every 2 years. The results of the smoke detector sensitivity test will be shared with the Quality Assurance team at the following quality assurance meeting which will make further recommendations based on the results of the testing.	
K 353 SS=L	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		11/13/24

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K 353	Continued From page 11 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) and as required by previous waivers. Specifically, the facility failed to ensure its sprinkler system had a reliable water source, was functional, and the water source was monitored per the facility's approved waiver. This deficient practice had the potential to affect all 73 residents. The facility's failure to maintain their sprinkler system to ensure there was a reliable water source and functional posed a likelihood of serious and immediate threat to the safety and well-being of all 73 residents, staff, and visitors in the facility. This deficient practice resulted in an Immediate Jeopardy (IJ) situation.	K 353	The facility began fire watch around the clock by an employee that had no other responsibilities. The pool was cleaned and treated by a pool company it to ensure the clarity of the water. The fire sprinkler company inspected the fire pump to ensure its integrity and that there is no debris in the fire sprinkler system and found it to be ok. All residents have the potential to be affected by this cited deficiency. Permits have been issued to convert the fire sprinkler from the pool holding tank to city water. Work will commence once the water company grants its approval. Until this conversion is completed, the chlorine level will be tested weekly by the Maintenance director or designee and	

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K 353	Continued From page 12 The IJ began on 10/03/24 at 11:45 AM, when the surveyor observed the storage tank (pool), serving as the primary water supply to the sprinkler system, had a thick layer of debris that could obstruct the sprinkler piping preventing it from functioning as designed during a fire emergency. The Administrative staff was notified of the Immediate Jeopardy by telephone on 10/04/24 at 2:56 PM. The facility submitted an acceptable Removal Plan (RP) on 10/07/24 at 4:25 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 10/08/24. The findings include: A review of the facility's "Emergency Preparedness Plan" updated 6/17/24, included where a fire alarm system is out of service for more than four hours in a twenty-four-hour period, or a sprinkler system is out of service for more than ten hours in a twenty-four-hour period, the impairment coordinator shall implement a fire watch. A fire watch shall consist of a staff member, with no other duties, who continuously patrols the affected area. The entire area must be checked at least once every thirty minutes... A review of the facility's previous "Statements of Deficiencies," dated 06/14/21 and 11/10/23, revealed that the facility used a pool as a water storage tank for the primary water supply to the sprinkler system. A waiver was granted in 2021, to allow time to connect the sprinkler system to city water. The facility alleged that until the fire sprinkler system was connected to city water, the facility would ensure the following was done: the Maintenance Director or designee inspected the water level on a weekly basis to ensure no	K 353	chlorine will be added as necessary. Water will be added on a weekly basis as needed. These checks will be documented when completed. The Administrator or designee will check the documentation weekly to ensure that it was done and will check the pool water to ensure for clarity. This will continue until the conversion is completed. The results of these checks will be shared with the Quality Assurance committee at the Monthly and quarterly meetings who will make further recommendations based on the results of these checks.	

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	315414	A. BUILDING 01 B. WING _____	10/08/2024

