STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD ALLENWOOD, NJ 08720**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 1/24/23 Census: 125 Sample: 25 + 2 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 812 SS=D	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.	F 812		1/27/23

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

Electronically Signed | 02/10/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD ALLENWOOD, NJ 08720**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 1 §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.) maintain multiuse food-contact surface cutting board in a manner to prevent microbial growth; b.) store, label, and date potentially hazardous foods to prevent food-borne illness; and c.) perform hand hygiene in accordance with infection control standards. This deficient practice was evidenced by the following: On 1/13/23 at 9:14 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and observed the following: 1. In the walk-in refrigerator, one opened container of ricotta cheese. The container was not labeled when opened or when to use by. The packaging indicated best quality is three days. The FSD acknowledged the container was not labeled when opened or when to discard. 2. In the reach-in refrigerator, seven health shakes not dated; one health shake dated 1/2/23; and two health shakes dated 1/9/23. The FSD stated that the health shakes came in frozen and when pulled from the freezer, they needed to be used or discarded within fourteen days. The FSD stated the 1/2/23 and 1/9/23 were the dates the health shakes should have been discarded. 3. On a storage rack, the surveyor observed one large red, one large brown, one large beige, three large white, one medium red, two light blue, and	F 812	Food Procurement, Store/Prepare/Serve-F812 Sanitary CFR(s): 483.60(i)(1)(2) In the walk-in refrigerator, one opened container of ricotta cheese. The container was not labeled when opened or when to use by. The packaging indicated best quality is three days. The FSD acknowledged the container was not labeled when opened or when to discard. 1. The opened container of ricotta cheese was immediately discarded. 2. All residents have the potential to be affected by this deficient practice. 3. All Dietary Staff has been in-serviced on the Labeling & Dating / Food Storage policy on 1/13/23 & 1/19/23. Re In-servicing will be completed monthly for 3 months and continue quarterly. Review of all labeling & dating and proper storage of all food items will daily by Food Service director/ designee to ensure compliance. 4. Monitoring of the labeling & dating/Food Storage has been added to the Manager's QA checklist and will be monitored 3x/week for 3 months. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD ALLENWOOD, NJ 08720**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 2 one large yellow cutting boards. The cutting boards were all deeply pitted and discolored. The FSD confirmed the kitchen should not be using these cutting boards because the pitting and discoloration could lead to bacterial growth. On 1/19/23 at 12:00 PM, the surveyor conducted a follow-up kitchen inspection and observed a Dietary Aide (DA) mop the kitchen floor, remove her gloves, and performed hand hygiene using soap and water. The surveyor observed the observed the DA turn the water on, wet her hands, lathered her hands with soap outside the flow of running water for six seconds and then began rubbing her hands under the flow of running water. At this time, the surveyor asked the DA the process of washing your hands using soap and water. The DA responded that you lathered your hands with soap for twenty seconds in the flow of running water. The surveyor asked the DA to show them the hand washing process and she again lathered her hands with soap outside the flow of running water for six seconds. At this time, the Regional FSD was present, and the surveyor asked him what the process for washing your hand using soap and water? The Regional FSD responded "my understanding the whole process twenty seconds." When asked how long outside do you lather your hands with soap outside the flow of water? The Regional FSD responded there was no set time, the whole process was twenty seconds. Then the Regional FSD located hand washing instructions on the wall by the dish station and stated you lather your hands with soap for twenty seconds outside the flow of running water. On 1/19/23 at 12:22 PM, the surveyor interviewed	F 812	In the reach-in refrigerator, seven health shakes not dated; one health shake dated 1/2/23; and two health shakes dated 1/9/23. The FSD stated that the health shakes came in frozen and when pulled from the freezer, they needed to be used or discarded within fourteen days. The FSD stated the 1/2/23 and 1/9/23 were the dates the health shakes should have been discarded. 1. The 10 health shakes identified were immediately discarded, these health shakes should have been clearly dated with a best-by date of 14 days after pulling from the freezer. 2. All residents have the potential to be affected by this deficient practice. 3. All Dietary Staff has been in-serviced on the labeling & dating/Food Storage policy. Re In-servicing will be completed monthly for 3 months and continue quarterly. Review of all labeling & dating and proper storage of all food items will continue 2x daily by managers to ensure compliance. 4. Monitoring of the labeling & dating/Food Storage has been added to the Manager's QA checklist and will be monitored 3x week for 3 months. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD ALLENWOOD, NJ 08720**