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K 353	Continued From page 13 leakage; the pool water was treated on a regular basis to maintain clarity of the water; pool water was heated through the winter months to ensure the water did not freeze; and the entire sprinkler system was inspected by the fire sprinkler company on a quarterly basis to ensure its integrity and that it was in proper working order in case of a fire. During an interview on 10/03/24 at 11:30 AM, the U.S. FOIA (b)(6) confirmed the sprinkler system was still not connected to city water; however, the building was connected to city service. According to the U.S. FOIA (b)(6), the pool was still being used as the primary water source for the sprinkler system due to issues with the permit from the Department of Community Affairs (DCA). Observations on 10/03/24 at 11:45 AM, of the storage tank (pool) serving as the primary water supply to the sprinkler system revealed a thick layer of debris (plant growth, leaves, pine needles) that could obstruct the sprinkler piping and prevent it from functioning as designed during a fire emergency. The pool cover was torn in multiple places and the water level was over one foot below the normal water level and skimmers. The excessive debris and low water level had been present long enough to leave dark stains around the edges of the storage tank (pool). During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was aware of the damaged protective cover, the excessive debris, and the low water level in the storage tank (pool). According to the U.S. FOIA (b)(6), the low	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 14 water level was due to a leak in the storage tank and the debris was due to the ripped cover. Instead of repairing the storage tank components, the pool was drained and refilled weekly using a garden hose and spigot connected to city water. The U.S. FOIA (b)(6) stated the process to drain the pool and to refill the pool took around eight hours to complete. The U.S. FOIA (b)(6) also stated the reason the storage tank had not been maintained was because the facility would connect to the city water system in the future and the facility did not want to spend money on the existing water supply system. The following documentation was requested by the surveyor but was not provided by the facility during the survey: 1. Documentation of the system's design characteristics, including filter flow rates, heating elements to protect the water from freezing, and its connection to the emergency generator and fire alarm system. 2. Maintenance records from qualified individuals of system components. 3. Verification from the sprinkler vendor that the system was not impaired by the excessive debris and low water levels at the storage tank (pool). 4. Internal Obstruction Investigation Reports. 5. Permit records indicating progress with connecting the sprinkler system to city water. 6. Weekly maintenance records required by previous waivers. During a follow-up observation with the U.S. FOIA (b) (6) on 10/03/24 at 1:50 PM, the surveyor observed the inside of the fire pump storage shed that housed the fire pump. The surveyor observed a cement well in the floor that	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 15 held water, and the U.S. FOIA (b)(6) stated that the well was connected to the pool, and the water ran through the fire pump to the sprinkler system. The surveyor asked how many gallons the well held, and the U.S. FOIA (b)(6) stated that he was unsure, but the fire pump pumped 550 gallons a minute to the sprinkler system when activated. The surveyor asked if the water went through a filter prior to going into the well, and the U.S. FOIA (b)(6) stated yes. The surveyor asked how long it took for the water to be filtered before entering the well, and the U.S. FOIA (b)(6) could not answer, he stated the pump pumped 550 gallons a minute. The U.S. FOIA (b)(6) stated the water level in the well was a little low and he needed to use the hose to fill it with water. The surveyor asked if the pipes ever froze, and the the U.S. FOIA (b)(6) stated no, that the facility had a space heater that kept the fire pump storage shed at a certain temperature, and if the shed became too cold, an alarm triggered. The surveyor observed a small space heater plugged into an extension cord on the floor near the well that was set to 72 degrees Fahrenheit (F). The surveyor then observed the storage tank (pool) which had the ripped pool cover with dark green water that was below the pool skimmer level. The surveyor asked if the water level was appropriate, and the U.S. FOIA (b)(6) stated that the level was slightly low because the liner was ripped, and that he used the hose every Friday to bring the level up. The surveyor asked at what level should the water be at, and the U.S. FOIA (b)(6) did provide an answer, but stated the level did not have to reach the skimmer baskets and that the water did not filter through them. The surveyor then questioned the	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING 01 B. WING _____	10/08/2024