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F 812	Continued From page 3 the Director of Nursing (DON) regarding the hand washing process using soap and water. The DON stated that you lathered your hands outside the flow of running water for twenty seconds per the Centers for Disease Control (CDC) guidelines. On 1/24/23 at 11:12 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON and survey team, acknowledged these findings. A review of the undated facility provided "Label and Dating" policy included... all foods stored in the refrigerator or freezer will be covered, labeled and dated using the "use by date" to ensure proper rotation... A review of the undated facility provided "Food Storage and Retention Guide" included... thawed health shakes fourteen days after thawing or removing from freezer. A review of the facility provided "Hand Washing" policy dated 11/4/22, included... hand washing procedures: wash hands with clean running water; apply adequate amount of soap to hands; lather your hands by rubbing them together with soap. Be sure to lather the back of your hands between your fingers and your nails; scrub your hands for at least twenty seconds; rinse your hands well under running water... NJAC 8:39-17.2(g)	F 812	On a storage rack, the surveyor observed one large red, one large brown, one large beige, three large white, one medium red, two light blue, and one large yellow cutting boards. The cutting boards were all deeply pitted and discolored. The FSD confirmed the kitchen should not be using these cutting boards because the pitting and discoloration could lead to bacterial growth. 1. The one large red, one large brown, one large beige, three large white, one medium red, two light blue, and one large yellow cutting boards were immediately removed from service and discarded. Replacement cutting boards were put into service. 2. All residents have the potential to be affected by this deficient practice. 3. All staff were in service on recognizing the condition of the cutting boards Monitoring of the condition and cleanliness of cutting boards been added to the Manager's Daily Checklist. In addition, the food service director/designee will review the condition of cutting boards bi-weekly to ensure compliance. 4. Monitoring of the condition of kitchen cutting boards has been added to the Manager's QA checklist and will be monitored weekly for 3 months then monthly Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and	

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	315397	A. BUILDING _____ B. WING _____	C 01/24/2023

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F 812	Continued From page 4	F 812	necessity for future audits. 5. Completion date: 1/27/23 On 1/19/23 at 12:00 PM, the surveyor conducted a follow-up kitchen inspection and observed a Dietary Aide (DA) mop the kitchen floor, remove her gloves, and performed hand hygiene using soap and water. The surveyor observed the observed the Dietary Aide turn the water on, wet her hands, lathered her hands with soap outside the flow of running water for six seconds and then began rubbing her hands under the flow of running water. At this time, the surveyor asked the Dietary Aide The surveyor asked the DA to show them the hand washing process and she again lathered her hands with soap outside the flow of running water for six seconds. 1. The Dietary Aide and the regional food service director were in serviced by the infection preventionist on 01/19/2023. 2. All residents have the potential to be affected by this deficient practice. 3. All dietary staff have been in serviced in proper hand washing process. In servicing will continue monthly for 3 months and then quarterly x 2 then as needed. 4. The infection preventionist will do random audits of 3 dietary staff weekly for one month then 3 staff monthly x3 Reports of the audits will be presented to the Quality assurance committee who	

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	315397	A. BUILDING _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD ALLENWOOD, NJ 08720**

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F 812	Continued From page 5	F 812	meet quarterly who will review and determine the frequency and necessity for future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061330	A. BUILDING: _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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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 documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 9 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1. There were no care concerns reported on the 5 shifts that were identified. 2. All residents have the potential to be affected by this deficient practice. The Director of Nursing reviewed the last 30 days of the CNA staffing report. The IDC team reviewed facility grievance log and care and no care concerns were identified. 3. Facility Staffing Coordinator was in serviced on 01/24/2023 on the requirements for proper CNA staffing and ratios and the need to review and address the staffing needs daily to meet the state requirements. Recruitment efforts are in place to assist	1/31/23