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K 353	Continued From page 16 color of the pool and the debris, and the U.S. FOIA (b)(6) stated it was just on top, it was "pollen", that the water underneath was clear. The surveyor asked if the facility used any chemicals to treat the water and the U.S. FOIA (b)(6) stated that once a month he put chlorine into the pool. The surveyor asked how much, and the U.S. FOIA (b)(6) did not provide an answer. The surveyor asked why the water was only treated monthly, and the U.S. FOIA (b)(6) stated that there was enough chlorine in the hose water to satisfy the needs. The surveyor questioned the chlorine amount in the facility's tap water, and the U.S. FOIA (b)(6) confirmed again it was adequate. On 10/03/24 at 6:30 PM, a Fire Watch was implemented by the facility. The facility was reminded at that time that the person conducting the fire watch could not have any other responsibilities other than conducting the fire watch. During an interview on 10/07/24 at 9:25 AM, the U.S. FOIA (b)(6)), in the presence of the U.S. FOIA (b)(6) , stated that the facility had been conducting a fire watch since Thursday (10/03/24) night. The U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6)) was in charge of the fire watch, and she assigned the staff. At that time, the surveyor requested all fire watch logs. During an interview on 10/07/24 at 10:04 AM, the U.S. FO stated that the assigned staff member walked the entire building to ensure they did not smell smoke or see a physical fire, and they glanced at the pipes to ensure no leakage. The U.S. FO stated that the staff member did not go into the rooms,	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 17 they were expected to just walk the hallway, and they did not go into the kitchen, they asked kitchen staff if they smelled smoke. The U.S. FO stated that the kitchen was closed at 8:00 PM, so staff did not check the kitchen afterwards. The U.S. FOIA stated that a U.S. FOIA (b)(6)) had been assigned the duty all weekend, and CNA #1 currently was assigned. The surveyor asked if CNA #1 had a resident care assignment today as well, and the U.S. FO confirmed yes. The U.S. FO stated that CNA #1 started 8:00 AM today, that the U.S. FOIA (b)(6)) person conducted a few checks this morning. During an interview on 10/07/24 at 10:15 AM, U.S. FOIA confirmed she conducted fire watches that morning, and she was educated on the process. U.S. FOIA stated that she was educated to go to all the units to see if she smelled smoke, saw fire, or saw something suspicious. U.S. FOIA confirmed that she just walked through the hallways and did not inspect any rooms. During an interview on 10/07/24 at 10:25 AM, CNA #1 confirmed she was currently assigned to fire watch, and she walked the entire building to see if she smelled smoke or saw fire. CNA #1 stated that she did not have to go into the rooms, and she was expected to walk the hallways every thirty minutes. The surveyor asked CNA #1 if she had a resident care assignment for the day as well, and CNA #1 confirmed yes, that she started fire watch around 9:30 AM, after she completed morning care. During an interview on 10/07/24 at 10:35 AM, the U.S. FO stated that she had inserviced all staff either in the building or by telephone prior to conducting fire watch on the fire watch process.	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 18 During an interview on 10/07/24 at 10:57 AM, the U.S. FOIA (b)(6)) stated that they inspected the facility's fire sprinkler system quarterly, and annually in May, they conducted a fire pump flow test where it was noted no debris. The U.S. FOIA acknowledged that it was unusual for the inspector to have noted "no debris". The U.S. FOIA stated that the other three quarterly inspections, they walked the facility to ensure all the sprinkler plates were attached, sprinkler heads were not painted over, and items were stored below eighteen inches from the ceiling. The U.S. FOIA confirmed that during the facility's inspections, the company did not visually inspect the water in the facility's pool. The U.S. FOIA stated that as far as he knew, there was no filter for the pool water. The U.S. FOIA confirmed that any debris in the pool had the potential to clog the fire sprinkler head; that even a "pebble" had the potential to clog it. The U.S. FOIA confirmed that when the fire pump was activated, that the force would churn any debris in the pool which could clog the sprinkler head. The U.S. FOIA acknowledged that best practice would be that the pool was maintained clear and free of debris. The surveyor asked the U.S. FOIA if the facility's storage tank was heated, and the U.S. FOIA confirmed no and that there was potential for some of the water to freeze in the winter. Observation on 10/07/24 at 12:00 PM, revealed CNA #1 was on the 400 nursing unit passing out lunch trays. On 10/07/24 at 12:30 PM, the surveyor reviewed the "Fire Watch Log" from 10/03/24 until present, and compared it to the CNA assignments for the same time period, which revealed the CNAs that were assigned fire watch also had resident care	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING 01 B. WING _____	10/08/2024

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K 353	Continued From page 19 assignments. During an interview on 10/07/24 at 1:08 PM, the [redacted] stated that staff assigned to fire watch were expected to walk the entire building, to check the hallways, and staff were not expected to go into each room. The [redacted] stated that staff ensured they did not smell or see smoke. The [redacted] stated that the line staff was assigned the duty, and the designated staff member also had a resident care assignment. The acceptable Removal Plan (RP) 10/07/24 at 4:25 PM, indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including; the facility began fire watch on 10/03/24 at 6:30 PM, around the clock, and on 10/07/24 at 2:30 PM, the fire watch included the entire building by a designated staff member; staff was in-serviced on fire watch policy; a licensed electrician verified the fire pump was connected to the emergency generator; pool will be cleaned out of debris; and the facility will convert fire sprinkler to city water continuing a fire watch until completed. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 10/08/24. Observation in the presence of the [redacted] on 10/08/24 at 9:30 AM, revealed that the emergency generator was connected to the sprinkler system. At the time of the observation, the [redacted] stated that the vendor was at the facility and they verified that the sprinkler system was directly connected to the emergency generator,	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING **01** B. WING _____	**10/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 20 and not connected to the wall panel. No additional information was provided. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors 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	K 363		11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING 01 B. WING _____	10/08/2024

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K 363	Continued From page 21 restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors closed and latched into the frame without impediment; and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.6.3. This deficient practice had the potential to affect 73 residents. Findings include: An observation on 10/03/24 at 3:32 PM revealed the corridor door of Room 303 failed to fully close and latch in the frame. An observation on 10/03/24 at 3:42 PM revealed the corridor door of Room 320 failed to fully close and latch in the frame. An observation on 10/03/24 at 3:43 PM revealed the corridor door of Room 317 failed to fully close and latch in the frame. An observation on 10/03/24 at 4:09 PM revealed the corridor door of Room 401 failed to fully close and latch in the frame. An observation on 10/03/24 at 4:10 PM revealed the corridor door of Room 402 failed to fully close and latch in the frame.	K 363	The corridor doors for rooms 303, 317, 320, 401 and 402 have been made to fully close and latch in the doorframe. All residents have the potential to be affected by this cited deficiency. The Maintenance Director inspected the doors throughout the facility to ensure that they fully close and latch. The Administrator educated the U.S. FOIA (b) (6) on the requirement to ensure that all corridor doors fully close and latch. The Maintenance Director will check corridor doors monthly for 6 months to ensure that all doors fully close and latch. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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K 363	Continued From page 22 During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the doors failed to latch in the frames. He stated the facility was unaware the doors were not latching.	K 363		
K 511 SS=F	NJAC 8:39-31.2(e) Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to meet the requirements of NFPA 1 Fire Code (2012 Edition), Section 11.1.2 and NFPA 70 National Electrical Code (2011 Edition), Article 314.25. This deficient practice had the potential to affect all 73 residents. Findings include: Observations on 10/03/24 at 12:28 PM of the stairwell by the Laundry Room revealed exposed electrical wires and a missing junction box cover.	K 511	The missing junction box cover by the stairwell of the laundry room was replaced. All residents have the potential to be affected by this cited deficiency. The Maintenance Director inspected the building to ensure that there are no exposed wires. The Administrator in-serviced the U.S. FOIA (b) (6) to ensure that there are no exposed wires in the building.	11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING 01 B. WING _____	10/08/2024

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K 511	Continued From page 23 During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the finding and stated the facility was unaware of the exposed wires prior to the survey. NJAC 8:39-31.2(e) NFPA 70	K 511	The Maintenance Director will check the facility monthly for 6 months to ensure that there are no exposed wires. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills at least quarterly per shift under varied conditions, as required by NFPA 101 Life Safety Code (2012 Edition), Section 19.7.1 and 18.7.1. This deficient practice had the potential to affect all 73 residents. Findings include: A review of the facility's "Fire Drill" reports provided by the facility revealed fire drills were not	K 712	The missing fire drill documentation for the fourth quarter of 2023 was located and placed in the inspection logbook. The Administrator educated the U.S. FOIA (b) (6) on the importance of keeping the inspection logbooks in order and ensuring that all required inspection reports are in it. The Administrator will check the	11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING 01 B. WING _____	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 712	Continued From page 24 conducted under varied times and conditions at least quarterly per shift. According to documentation provided by the facility during the survey, fire drills were conducted during the previous twelve months prior to the survey as follows: First Shift (7:00 AM - 3:00 PM): 07/08/24 at 10:55 AM 04/02/14 at 12:58 PM 01/08/24 at 9:28 AM Missing 2023 Fourth Quarter Second Shift (3:00 PM - 11:00 PM): 08/06/24 at 6:07 PM 05/10/24 at 4:51 PM 02/03/24 at 3:25 PM Missing 2023 Fourth Quarter Third Shift (11:00 PM - 7:00 AM): 09/10/24 at 5:33 AM 06/17/24 at 2:32 AM 03/08/24 at 12:46 AM Missing 2023 Fourth Quarter Documentation of the missing fire drills for 2023 was requested by the surveyor on 10/03/24 at 8:30 AM, 10:00 AM, and 3:00 PM; however, no documented evidence was provided by the facility during the survey. During an interview on 10/03/24 at 6:15 PM, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was not able to locate the missing documentation. NJAC 8:39-31.2(e), 31.6(b)	K 712	maintenance logbooks monthly for 6 months to ensure that all required documentation is in it and is in order. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	
K 741 SS=F	Smoking Regulations	K 741		11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING 01 B. WING	10/08/2024

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K 741	Continued From page 25 CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to meet the requirements for smoking areas as required by NFPA 101 Life Safety Code (2012 Edition) Section 19.7.4. This deficient practice had the potential to affect all residents. Findings include:	K 741	The cigarette butts that were stuffed into the steps by the generator room were cleaned out. An ashtray of noncombustible material for cigarette butts to be thrown out in was placed in the area. All residents have the potential to be	

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	315414	A. BUILDING 01 B. WING	10/08/2024

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K 741	Continued From page 26 Observations on 10/03/24 at 12:18 PM of the concrete steps outside of the Generator Room revealed cigarette butts were stuffed into the concrete steps. A metal can was not available for cigarette butts to be thrown into. An island style ashtray was located about ten feet away. The diesel storage tank was also nearby. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was aware of the cigarette butts on the ground. He stated staff smoked there and threw their cigarette butts on the ground even though they were not supposed to do it. NJAC 8:39-31.2(e), 31.6(e)	K 741	affected by this cited deficiency. Staff that smoke have been in-serviced by the Administrator to only discard cigarette butts in approved receptacles. Housekeeping and Maintenance have been in-serviced to ensure that there are no cigarette butts on the ground or any area where it should not be. The Administrator or designee will inspect the perimeter of the building to ensure that there are no cigarette butts on the ground or any area where it should not be and that there are approved receptables in areas where staff smoke. This will be done weekly for 4 weeks then monthly for 3 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 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.	K 761		11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING 01 B. WING	10/08/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 27 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 record review and interview, the facility failed to maintain written records of the inspection and testing of fire doors in accordance with NFPA 101 (2012) Section 19.7.6 and NFPA 80 (2010) Section 5.2.1. The deficient practice had the potential to affect all 73 residents. Findings include: A review of the facility's Life Safety Code documentation revealed no documented evidence the facility's fire doors had been inspected and tested. This documentation was requested on 10/03/24 at 8:30 AM and 3:00 PM. During an interview on 10/03/24 at 6:20 PM, the U.S. FOIA (b)(6) confirmed the finding and stated the facility was unable to provide the written records for the inspection and testing of the facility's fire doors. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	The fire doors in the facility will be inspected and tested in accordance with the NFPA 80 requirements. All residents have the potential to be affected by this cited deficiency. The Administrator educated the U.S. FOIA (b) (6) on the requirement to have the fire doors inspected and tested annually. The results of the fire door inspection will be shared with the Quality Assurance team at the following quality assurance meeting which will make further recommendations based on the results of the testing.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety	K 926		11/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING 01 B. WING _____	10/08/2024

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K 926	Continued From page 28 guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure personnel that handled medical gases and the cylinders that contained medical gases were trained on the risks associated with handling and use as required by NFPA 99 Health Care Facilities Code (2012 Edition), Section 11.5.2.1. The deficient practice had the potential to affect staff and all 73 residents. Findings include: An observation on 10/03/24 of the Oxygen Storage Room revealed the facility uses oxygen E cylinders for resident care. A review of the facility's training records revealed no documented evidence the facility had trained their staff on the safe handling of oxygen gases and cylinders. This documentation was requested on 10/03/24 at 8:30 AM but was not provided by the facility during the survey. During an interview on 10/03/24 at 6:15 PM, the U.S. FOIA (b)(6) confirmed the finding and stated the facility was unaware of the missing training and documentation. NJAC 8:39-31.2(e) NFPA 99	K 926	Nursing staff have been in-serviced by the DON on safe handling of oxygen gases and cylinders. All residents have the potential to be affected by this cited deficiency. Safe handling of oxygen gases and cylinders have been added to the orientation curriculum for new employees and to the list of annual in-services that are provided to the staff. The DON or designee will check the in-service record of nursing staff to ensure that they are up to date with the in-service of safe handling of oxygen gases and cylinders. This will be done monthly for the next 6 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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
315414 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

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 K0324	11/20/2024	LSC K0345	11/26/2024	LSC K0511	11/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0712	11/20/2024	LSC K0761	11/20/2024	LSC K0926	11/20/2024
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?
10/8/2024	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315414 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/18/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

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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 K0161	02/10/2025	LSC K0211	02/05/2025	LSC K0321	02/05/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	12/05/2024	LSC K0363	12/12/2024	LSC K0741	12/12/2024
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?
10/8/2024	☐ YES ☐ NO