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

Electronically Signed | 02/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061330	A. BUILDING: _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 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 1/13/23 at 9:44 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and Infection Preventionist/Registered Nurse, informed the surveyor that the facility staffing was challenging and the facility utilized Agency staff as well as offered incentives to their staff. The DON stated that the residents were all being cared for. As per the "Nurse Staffing Report" completed by the facility for the weeks of 12/25/22 to 12/31/22 and 1/1/23 to 1/7/23, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift and total staff for residents on the overnight shift as documented below: 12/25/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs. 12/25/22 had 8 total staff for 125 residents on the	S 560	the facility in hiring staff. CNA's receive sign on bonuses, referral bonuses and tuition aid for CNA classes at times. The facility also has contracts with staffing agencies as well as paid advertisements to help with our recruitment effort. The Staffing Coordinator or designee also reviews staff attendance records to ensure that excessive callouts are addressed. 4. The Facility Administrator, Director of Nursing and the Staffing Coordinator will conduct weekly meetings x4 then monthly x 6 to review staffing schedules, upcoming needs, and the efficacy of the systems in place to fill the facility needs. The findings will be reported at the quarterly QAPI Committee meetings x3 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061330	A. BUILDING: _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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S 560	Continued From page 2 overnight shift, required 9 total staff. 12/26/22 had 8 total staff for 125 residents on the overnight shift, required 9 total staff. 12/29/22 had 13 CNAs for 124 residents on the day shift, required 15 CNAs. 12/31/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs. 1/1/23 had 14 CNAs for 124 residents on the day shift, required 15 CNAs. 1/3/23 had 14 CNAs for 123 residents on the day shift, required 15 CNAs. 1/6/23 had 14 CNAs for 122 residents on the day shift, required 15 CNAs. 1/7/23 had 12 CNAs for 122 residents on the day shift, required 15 CNAs. NJAC 8:39-5.1(a)	S 560		

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
315397 Y1	A. Building B. Wing Y2	2/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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 F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/27/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061330 Y1	A. Building B. Wing Y2	2/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/31/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING **01** B. WING _____	C **01/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD** **ALLENWOOD, NJ 08720**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The building construction was stated to be 90's, with no current major renovations or noted additions. It is a one-story building Type V (111) protected construction and is fully sprinklered. The facility is divided into 14 smoke zones. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, fire pump, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The 500 KW generator does 100 % of the building. The fire sprinkler system utilizes an electric fire pump. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 135 certified beds. At the time of the survey the census was 125. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101	K 211		1/31/23

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

Electronically Signed | 02/09/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING **01** B. WING _____	C **01/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD** **ALLENWOOD, NJ 08720**

(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 211	Continued From page 1 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, interview, and documentation review on 1/17/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was identified for 8 of 8 fire doors observed and was evidenced by the following: On 1/17/23 at 9:45 AM, the surveyor asked the MD to provide the annual testing requirements for fire door assemblies in accordance with NFPA 80. The MD stated that currently the facility did not have any documentation on fire door assemblies. The Licensed Nursing Home Administrator was informed of the finding at the Life Safety Code Exit Conference on 1/18/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	1) All 8 fire door assemblies throughout the facility were inspected and documented in accordance with NFPA 80 by the maintenance director on January 18, 2023. 2) All residents have the potential to be affected by this deficient practice. 3) The Maintenance Director was in-serviced by the Administrator on January 18, 2023, regarding NFPA 80, inspect fire doors annually. 4) Maintenance director/designee will conduct monthly audits x 3 then quarterly x2 then annually to ensure compliance. Reports of audits will be presented to Quality Assurance Committee who meets quarterly. This committee will determine frequency and necessity for future audits.	
K 281 SS=E	Illumination of Means of Egress	K 281		1/31/23

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	315397	A. BUILDING **01** B. WING _____	C **01/24/2023**

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K 281	Continued From page 2 CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/18/23, in the presence of facility Maintenance Director (MD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 1 of 6 occupied access areas observed and was evidenced by the following: On 1/18/23 at 11:58 AM, the surveyor in the presence of the MD, observed in the occupied family lounge, that 9 of 9 ceiling light fixtures were controlled by 3-wall switches. The switches were turned off and the room was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The Maintenance Director confirmed the finding at the time of observation. The Licensed Nursing Home Administrator was informed of these findings at the Life Safety Code survey exit conference on 1/18/23. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2)	K 281	1. On 1/18/23 5pm we contracted a license electrician to install a continuous illumination of the means of egress without manual intervention which was installed 1/18/23 as per NFPA 101 section 19.2.8 and 7.8. 2. All residents have the potential to be affected by the deficient practice. 3. On 01/18/2023 Administrator and Maintenance director reviewed and was in serviced on the NFPA 101 Section 19.2.8 and 7.8 on the need for Illumination of means of egress that shall be continuous in operation of automatic in operation. 4. Maintenance director/designee will conduct weekly audits for 1 month and quarterly x2 then Annually x1 to ensure compliance and submit reports to the administrator. Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits.	

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K 281	Continued From page 3 NJAC 8:39-31.2(e)	K 281		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 1/17/23, in the presence of the Maintenance Director (MD) and the Licensed Nursing Home Administrator (LNHA), it was determined that the facility failed to a.) inspect the fire alarm system on a semi-annual inspection and b.) ensure the smoke alarm sensitivity inspection report was documented in accordance with NFPA 72. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: 1. A review of the facility's fire alarm system inspections for the previous 12 months revealed that the system was inspected by a licensed vendor on 6/10/22 only. The fire alarm had sealed lead acid batteries which required the system to be inspected on a semi-annual basis as per NFPA 72. An interview was conducted with the Maintenance Director during document review. The Maintenance Director was not sure why the	K 345	1) On 1/19/2023 we contacted our Licensed vendor to schedule our semiannual fire alarm inspection which was completed on 01/26/2023 On 1/19/2023 we contacted our Licensed vendor five-year smoke alarm sensitivity test which was completed on 01/25/2023 in accordance with NFPA 72. 2) All residents have the potential to be affected by this deficient practice. 3) The Maintenance Director was in-serviced by the Administrator on January 18, 2023, regarding NFPA 72, on the need to a) inspect the fire alarm system on a semiannually b.) ensure the five-year smoke alarm sensitivity test was completed and documented. 4) Maintenance director/designee will conduct Monthly audits x 3 then quarterly x 1 then semiannually to ensure	1/31/23

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K 345	Continued From page 4 system was not inspected on a semi-annual basis and would call the vendor to follow-up and understand inspection requirements. 2. A review of all the fire alarm documents provided by the Maintenance Director on 1/17/23 revealed that no sensitivity test of the smoke detectors was performed. The sensitivity report was required every 5-years. The Maintenance Director confirmed that no documentation could be provided on this report and he would call the fire alarm vendor to see when it was last completed. No further information was provided. The LNHA was informed of the findings at the Life Safety Code exit conference on 1/18/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	compliance. Reports of audits will be presented to Quality Assurance Committee who meets quarterly. This committee will determine frequency and necessity for future audits.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		2/23/23

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	315397	A. BUILDING **01** B. WING _____	C **01/24/2023**

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PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD** **ALLENWOOD, NJ 08720**

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K 353	Continued From page 5 _____ 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 on 1/17/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. This deficient practice was identified for 1 of 1 dry systems from the provided documentation by the MD and was evidenced by the following: The fire sprinkler vendor on 3/16/22 indicated on their 3-year dry system pressure test documentation that the system failed the pressure test. The MD and Licensed Nursing Home Administrator (LNHA) confirmed that the fire sprinkler document dated 3/16/22, included the 3-year dry system pressure test "failed". The LNHA stated that he would call the vendor for further status. The LNHA was informed of the findings at the Life Safety Code exit conference on 1/18/23. No further information was provided. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	1) On January 19, 2023, we reached out to Midlantic fire company to schedule a 3 year pressure test on the dry system which will be performed on 02/23/23. As per NFPA 25. The test was completed and passed on 02/23/2023. 2) All residents have the potential to be affected by this deficient practice. 3) The Maintenance Director was in-serviced by the Administrator on January 19, 2023, regarding NFPA 25 Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. 4) Maintenance director/designee will conduct monthly audits x 3 then quarterly x2 then annually to ensure compliance. Reports of audits will be presented to Quality Assurance Committee who meets quarterly. This committee will determine frequency and necessity for future audits.	
K 521 SS=E	HVAC CFR(s): NFPA 101	K 521		1/31/23

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K 521	Continued From page 6 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/18/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure a.) resident bathroom ventilation systems were adequately maintained and b.) PTAC (Packaged Terminal Air Conditioners) were operating in optimal condition. in accordance with the National Fire Protection Association (NFPA) 90 A, B and B). This deficient practice was identified for 13 of 40 resident room bathrooms vents observed and 8 of 30 PTAC units observed and was evidenced by the following: 1. On 1/18/23, during a tour of the building, the surveyor with the MD, toured the facility and observed that the ventilation in the following Resident Room bathrooms did not function: #307, #309, #330, #332, #401, #404, #405, #408, #411, #412, #413, #414, and #416. At the time of observations, the surveyor requested that the Maintenance Director confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling	K 521	1. On 1/19/23 the maintenance team Immediately cleaned the filters in rooms 209,210,211,213,401,405, &414 and installed a filter in 228. They also started an audit on all PTAC filters in the building which was completed on 01/23/2023. On 1/18/2023 the maintenance director checked all the ventilation units on the roof. Two were found to be not working properly. Parts were immediately ordered and installed on 01/20/2023. Maintenance director did an audit on all bathroom ventilation fans to ensure they are working properly. 2. All residents have the potential to be affected by the deficient practice. 3. On 01/19/2023 Administrator and Maintenance director reviewed and was in serviced on the NFPA 101 Section 18.5.2.1,19.5.2.1,9.2 on the need for properly functioning Hvac and ventilation units to be installed and maintained in accordance with the manufacturers	

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	315397	A. BUILDING **01** B. WING _____	C **01/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD** **ALLENWOOD, NJ 08720**

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K 521	Continued From page 7 grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. 2. On 1/18/23, while touring the building with the MD, it was observed that PTAC unit filters were clogged and dirty in the following resident rooms: #209, #210, #211, #213, #401, #405, and #414. #228 had no filters in place. The MD confirmed the findings during the observations. No policy and procedure on PTAC maintenance was provided and no PTAC filter cleaning schedule and or log was provided by the facility. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code Exit Conference on 1/18/23. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	specifications. 4. Maintenance director/designee will conduct weekly audits of the bathroom ventilation system on 10 rooms per unit for 3 months and quarterly x2 then Annually x1 to ensure compliance and submit reports to the administrator. B) Maintenance director/designee will conduct Monthly audits of the PTAC filters for 3 months and then quarterly x 2 going forward to ensure compliance and submit reports to the administrator Reports of the audits will be presented to the Quality assurance committee who meet quarterly who will review and determine the frequency and necessity for future audits.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918		1/31/23

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 918	Continued From page 8 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/18/23, in the presence of the Maintenance Director (MD) and Licensed Nursing Home Administrator, it was determined that the facility failed to ensure a remote manual stop station for one of one generators and installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following:	K 918	1) On January 18, 2023, our generator vendor was contracted to install a remote manual stop station for the generator which was installed on 1/31/23 in accordance with NFPA 110. 2) All residents have the potential to be affected by this deficient practice. 3) The Maintenance Director was in-serviced by the Administrator on	

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 918	Continued From page 9 On 1/18/23 at 1:05 PM, the surveyor and MD observed the exterior generator. There was no remote manual stop station observed remotely outside the area of the generator location. An interview was conducted during the time of the observation with the MD, who confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation, located remotely outside the area of the enclosure housing the prime mover. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference held on 1/18/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	January 18, 2023, regarding NFPA 110, to ensure a remote manual stop for the generator. 4) Maintenance director/designee will conduct monthly audits x 3 then quarterly x2 then annually to ensure compliance. Reports of audits will be presented to Quality Assurance Committee who meets quarterly. This committee will determine frequency and necessity for future audits.	

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
315397 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	01/31/2023	LSC K0281	01/31/2023	LSC K0345	01/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	02/23/2023	LSC K0521	01/31/2023	LSC K0918	01/31/2023
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	
1/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO