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F 000	INITIAL COMMENTS Complaint #s NJ 158164, 159096, 159436, 160185, 162182, 164918, 165258, 165638, 166264, 168619, 170718, 172424, 173595, 173895 STANDARD SURVEY: 8/14-8/22/24 CENSUS: 516 SAMPLE SIZE: 35+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure an NJ Ex Order 26.4(b)(1) medication was administered in accordance with professional standards of clinical practice to Resident #112 who had NJ Ex Order 26.4(b)(1). This deficient practice was observed for one (1) of four (4) nurses who administered to one (1) of six (6) residents during the medication	F 658	ELEMENT ONE - Corrective Action During the survey, an immediate 1-1 in-service was done with the nurse identified as not ensuring the medication was given in the correct manner. A facility-wide in-service was conducted with all licensed Nurses regarding medication administration to ensure that the residents receive the correct dose of the medication and that the nurses follow	9/13/24

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

Electronically Signed | 09/11/2024

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F 658	Continued From page 1 administration observation and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The nurse practice act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The nurse practice act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 8/20/24 at 9:29 AM, during the medication pass observation, the US FOIA (B) (6) reviewed with the surveyor the four (4) medications to be administered to Resident #112 which included NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted] The US FO stated he had to add the NJ ex order 26.4b1 NJ ex order 26.4b1	F 658	the proper procedure to meet professional standards. ELEMENT TWO - Identification of At-Risk Residents All residents in the facility have the potential to be affected by this practice. Residents #112 had no ill effects from this practice. No other residents were identified. ELEMENT THREE - Systemic Change All licensed Nursing staff received re-education regarding the professional standards of medication administration. The Pharmacy Consultant and the facility Educator will continue to provide ongoing education to ensure that professional standards of preactice are followed regarding administration of medication to ensure accuracy of dosage. ELEMENT FOUR - Quality Assurance Weekly audits are conducted by the Assistant Director of Nursing on each unit to ensure professional standards of practice for administering the complete dosage of medication. The results of the weekly audits will be acted upon immediately and reported to the Director of Nursing and Administrator. The trend analysis will be completed, and the findings will be reported by the Director of Nursing to the Quality Assurance Performance Improvement Committee and Administration for action as appropriate.	

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because the resident did not like NJ Ex Order 26.4(b), and the resident preferred the medication to be taken this way.

On 8/20/24 at 9:45 AM, the US FOIA and the surveyor entered the resident's room. The US FOIA verified the resident's name and gave the resident their NJ ex order 26.4b1, followed with the NJ ex order 26.4b1 Resident #112 NJ ex order 26.4b1 to the RN.

On 8/20/24 at 9:46 AM, while the US FOIA and the surveyor were walking back to the cart, the US FOIA spilled liquid from the cup that contained the NJ Ex Order 26.4(b)(1) solution on his hand and threw the cup into the trash bin attached to his cart. The surveyor observed the cup in the trash bin that contained more liquid.

On 8/20/24 at 9:49 AM, the surveyor observed the US FOIA sign the electronic Medication Administration Record (eMAR) that he had administered all four medications to Resident #112. At that time, the surveyor, and the US FOIA both looked at the cup in the trash bin and the US FOIA confirmed that he saw the NJ ex order 26.4b1 NJ ex order 26.4b1, and NJ ex order 26.4b1

On 8/20/24 at 10:04 AM, in the presence of the US FOIA (B) (6), and the surveyor, the US FOIA stated that he should have given the remainder of the NJ Ex Order 26 NJ ex order 26.4b1 to the resident. The US FOIA stated he did not think the resident NJ ex order 26.4b1 as ordered by the physician. At that time, the US FOIA stated in the future he would ensure the resident would receive the full dose. The US FOIA stated he would

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contact physician, NJ Ex Order 26.4b1 and inform his supervisors.

The surveyor reviewed the hybrid medical record for Resident #112.

According to the Admission Record, Resident #112 was admitted to the facility with diagnoses NJ ex order 26.4b1 .

A review of a Quarterly Minimum Data Set, an assessment tool, dated NJ ex order 26.4b1 revealed that the resident had a Brief Interview for Mental Status score of NJ ex out of 15 which indicated that the resident NJ ex order 26.4b1 .

A review of the resident's Order Summary Report as of NJ ex order 26.4b1 , included an order, dated NJ ex order 26.4b1 for NJ ex order 26.4b1

A review of Resident #112's NJ ex order 26.4b1 NJ ex order 26.4b1 /Monthly Summary for NJ ex order 26.4b1 NJ ex order 26.4b1 reflected monitoring of resident's behavior, non-drug interventions for the documented behaviors, and the behaviors exhibited and monitored by the nursing staff. The behaviors exhibited were:
-NJ ex order 26.4b1
-NJ ex order 26.4b1
NJ ex order 26.4b1
NJ ex order 26.4b1
NJ ex order 26.4b1 .

A review of the NJ ex orde Medication Pass Observation competencies reflected the following:
-on NJ ex order 26.4b1 , the US FO had 0% errors

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F 658	Continued From page 4 -on NJ ex order 26.4b, the RN had NJ ex order 26.4b1 -on NJ ex order 26.4b, the RN had NJ ex order 26.4b1 On 8/21/24 at 1:53 PM, in the presence of the survey team, the US FOIA (B) (6) and the US FOIA (B) (6) the surveyor discussed the concern regarding the medication pass wherein Resident #112 NJ ex order 26.4b1 of the NJ ex order 26.4b1 that NJ ex order 26.4b1. At that time, the US FOIA (B stated that the US FOIA was in-service (educated) to ensure the residents received the correct dose. On 8/20/24 at 9:00 AM, the surveyor received a copy of the in-service provided to the US FO. A review of the policy provided Administering Medication dated NJ ex order 26.4, reflected under Policy Statement that medications shall be administered in a safe and timely manner, and as prescribed.	F 658		
F 755 SS=D	NJAC 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		9/13/24

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F 755	Continued From page 5 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to consistently provide pharmaceutical services in accordance with professional standards to ensure a.) a refrigerator that contained prescription medications was lockable, b.) disposition (destruction) and reconciliation of [redacted] dangerous substance ([redacted] medications, that due to their NJ Ex Order 26.4(b)(1), are tracked with detail) was removed from active inventory when Unsampled Resident # 399 was NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1, c.) against borrowing medications from other residents to administer to a NJ Ex Order 26.4b1 resident (Unsampled Resident #1073), d.) a NJ ex order 26.4b1 for Unsampled Resident #359 NJ ex order 26.4b1 [redacted], and e.) a biological supply that	F 755	ELEMENT ONE - Corrective Action LPN #1, LPN #2, LPN #3, RN #1 were educated immediately about standards of practice and policy for medication administration, storage, documentation, and the policy of borrowing medication and declining narcotics. A facility wide re-education for all licensed nurses was conducted about borrowing medication and the reconciliation of [redacted] Immediately, an audit was conducted to ensure that all medication refrigerators were locked, and that the key was in working order. An audit was conducted on all medication carts to ensure that there was no discharge medication on the medication carts in the facility.	

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F 755	Continued From page 6 required dating was dated. These deficient practices were identified for one (1) of five (5) medication storage rooms and three (3) of 13 medication carts inspected during the medication storage observation. a.) On 8/20/23 at 10:31 AM, the surveyor observed the medication room door located on 3-West was half opened. At that time, the Licensed Practical Nurse (LPN #1) was in the room. On 8/20/24 at 10:35 AM, during the inspection of the medication room refrigerator in the presence of LPN #1, the surveyor observed the refrigerator had a metal string, that was bolted on the side, and the front of the refrigerator door. The metal string was easily unhooked from the front, and not locked. The refrigerator contained prescription medications such as insulin (injectable medication to reduce blood sugar) and an empty storage box for refrigerated narcotic medication. At that time, LPN #1 stated that the refrigerator was unlocked from the beginning of her shift that morning and did not know if there was a lock for the medication refrigerator. LPN #1 used the telephone to call her supervisor. On 8/20/24 AM at 10:58 AM, LPN #2 walked into the medication room and stated that there was a lock for the medication room refrigerator located on the bolted side of the refrigerator. LPN #2 tried several keys in her possession to demonstrate that the lock was functional. At that time, both nurses tried multiple keys in their possession and could not show the lock for the medication room refrigerator was lockable.	F 755	ELEMENT TWO - Identification of at Risk Residents All residents have the potential to be affected by this practice. ELEMENT THREE -Systemic Change All licensed staff were provided re-education on this practice by the facility Educator and Pharmacy Consultant to ensure that these standards of practice are met. On a daily basis, staff will check each medication cart and medication refrigerator to ensure that they do not have discharge medications on the cart and that the medication storage complies with standards of practice ELEMENT FOUR - Quality Assurance Random weekly audits for the next Four months will be conducted by the Assistant Directors of Nursing to ensure that the proper storage of medication, declining of narcotics, no borrowing of medication from other residents. The results of the weekly audits will be acted upon immediately and reported to the Director of Nursing and Administrator. Trend analysis will be completed, and the findings will be reported quarterly by the Director of Nursing to the Quality Assurance Performance Improvement Committee and Administration for action as appropriate	

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On 8/20/24 at 11:01 AM, the US FOIA (B) (6) entered the medication room in 3-West. In the presence of LPN #1, LPN #2, and the surveyor the US FOIA (B) (6) for the 3rd floor tried LPN#1's, LPN#2's and her own set of keys to demonstrate that the prescription refrigerator door was lockable. At that time, the US FOIA (B) (6) confirmed she did not have the key to lock the refrigerator door, had not received a report from any nurses concerning the lock and was unsure how long the medication room refrigerator door was not lockable.

On 8.21/24 at 1:53 PM, in the presence of the survey team, the US FOIA (B) (6) and the US FOIA (B) (6) US FOIA (B) (6), the surveyor discussed the concern regarding the unlockable refrigerator. At that time, the US FOIA (B) stated that the lock was changed, the staff did not have any prior problems with the lock and was not sure what went wrong.

b.) On 8/20/24 at 10:42 AM, in the presence of LPN #1, the surveyor began the NJ Ex Order 26.4(medication inspection, which was stored in a mounted, double locked portion of the medication cart B (NJ Ex Order 26.4(b)(1) located on 3-West. The medication cart B parked inside the medication room. A review of the facility's "Record of Narcotic Use Drug Count and Syringe Count" (a shift-to-shift count/sign in sheet, used to account for the NJ Ex Order 26.4(b) and syringes within the medication cart) for NJ ex order 26.4b1, reflected that the counts were conducted on three shifts (7:00 AM, 3:00 PM and 11:00 PM), daily from 8/1/24 at 7:00 AM, to at NJ ex order 26.4b at 7:00 AM.

At that time, the surveyor and LPN #1 observed Resident #399's NJ ex order 26.4b1

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NJ ex order 26.4b1

At that time, the surveyor compared the count of the bingo card against the Individual Patient NJ Ex Order 26.4(b)(1) Administration Record (declining inventory log) for Resident #399's NJ ex order 26.4b1 and was last signed by the administering nurse on NJ ex order 26.4 at 9:46 PM.

At that time, the surveyor questioned the one (1) tablet discrepancy of the count. LPN #1 stated that she usually signed the declining inventory log but had forgotten that day. LPN #1 stated she removed the NJ ex order 26.4b1 for administration to Resident #399 that morning, and at the same time was informed that Resident #1073 was NJ Ex Order 26 at center court. LPN #1 stated she administered the NJ ex order 26.4b1 to Resident #399 before running to center court, and that was the reason she had forgotten to sign the declining inventory log.

At that time, the LPN #1 stated she should have signed the declining sheet upon removal of the NJ ex order 26.4b1 from the NJ Ex Order 26.4 box.

The surveyor reviewed the hybrid medical record for Resident #399.

According to the Admission Record, Resident #399 was admitted to the facility with diagnoses that include NJ ex order 26.4b1

A review of Resident #399's electronic Medical

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Record reflected the resident was transferred out of the facility on [NJ ex order 26.4b]

A review of the resident electronic Medication Administration Record (eMR) reflected the last administration was on [NJ ex order 26.4].

A review of the paper-based chart contained the Universal Transfer Form that indicated Resident #399 NJ ex order 26.4b1 on [NJ ex order 26.4] at 2:19 PM for NJ ex order 26.4b1.

On 8/20/24 at 10:42 AM, the surveyor and [US FOIA] #1 reviewed Resident #399's eMR together which revealed Resident #399 NJ ex order 26.4b1 [NJ ex order 26.4] and had not returned to the facility at that time. The [US FOIA] confirmed the Resident #399 NJ ex order 26.4b1. The [NJ ex order 26.4b1] NJ ex order 26.4b1 for Resident #399 could not have been administered to Resident #399 since the resident NJ ex order 26.4b1 [NJ ex order 26.4b].

On 8/20/24 at 10:46 AM, LPN #1 stated she was part of the error with the shift-to-shift count for the missing [NJ Ex Order 26.4(] The [US FOIA] stated that she and the 11-7 AM nurse NJ ex order 26.4b1 that morning and was unsure when the [NJ ex order 26.4b1] Resident #399's NJ ex order 26.4b1. At that time, the LPN #1 stated the Resident #399's NJ ex order 26.4b1 should have been sent back to the pharmacy, or should have been disposed by two (2) nurses.

On 8/20/23 at 11:03 AM, in the presence of [US FOIA] #1 and the surveyor, the [US FOIA (B) (] confirmed that Resident #399's [NJ ex order 26.4b1] should have been pulled when they learned the resident was

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admitted to the hospital on NJ ex order 26.4b1
The US FOIA (B) (6) also stated that this was important to avoid medication errors, misplacement, theft, and proper count of pills should have been returned [when applicable, for credit towards the resident's account]. At that time, the US FOIA (B) (6) stated she would investigate and inform the US FOIA (B) (6)
US FOIA (B) (6)

On 8/20/24 at 1:14 PM, during a meeting with the US FOIA (B), the surveyor discussed the concern regarding the missing NJ ex order 26.4b1 of NJ ex order 26.4b1 for Resident #399. At that time, the US FOIA (B) stated that all discharged medications should have been removed once the resident was admitted to the other facility. The US FOIA (B) stated that she would investigate Resident #399's NJ ex order 26.4b
NJ ex order 26.4b1

c.) A review of the provided facility policy dated/revised on 6/12/24. included the following under Policy Interpretation and Implementation. "The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties and shall give the Administrator a written report of such findings".

The surveyor reviewed the hybrid medical record for Resident #1073.

According to the Admission Record, Resident #359 was admitted to the facility with diagnosis that included generalize NJ ex order 26.4b1

A review of the New Jersey Universal Transfer Form reflected Resident #1073 was admitted the

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day before NJ Ex Order 26.4b1 at 8:00 PM and was transferred out of the facility on that morning at 8:25 AM.

A review of the Order Summary Report for Resident #1073 included the following:

- NJ ex order 26.4b1 with a start date of NJ ex order 26.4b1
- NJ ex order 26.4b1 with a start date of NJ ex order 26.4b1
- NJ ex order 26.4b1 with a start date of NJ ex order 26.4b1

A review of the electronic Medication Administration Record (eMAR) for NJ ex order 26.4b1 did not reflect an order and an administration of NJ ex order 26.4b1.

A review Resident #1073's paper-based chart, under progress note, reflected a documentation on NJ ex order 26.4b1 [without time or department], revealed a NJ ex order 26.4b1 "

On 8/21/24 at 9:20 AM, during a meeting with the surveyors, the US FOIA (B) stated that she had investigated the missing NJ Ex Order 26.4 after surveyor inquiry, removed the nurse from the cart, counted the NJ Ex Order 26.4(b)(1) reviewed the cameras, informed the US FOIA (B), the US FOIA (B) (6) and the U.S. FOIA (b) (6), and filed a reportable with

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the state and the NJ ex order 26.4b1. The US FOIA (B explained that Resident #1073 NJ ex order 26.4b1 at approximate 7:30 AM. The physician was notified and placed a stat (immediate) order of NJ ex order 26.4b1. Resident #1073 NJ ex order 26.4b1 and their medications had not yet arrived for the 9:00 AM administration.

At that time, the US FOIA (B stated that LPN #1 borrowed the NJ ex order 26.4b1 from Resident #399 and the NJ ex order 26.4b from Resident #217.

At that time, the US FOIA (B showed a paper-based Medication Administration for Resident #1073 that revealed, one (1) time administration of the NJ ex order 26 at 7:35 AM.

At that time, the US FOIA (B confirmed the nurse should have gone to the back-up box to get the emergency order of NJ ex order 26.4b1 for Resident #1073.

At that time, the US FOIA (B also stated that LPN #1 tried to deny the act of borrowing while the camera showed that she had.

At that time, the US FOIA (B stated that she would contact the pharmacy to ensure Resident #359 NJ ex order 26.4b1).

The surveyor reviewed the hybrid medical record for Resident #217

According to the Admission Record, Resident #359 was admitted to the facility with diagnosis that NJ ex order 26.4b1.

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A review of the eMAR for NJ ex order 26.4b1, reflected an NJ ex order 26.4b1 The eMAR also reflected that Resident #359 NJ ex order 26.4b1 .

No further information was provided.

d.) On 8/20/24 at 11:57 AM, in the presence of the Registered Nurse (RN #1), the surveyor began the medication cart B inspection located on 2-East.

On 8/20/24 at 12:06 PM, the surveyor observed NJ ex order 26.4b1 for Resident #359.

At that time, the surveyor and RN #1 reviewed the electronic Medication Administration Record (eMAR) together which revealed a physician's order for NJ ex order 26.4b1 NJ ex order 26.4b1 . The eMAR did not reflect the exact measurement (in inches or centimeter) to indicate the dose for each administration.

At that time, RN #1 stated that the Resident was sent out of the facility and was admitted to another facility. RN #1 NJ ex order 26.4b1 RN #1 also stated that Resident #359 NJ ex order 26.4b1 but had NJ ex order 26.4b1

The surveyor reviewed the hybrid Medical Record for Resident #359.

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According to the Admission Record, Resident #359 was admitted to the facility with diagnosis that included NJ ex order 26.4b1 [redacted].

A review of the Order Summary Report for [redacted] did not include a current order for NJ ex order 26.4b1 [redacted].

On 8/21/24 at 1:53 PM, in the presence of the survey team, the US FOIA (B) (6) [redacted] and the US FOIA (B) (6) [redacted] the surveyor discussed the concern regarding the Resident#359's NJ ex order 26.4b1, NJ ex order 26.4b1 that NJ ex order 26.4b1 [redacted].

No further information was provided.

e.) On 8/20/24 at 12:30 PM, in the presence of LPN #3, the surveyor began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart B (narcotic box) located on 2-West.

At that time, in the back of the narcotic box buried underneath vials of Haldol injectable, the surveyor and LPN #3 observed an opened, undated blood glucose (bg) test strips bottle (used with a glucometer to provide immediate reading of blood sugar, or glucose level). The package insert indicated use within 90 days after first opening.

At that time, LPN #3 confirmed the bg test strips should have been dated. LPN #3 stated she would discard the bg test strips since she was unsure when it was opened.

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A review of the Manufacturer Specification for Assure Platinum included the following under FAQs.
What is the operating range for the Assure Platinum Test Strips and how should I store them?
Operating range: 39°F-86°F (4°C - 30°C). Use within 90 days of first opening. Do not freeze or refrigerate. Do not use beyond expiration date.

On 8.21/24 at 1:53 PM, in the presence of the survey team, the US FOIA (B) (6) [redacted] and the US FOIA (B) (6) [redacted], the surveyor discussed the concern regarding the undated bg test strips that was stored in the narcotic box.

No further information was provided.

A review of the provided facility policy dated/revised on 6/12/24, included the following under Policy Interpretation and Implementation:
6. The Nurse will maintain the keys to controlled substance for their medication cart. The Director of Nursing Services will maintain a set of back-up keys for all drug storage areas including keys to controlled substance containers.
8. Nursing staff count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing.

A review of the provided facility policy, Administering Medications, dated/revised on 11/5/23, included the following under Policy Interpretation and Implementation: Medications ordered for a particular resident may not be administered to another resident, unless

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F 755	Continued From page 16 permitted by State law and facility policy, and approved by the Director of Nursing Services. A review of the provided facility policy, Charting and Documentation dated/reviewed on 3/7/24, under policy statement reflected: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. A review of the provided facility policy, Storage of Medications dated/revised on 6/15/24, included the following under Policy Interpretation and Implementation: 3 ...there is a secured medication locked cabinet to ensure the medication cannot be accessed by other residents 5. The facility shall not use discontinued, outdated, deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. NJAC 8:39-29.2 (d), 29.4(g)(d)	F 755		
F 880 SS=E	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	F 880		9/13/24

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, 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 §483.70(e) 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

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F 880	Continued From page 18 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the 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, interviews, and review of pertinent facility documents, it was determined the facility failed to a.) follow appropriate infection control practices and perform appropriate hand hygiene as indicated during meal service observation in 2 of 12 units (first floor JDT and 2 East) for 2 of 4 staff observed during meal service and, b.) follow appropriate infection control practices and perform hand hygiene as indicated for 1 of 1 Resident (Resident #139) observed during NJ ex orde 26.4b1. This deficient practice was evidenced by the following: A review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Clean Hands Count for Healthcare Providers, reviewed 1/8/2021, included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for	F 880	ELEMENT ONE - Corrective Action LPN #1, CNA #1, and CNA #2 were immediately provided with re-education by the ICP Team and received education on proper handwashing and hand sanitizing. The individuals were also re-educated regarding EBP resident protocol to ensure the safety of the residents. The ICP Team and the the facility Educator conducted a facility wide re-education to all Departments to ensure the proper procedure for hand hygiene for resident/staff safety and the rationale for following the proper procedures. ELEMENT TWO - Identification of at Risk Residents All residents have the potential to be affected by this practice. ELEMENT THREE - Systemic Changes All facility staff received additional re-education regarding Hand Hygiene and	

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F 880	Continued From page 19 at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry." On 8/19/24 at 12:39 PM, the surveyor observed the lunch meal service in the JDT first-floor unit. The surveyor interviewed a Certified Nursing Assistant (CNA #1) who stated that all residents on the unit were served the lunch trays in their rooms. The surveyor observed the CNA #1 approached the food, removed a tray and entered room # [NJ ex 6]. The CNA #1 placed the food tray on the bed side table (BST) of the resident; removed the plate cover, removed the plastic covering from the food items and silverware on the tray, then opened the hand wipe and cleaned the resident's hands. The CNA #1 moved the BST closer to the resident. The resident requested an alternative food option, so the [US FOIA (B] went directly to the nurse's station and picked up the phone with no observed hand hygiene. The CNA #1 returned to the food cart, removed a tray and entered resident room [NJ ex 6]. The CNA #1 placed the food tray on the BST, opened the hand wipe and handed it to the resident. The CNA #1 exited room [NJ ex 6], went to a cabinet in the nurse's station, removed a cup and a can of soda, went to the ice cooler removed the lid and filled the cup with ice. The CNA #1 entered room [NJ ex 6] with no observed hand hygiene. On 8/19/24 at 12:50 PM, the CNA #1 told the surveyor that all the trays had been passed. The surveyor asked the CNA #1 if it was the facility's policy to perform hand hygiene between residents when assisting with meals. The [US FOIA (B] acknowledged that she should have sanitized her hands between residents.	F 880	Enhanced Barrier Precautions. The ICP Team and Education Department will continue to do on-going education on a quarterly basis and upon new hires to ensure that the necessary education is provided to the staff to keep residents/staff safe with proper hand hygiene. ELEMENT FOUR - Quality Assurance Daily rounds are conducted by the ICP staff to ensure compliance with hand hygiene and the procedures for Enhanced Barrier Precautions. Any findings that do not comply with standardss of practice are addressed immediately with immediate re-education. For the next Four months, weekly audits will be conducted by the Assistant Directors of Nursing to monitor compliance with hand hygiene and Enhanced Barrier Precaution protocols. The results of the weekly audits will be acted upon immediately and reported to the Director of Nursing and to the Administrator. Trend analysis will be completed and the findings will be reported quarterly by the Director of Nursing to the Quality Assurancxe Performance Improvement Committee and Administration for action as appropriate.	

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On 8/21/24 at 8:24 AM, the surveyor observed meal service on the 2 East unit. The surveyor observed signage outside room [NJ ex order] which indicated the resident in room [NJ ex order 2] was on NJ Ex Order 26.4(b)(1)) which included: everyone must clean their hands, including before entering and when leaving the room; wear gloves and a gown for the following High-Contact Resident Care Activities which included...dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use including central line, urinary catheter, feeding tube (gastrostomy tube), tracheostomy; wound care including any skin opening requiring a dressing.

On 8/21/24 at that same time, the surveyor observed the CNA #2 approached the food truck, removed a tray and entered room [NJ ex order 26.4] The CNA #2 placed the tray on the BST of the resident in the window bed. The CNA #2 removed the plate cover, removed the plastic covering from the food items and silverware on the tray. The CNA #2 moved the BST closer to the resident. The CNA #2 exited the room without any observed hand hygiene. The CNA #2 approached the coffee cart, brought a cup of coffee into resident room [NJ ex order 2] The CNA #2 exited the room with no observed hand hygiene. The CNA #2 returned to the food cart, removed a tray and entered room [NJ ex order]. The CNA #2 placed the tray on the BST and exited the room with no observed hand hygiene. The CNA #2 returned to the food cart, removed a tray and entered room [NJ ex order]. The CNA #2 placed the tray on the BST of the resident in the door bed. The [US FOIA (b] exited the room with no observed hand hygiene. The surveyor observed signage outside room [NJ ex order]

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which indicated the resident was on [NJ Ex Orde] The surveyor observed the CNA #2 returned to the food cart, removed a tray and entered room [NJ ex order] and placed the tray on the BST of the resident in the middle bed. The surveyor observed the CNA #2 performed hand hygiene. The CNA #2 turned on the faucet, applied soap to her hands and immediately placed hands under the stream of water without first lathering or applying friction.

On that same date at the same time, the surveyor discussed the breaks in infection control with the CNA #2 who acknowledged she should have performed hand hygiene between residents and when she entered and exited a resident's room who was on [NJ Ex Orde] The CNA #2 further stated that she should have washed her hands with soap lathering for 20 to 30 seconds outside the stream of water but acknowledge she did not wash correctly because she "forgot."

2. On 8/20/24 at 9:28 the surveyor observed the [US FOIA (B) (6)] on [NJ Ex Order] unit perform hand hygiene. The [US FOIA] turned on the faucet, applied soap and immediately placed her hands under the stream of water without first lathering outside of the water. The [US FOIA] turned off the faucet with her bare hands, then dried her hands with a papertowel.

On 8/21/24 at 8:36 AM, the surveyor observed signage outside room [NJ ex order 26.4b1] which indicated Resident #139 was on [NJ Ex Orde] The surveyor observed the [US FOIA] provide [NJ Ex Order 26.4(b)(1)] care to Resident #139. The [US FOIA] turned on the faucet, applied soap to her hands, and immediately placed her hands under the stream of running water without lathering or applying friction outside of the stream of water. The [US FOIA] dried her hands

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and used the same paper towel to turn off the faucet. The [US FOIA] provided NJ ex order 26.4b1 per the physician's order. During the treatment the surveyor observed the [US FOIA] performed hand hygiene at three different times. The [US FOIA] applied soap to her hands and immediately placed them under the stream of water without lathering, dried her hands and used the same paper towel to turn off the faucet.

On 8/21/24 at that same time the surveyor discussed the above observations and concerns with the [US FOIA]. The [US FOIA (B)] acknowledged that she should have performed hand hygiene by lathering her hands outside the stream of running water for at least 20 seconds and should have used a clean paper towel to turn off the faucet. The [US FOIA] stated that she didn't wash her hands properly because she was nervous.

A review of the Hand Hygiene policy and procedure, dated as Revised 9/10/23 revealed...the facility considers hand hygiene the primary means to prevent the spread of infections...Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...
" Before and after entering isolation precaution settings.
" Before and after eating or handling food (hand washing with soap and water)
" Before and after assisting a resident with meals

Procedure:

Vigorously lather hands with soap and rub them together, creating friction to all surfaces for at

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least 20 seconds...rinse hands thoroughly...dry hands with paper towels and then turn off faucets with a clean, dry paper towel.

Using Alcohol-Based Hand Rubs (ABHR)...apply product to palm of hand and rub hands together, cover all surfaces of hands and fingers until hands are dry.

The facility's Enhanced Barrier Precaution Policy dated as revised 3/26/24 revealed ...the EBP program is a tool to help control the spread of colonized Multidrug-resistant organisms (MDROs) infections. The facility will use the EBP on all nursing home residents with wounds and indwelling medical devices. These residents are at increased risk for acquisition of and colonization with MDROs ...staff shall be adequately trained in the various aspects of EBP to ensure appropriate decision-making in various clinical situations ...

On 8/21/24 at 11:33 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the staff should perform hand hygiene between residents using ABHR or washing their hands following the proper procedure...turn on the faucet, wet hands, apply soap and lather outside the stream of water for 20-30 seconds, rinse hands, dry hands and use a new paper towel to turn off the faucet. The US FOIA further stated that staff and visitors should sanitize their hands before entering and when exiting the room of a resident who is on NJ Ex Orde

On 8/21/24 at 1:51 PM, the surveyor discussed the above observations and concerns with the US FOIA (B) (6) and US FOIA (B) (6) who acknowledged that hand

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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 880	Continued From page 24 hygiene should be performed according to CDC regulations including before entering and exiting a resident's room who is on [NJ Ex Orde] No further information was provided.	F 880		
F 883 SS=D	NJAC 8:39 - 19.4(a); (n) Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		9/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING _____ B. WING _____	C 08/26/2024

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F 883	Continued From page 25 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure Resident #114 NJ ex order 26.4b1 [redacted] according to the current Centers for Disease and Control Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations. This deficient practice was identified for one (1) of five (5) residents reviewed for NJ Ex Order 26.4(b)(1). The deficient practice was evidenced by the following:	F 883	ELEMENT ONE - Corrective Action All Licensed staff and attending physicians were informed of the CDC recommendations for the NJ Ex Order 26.4(b)(1) [redacted]. Resident #114 NJ ex order 26.4b1 [redacted] per recommendations. All education material was delivered to residents and family of CDC recommendations for Pneumococcal vaccinations and offered the latest vaccine as required.	

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F 883	Continued From page 26 Reference: A review of the CDC's Advisory Committee on Immunization Practices (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 2/13/23, included the following. The CDC recommends routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults 65 years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccination history is unknown ... A review of the facility's policy for Pneumococcal Vaccine dated/reviewed 9/10/23, included the following: Policy Statement: All residents will be offered Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections (e.g. pneumonia). Under Policy Interpretation and Implementation subsection 7 reflected that Administration of the pneumococcal vaccination or revaccination will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination. A review of the facility's policy for Vaccination of Residents dated 9/10/23, included the following under Policy Interpretation and Implementation. All new residents shall be assessed for current vaccination status upon admission. If the resident receives a vaccination, at least the following information shall be documented in the resident's medical record: site of administration, date of administration, lot number of the vaccine (located on the vial), expiration date (located on the vial), and name of the person administering the vaccine. Inquiries concerning the policy should be referred to the Infection Preventionist or the Administrator.	F 883	ELEMENT TWO - Identification of at Risk Residents All residents have the potential to be affected by this practice. An audit of all residents in the facility was conducted relating to the administration of the proper Pneumococcal vaccine. No other residents were found to have received this vaccine. The policy was immediately updated to reflect the current standards of administration for Pneumococcal vaccination based on CDC recommendations for standards of practice. ELEMENT THREE- Systemic Changes Nursing and provider physicians were provided with the most up to date recommendations for Pneumococcal vaccine administration. The ICP team and administrative nursing staff were educated that if a physician recommends administration of a vaccine outside of the current CDC recommendations for standards of practice, the Medical Director and Director of Nursing should be notified immediately for corrective action. ELEMENT FOUR - Quality Assurance The ICP team will conduct a monthly audit for the next four months to ensure that each resident has received the proper vaccine administration. The results of the audits shall be acted upon immediately and reported to the Director of Nursing. Trend analysis will be completed and the findings will be reported by the Director of Nursing at the quarterly Quality Assurance Performance Improvement committee for	

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F 883	Continued From page 27 On 8/14/24 at 12:08 PM, a surveyor observed Resident #114 NJ ex order 26.4b1 by a US FOIA (B) (6). The resident stated that they NJ ex order 26.4b1 The resident stated that NJ ex order 26.4b1 The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #114. According to the Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ ex order 26.4 NJ ex order 26.4b1 Resident #114's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ ex out 15 which indicated the resident's NJ ex order 26.4b1. Further review of the qMDS dated NJ ex order 26.4b, under section NJ Ex Order 26.4(b)(Is the resident's NJ ex order 26.4b1 ? The response was marked NJ E which reflected NJ ex orde A review of the electronic Medical Record (eMR) reflected Resident #114 had received NJ ex order 26.4b NJ ex order 26.4b1 Additionally, the eMR did not reflect historical information of prior	F 883	action as appropriate	

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NJ Ex Order 26.4(b)(1) received in or out of the facility.

A review of the paper-based chart reflected an undated Permission [request] for NJ Ex Order 26.4(b)(1) [redacted] [administration consent] form. The administration consent form was signed by the resident and did not specify which NJ Ex Order 26.4(b)(1) [redacted] was to be administered.

A review of the resident's NJ Ex Order 26.4(b)(1) Record Sheet, under NJ Ex Order 26.4(b)(1), revealed a blank space for the following: the type of the NJ Ex Order 26.4(b)(1) administered, previously received, site of administration, date of administration, NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) [redacted]), expiration date (NJ Ex Order 26.4(b)(1)), and the name of the person administering the NJ Ex Order 26.4(

A review of the hybrid medical record did not reflect documentation that NJ ex order 26.4b1 was offered to the resident or the rationale for administration of NJ ex order 26.4b1

On 8/21/24 at 11:01 AM, in the presence of the survey team, the US FOIA (B) (6) US FOIA (B) (6) US FOIA (B) (6) stated that she participated with the NJ Ex Order 26.4(b)(1) activities for the facility and identified that the policy on hand was the most recent NJ Ex Order 26.4(b)(1) policy.

On 8/21/24 at 11:33 AM, during an interview with the surveyor, the US FOIA (B) stated that before every NJ Ex Order 26.4(b)(1) during QAPI (Quality Assurance and Performance Improvement) meetings, the NJ Ex Order 26.4(b)(1) doctor, the pharmacy, the US FOIA (B and U.S. FOIA (b) (6) discussed NJ Ex Order 26.4(b)(1) for the residents using the recommendation from the

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CDC. "We (the [U.S. FOIA (b)], the US FOIA (B) (6), the US FOIA (B) (6) and the US FOIA (B) (6) [NJ Ex Order 26.4(b)(1)] sat down and reviewed the [NJ Ex Order 26.4(b)(1)] for each new admission". The documentation of the [NJ Ex Order 26.4(b)(1)] was hybrid and contained the type of [NJ Ex Order 26.4] given, the lot number, site of administration and the date the [NJ Ex Order 26.4] was administered in the facility. The surveyor asked why the policy did not reflect the current CDC and the ACIP recommendations for the NJ Ex Order 26.4(b)(1). The [U.S.] had no response.

On 8/21/24 at 1:53 PM, in the presence of the survey team, the [US FOIA (B)] and the [US FOIA (B)], the surveyor discussed the concern regarding Resident #114 who was not offered NJ Ex Order 26.4(b)(1) according to the current Centers for Disease and Control Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations.

On 8/22/24 at 10:35 AM, during an interview with the surveyor, the [US FOIA (B)] stated that the policy was updated after surveyor inquiry to reflect the current NJ Ex Order 26.4(b)(1) recommendation. The [US FOIA (B)] also stated that [NJ Ex Order 26.4(b)(1)] was administered to Resident #114 because that was what the physician ordered. The surveyor asked the [US FOIA (B)] why there were no documentations made by the staff on the resident's hybrid medical record of the communication made to the physician regarding the current CDC recommendation for NJ Ex Order 26.4(b)(1) and the physician's rationale for choosing [NJ ex order 26.4b1], which was not in line with the current CDC recommendation for a resident who was over 65 years old who had no

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documented history of prior [NJ Ex Order 26.4(b)(1)] [redacted]. The [US FOIA (b)] [redacted] stated moving forward that they will document that the current CDC ACIP recommendations were communicated to the physician.

On 8/22/24 at 10:53 AM, during an interview with the survey team, the physician stated that [NJ ex order 26.4b1] [redacted] was still pertinent and can administer [NJ ex order 26.4] [redacted] as the following dose.

A review of the provided facility policy, Charting and Documentation dated/reviewed on 3/7/24, under policy statement reflected: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.

No further information was provided.

N.J.A.C. 8:39-19.4 (i)

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S 000	Initial Comments Complaint NJ # 160185, 165258, 164918 THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY 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: Complaint NJ # 160185, 165258, 164918 Based on observation, interview, and review of pertinent facility documentation, 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. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER	S 560	ELEMENT ONE - Corrective Action A staffing analysis was completed to identify, by shift, the minimum amount of direct6 care staff and licensed nursing staff required by regulatory requirements to meet the care needs of the residents based on the daily census. The staffing schedule was reviewed by the Director of Nursing with the staffing coordinators to identify, by shift, the required number of staff.	9/13/24

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

Electronically Signed | 09/11/24

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S 560	Continued From page 1 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of	S 560	* Agencies are contacted to fill vacant Direct Care CNA positions while the facility advertises for new staff. * Facility staff are offered bonuses for picking up extra shifts * Facility continues to run on-line ads for staff * Facility offers sign-on Bonuses * Facility offers referral bonuses to staff to attract new employees * Interviews are being conducted on a daily basis as applicants apply *The staffing coordinator reviews on a daily, weekly, monthly basis, the staffing schedules with the Director of Nursing to assure staffing levels meet the regulatory requirements and to offer extra shifts to cover, in advance, vacation and days off. ELEMENT TWO - Identification of at Risk Residents All residents have the potential to be affected by this practice ELEMENT THREE - Systemic Changes The Director of Nursing, together with the Assistant Directors of Nursing, will review staffing daily and weekly to ensure that all resources have been used to staff the facility in accordance with State Mandates. Agencies will be sent all staffing needs as well as to cover call outs. * The facility continues to work with a recruiter, to partner with CNA schools, to employ the use of digital media to staff the facility in accordance with regulatory mandates.	

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S 560	Continued From page 2 required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the week of Complaint staffing from 10/23/2022 to 10/29/2022. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in total staff for residents on 1 of 7 evening shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -10/23/22 had 30 CNAs for 466 residents on the day shift, required at least 58 CNAs. -10/24/22 had 32 CNAs for 466 residents on the day shift, required at least 58 CNAs. -10/25/22 had 45 CNAs for 466 residents on the day shift, required at least 58 CNAs. -10/26/22 had 41 CNAs for 466 residents on the day shift, required at least 58 CNAs.	S 560	* The administration will continue the weekly meetings with the staffing committee and will conduct salary analysis and will implement creative strategies to attact new staff. * The staffing committee includes frontline staff and mangers who will work to identify ways that the facility can attract new employees. The recommendations are shared with the Regional and Corporate staff for review and implementation. * Incentive programs are in place to retain and attract staff. ELEMENT FOUR - Quality Assurance The Human Resource (HR) Department will receive weekly notices from the Director of Nursing as to the current staffing needs of the Nursing Department. On a monthly basis, the HR Department will provide the Administrator with an analysis of the number of new employees that have been hired. The Director of Nursing and the Administrator will communicate this information at the quarterly Quality Assurance Performance Improvement Committee for action and recommendations as appropriate	

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S 560	Continued From page 3 -10/27/22 had 47 CNAs for 466 residents on the day shift, required at least 58 CNAs. -10/27/22 had 46 total staff for 466 residents on the evening shift, required at least 47 total staff. -10/27/22 had 22 CNAs to 46 total staff on the evening shift, required at least 23 CNAs. -10/28/22 had 36 CNAs for 470 residents on the day shift, required at least 59 CNAs. -10/29/22 had 35 CNAs for 470 residents on the day shift, required at least 59 CNAs. For the week of Complaint staffing from 12/11/2022 to 12/17/22, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -12/11/22 had 43 CNAs for 476 residents on the day shift, required at least 59 CNAs. -12/12/22 had 47 CNAs for 474 residents on the day shift, required at least 59 CNAs. -12/13/22 had 46 CNAs for 471 residents on the day shift, required at least 59 CNAs. -12/14/22 had 45 CNAs for 471 residents on the day shift, required at least 59 CNAs. -12/15/22 had 45 CNAs for 471 residents on the day shift, required at least 59 CNAs. -12/16/22 had 47 CNAs for 466 residents on the day shift, required at least 58 CNAs.	S 560		

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S 560	Continued From page 4 -12/17/22 had 25 CNAs for 466 residents on the day shift, required at least 58 CNAs. For the week of Complaint staffing from 06/11/2023 to 06/17/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 evening shifts as follows: -06/11/23 had 25 CNAs for 457 residents on the day shift, required at least 57 CNAs. -06/11/23 had 28 total staff for 457 residents on the evening shift, required at least 33 total staff. -06/12/23 had 38 CNAs for 457 residents on the day shift, required at least 57 CNAs. -06/13/23 had 42 CNAs for 457 residents on the day shift, required at least 57 CNAs. -06/14/23 had 41 CNAs for 457 residents on the day shift, required at least 57 CNAs. -06/15/23 had 39 CNAs for 463 residents on the day shift, required at least 58 CNAs. -06/16/23 had 41 CNAs for 463 residents on the day shift, required at least 58 CNAs. -06/17/23 had 28 CNAs for 463 residents on the day shift, required at least 58 CNAs. For the 2 weeks of staffing prior to survey from	S 560		

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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) COMPLETE DATE
S 560	Continued From page 5 07/28/2024 to 08/10/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 2 of 14 evening shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -07/28/24 had 16 CNAs for 516 residents on the day shift, required at least 64 CNAs. -07/28/24 had 49 total staff for 516 residents on the evening shift, required at least 52 total staff. -07/28/24 had 21 CNAs to 49 total staff on the evening shift, required at least 24 CNAs. -07/28/24 had 35 total staff for 516 residents on the overnight shift, required at least 37 total staff. -07/29/24 had 25 CNAs for 516 residents on the day shift, required at least 64 CNAs. -07/30/24 had 29 CNAs for 516 residents on the day shift, required at least 64 CNAs. -07/31/24 had 34 CNAs for 514 residents on the day shift, required at least 64 CNAs. -08/01/24 had 31 CNAs for 510 residents on the day shift, required at least 64 CNAs. -08/02/24 had 27 CNAs for 510 residents on the day shift, required at least 64 CNAs. -08/03/24 had 24 CNAs for 510 residents on the day shift, required at least 64 CNAs. -08/04/24 had 23 CNAs for 510 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061409	A. BUILDING: _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
S 560	Continued From page 6 day shift, required at least 64 CNAs. -08/04/24 had 50 total staff for 510 residents on the evening shift, required at least 51 total staff. -08/05/24 had 29 CNAs for 510 residents on the day shift, required at least 64 CNAs. -08/06/24 had 31 CNAs for 510 residents on the day shift, required at least 64 CNAs. -08/07/24 had 40 CNAs for 511 residents on the day shift, required at least 64 CNAs. -08/08/24 had 31 CNAs for 511 residents on the day shift, required at least 64 CNAs. -08/09/24 had 35 CNAs for 511 residents on the day shift, required at least 64 CNAs. -08/10/24 had 32 CNAs for 511 residents on the day shift, required at least 64 CNAs. On 8/22/24 at 2:00 PM, the surveyor discussed the staffing ratios concerns with the Director of Nursing, who stated they were aware of the staffing ratio criteria.	S 560		
S2460	8:39-31.8(c)(8) Mandatory Physical Environment (c) All residents shall have, in their rooms: 8. Night lights;	S2460		9/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061409	A. BUILDING: _____ B. WING _____	C 08/26/2024

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S2460	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/26/24 in the presence of the Regional Director of Plant Operations (RDPO) and the Director of Plant Maintenance, it was determined that the facility failed to provide night lights in all the facility's resident rooms. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation of the residents rooms from 11:25 AM to 2:05 PM, revealed there were no night lights present in 35 of the 35 observed rooms. In an interview at the time, the DPM and RDPO confirmed the observations. In an interview at 12:58 PM, the RDPO stated that there were no night lights in the resident's rooms in this building. The Administrator was informed of the findings at the Life Safety Code exit conference at 3:20 PM.	S2460	ELEMENT ONE - Corrective Action The Maintenance Department staff checked all resident rooms to ensure that night lights were functioning as designed. ELEMENT TWO - Iddentification of at Risk Residents All residents have the potential to be affected by this practice. ELEMENT THREE - Systemic Changes The NJ Ex Order 26.4b1 and staff were educatted regarding monitoring of night lights in resident rooms ELEMENT FOUR - Quality Assurance Every quarter for one year, the Maintenance Director or Designee will randomly check night lights in resident rooms to ensure that night lights are functioning as designed. The information will be entered on to a log and the results will be presented at the quarterly Quality Assurance Performance Improvement committee for consideration	

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
315249 Y1	A. Building B. Wing Y2	10/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	499 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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 F0658	Correction	ID Prefix F0755	Correction	ID Prefix F0880	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	09/13/2024	LSC	09/13/2024	LSC	09/13/2024
ID Prefix F0883	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(d)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/13/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/26/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061409	A. Building B. Wing	10/2/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	499 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/13/2024	ID Prefix S2460 Reg. # 8:39-31.8(c)(8) LSC	Correction Completed 09/30/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/26/2024	☐ 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
	315249	A. BUILDING **01, 02** B. WING _____	**08/26/2024**

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LINCOLN PARK CARE CENTER	**499 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/22/24, 8/23/24 and 8/26/24. Lincoln Park Care Center 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. The Lincoln Park Care Center (LPCC) facility, building 01 is a 3-story building that was built in 1987. It is composed of Type II protected construction. The facility is divided into 22- smoke zones. The generator is 350 KW. The generator does approximately 35 % of the building. The facility has 547 certified beds. At the time of survey the census was 516. The facility is attached to a second building, the JDT building. The first floor and second floor of the LPCC building connect to the basement and lower level of the JDT building respectively. There is a 2 hour fire wall separating the building on both attaching floors.	K 000		
K 000	INITIAL COMMENTS	K 000		

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

Electronically Signed | 09/11/2024

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 000	Continued From page 1 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/22/24, 8/23/24 and 8/26/24, and the JDT Rehab facility 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. The JDT Rehab facility, building 02 is a 4-story building with basement that was built in 2009. It is composed of Type II protected construction. The facility is divided into 12 - smoke zones. The generator is 350 KW and is shared with the Lincoln Park Care Center (LPCC) building. The JDT Rehab facility is attached to a second building, the LPCC building. The first floor and second floor of the LPCC building connect to the basement and lower level of the JDT building respectively. There is a 2 hour fire wall separating the building on both attaching floors.	K 000		
K 281 SS=E	Illumination of Means of Egress 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 observations and interview on	K 281	It is the practice of the facility to ensure	9/30/24

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K 281	Continued From page 2 08/26/2024 in the presence of the US FOIA (B) (6) and US FOIA (B) (6) US FOIA (B) (6), it was determined that the facility failed to provide exit discharge lighting in accordance with NFPA 101:2012 edition, Section 7.8, 7.8.1.4 and 19.2.8. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:37 PM, revealed that there was 1 bulb in the exit discharge lighting fixture installed outside the 1 West Wing exterior exit and there was not another light source provided in the area. In an interview at the time, the US FOIA (B) and US FOIA (B) (6) confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference at 3:20 PM. NJAC 8:39-31.2(e)	K 281	that all egress paths are properly illuminated 1. The facility has replaced the 1 West exit discharge path lights with dual bulbs or LED fixtures. 2. All remaining egress path lightrs have been inspected and found to contain dual bulb fixtures. Fixtures have been tested and are in full operation. All resident areas are free from hazard abnd all systems are operating as designed. 3. Education is completed with Maintenance staff to confirm proper function and maintenance of all egress path lighting. 4. Every quarter for one year, the Maintenance Director or designee will review random exit path lights for function. Findings will be entered on a log and will be presented quaterly to the Quality Assurance erformance Improvement Committee.	
K 324 SS=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: * 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	K 324		9/30/24

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K 324	Continued From page 3 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 and interview on 8/26/24 in the presence of the US FOIA (B) (6) [redacted] and US FOIA (B) (6) [redacted] it was determined that the facility failed to provide the required instructional signage above the Class K portable fire extinguishers in accordance with the requirements of NFPA 101: 2012 edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 edition, Section 5.5.5.3(a). This deficient practice had the potential to affect all residents and was evidenced by the following: At 11:25 AM during the kitchen tour, the surveyor observed two K-type fire extinguishers that did not have the required instructional placard indicating: "Warning in case of appliance fire, use this extinguisher only after fixed suppression system has been activated." In an interview at the time, the US FOIA (B) and US FOIA (B) (	K 324	It is the practice of the facility to ensure that cooking facilities suppression devices have proper signage 1. We have installed a K-Type Fire Extinguisher sign with operation instructions and time of use information. 2. All other fire extinguishers have been inspected for proper signage and all comply. All resident areas are free from hazard and all systems are operating as designed. 3. Education is completed with Maintenance staff to confirm proper signage placement. 4. Every quarter for one year, the Maintenance Director or designee will randomly review areas for signage. This information will be entered on a log and will be presented to	

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K 324	Continued From page 4 confirmed the observation. The US FOIA (B) (6) was informed of the deficient practice at the Life Safety Code exit conference at 3:20 PM. NJAC 8:39-31.2(e)	K 324	the QAPI Committee	
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 observations, interview and record review on 8/22/24, 8/23/24 and 8/26/24 in the presence of the US FOIA (B) (6) and US FOIA (B) (6), it was determined the facility failed to ensure smoke detection sensitivity testing of the smoke detectors were completed every alternate year in accordance with NFPA 70: 2011 Edition and NFPA 72 National Fire Alarm and Signaling Code: 2010 Edition, Section 14.4.5.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: Record review on 8/22/24 between 9:33 AM and 12:00 PM of the facility's last 3 fire alarm system inspection and testing reports dated 6/14/24, 12/11/23 and 6/14/23 provided by the US FOIA (B),	K 345	It is the practice of the facility to have proper testing and reporting of the Fire Alarm System. 1. The facility's fire alarm company has performed the sensitivity testing on the addressable fire alarm system and all are within the required sensitivity levels. 2. All testing and maintenance paperwork was rechecked on 9/6/24 and found to comply. All resident areas are free from hazard and all systems are operating as designed. 3. Education is completed with Maintenance staff to confirem proper repairs on paperwork once deficiencies	9/30/24

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K 345	Continued From page 5 revealed the reports had no reference to smoke detector sensitivity testing. No other documents were provided. In an interview on 8/22/24 at 3:20 PM, surveyor asked the U.S. FOIA (b) (6) for a written record of the last fire alarm sensitivity testing along with other documents. No documents were provided. In an interview at 3:20 PM on 8/26/24 during the Life Safety Code exit conference, the US FOIA (B) (6) stated the fire alarm service company did not perform the sensitivity testing. At the same time, the US FOIA (B) confirmed the finding. Observations on 8/23/24 and 8/26/24, revealed smoke detectors were located in resident rooms (JDT), corridors, common areas, offices and other concealed areas throughout the buildings. The US FOIA (B) (6) was informed of the deficient practice at the Life Safety Code exit conference on 8/26/2024 at 3:20 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	are found. 4. Every quarter for one year, the Maintenance Director or Designee will review paperwork for proper paperwork and deficiency free reporting. This information will be entered on to a log and will be presented at the Quarterly Quality Assurance Performance Improvement committee meeting	
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.	K 353		9/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING **01, 02** B. WING _____	**08/26/2024**

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K 353	Continued From page 6 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 and interview on 8/26/24 in the presence of the US FOIA (B) (6) US FOIA (B) (6) and US FOIA (B) (6) US FOIA (B) (6), it was determined the facility failed ensure fire sprinkler system sprinkler heads were maintained in accordance with NFPA 101: 2012 edition, Sections 9.7.5, 19.3.5.1 and, NFPA 25: 2011 edition. This deficient practice had the potential to affect all residents and was evidenced by: An observation of Lincoln Park main building between 11:25 AM and 2:05 PM, revealed the following: 1. The fire sprinkler head escutcheon plates were missing on 2 of 3 sprinkler heads in the kitchen freezer and the third sprinkler head and escutcheon plate was corroded. Additionally, 1 sprinkler head in the kitchen walk-in refrigerator had a 1-inch space corroding out around the head in the ceiling. In an interview at the time, the US FOIA (B) (6) and US FOIA (B) confirmed the observations. 2. The 1st floor North dining room ceiling had 2	K 353	It is the practice of the facility to ensure that sprinker heads are free and clear of obstructions. 1. The sprinkler heads in the kitchen freezer have proper escutcheon plates installed free from corrosion, the 1 inch speace around the head has been cleaned and filled. The 1 North dining room escutcheons have been repaired. The ceiling tile in the 1st floor computer room has been replaced. The 3rd floor sprinkler escutcheon have been installed. The 2nd floor corridor escutcheons have been installed. In JDT, the 1 inch space in the 3rd floor utility closet has been sealed. In the laundry sorting room, space has been closed around the sprinkler head. In the corridor ceiling outside the laundry room the escutcheon plate has been installed. 2. All other areas have been checked and sprinklers are free and clear and are	

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	315249	A. BUILDING **01, 02** B. WING _____	**08/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	**499 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(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 353	Continued From page 7 sprinkler escutcheons hanging down 3/4-inch in the center path of the dining room. In an interview at the time, the [redacted] and [redacted] confirmed the observation. 3. In the laundry sorting room, 1 of 6 sprinkler heads had a space around the sprinkler in the ceiling. In the corridor ceiling outside the laundry room door, the escutcheon plate was missing from a sprinkler head. In an interview at the time, the [redacted] and [redacted] confirmed the observations. 4. In the 1st floor computer/ phone room a 2-foot by 2-foot ceiling tile was missing around a sprinkler head preventing the sprinkler from functioning properly, and another 2-foot by 2-foot ceiling tile was missing in the room. In an interview at the time, the [redacted] and [redacted] confirmed the observations. 5. In the 3rd floor recreation offices, the middle office sprinkler escutcheon was missing. In an interview at the time, the [redacted] and [redacted] confirmed the observations. 6. In the 2nd floor corridor, 2 sprinklers were missing escutcheons. One was located by room 205 and one by room 210. There were also 2 sprinkler escutcheons hanging down on there sprinkler, one by room 214 and one by room 215. In an interview at the time, the [redacted] and [redacted] confirmed the observations.	K 353	ready for use. 3. Education has been completed with Maintenance staff regarding proper inspection of sprinkler system and its components. 4. Every quarter for a year, the Maintenance Director or Designee will randomly check sprinkler heads throughout the facility to ensure that they are free from dust, paint, corrosion, or missing components. This information will be eneterd on a log and will be presented at the quarterly QAPI meeting	

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K 353	Continued From page 8 An observation of the JDT building on 8/23/24 at 10:25 AM in the presence of the [redacted], revealed a sprinkler head with a 1-inch space around it in the 3rd floor soiled utility closet. The US FOIA (B) (6) was informed of the deficient practice during the Life Safety Code exit conference at 3:20 PM on 8/26/24. NJAC 8:39-31.2(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	K 363		9/30/24

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K 363	Continued From page 9 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 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 on 8/23/24 and 8/26/24 in the presence of the US FOIA (B) (6) US FOIA (B) (6) and facility staff, it was determined the facility failed to ensure corridor doors resisted the passage of smoke for 20 of 53 doors observed in accordance with NFPA 101: 2012 edition, Sections 8.3.3, 8.5, 19.3.2, 19.3.6.3, 19.3.6.3.3 and NFPA 80: 2010 edition. The deficient practice had the potential to affect all residents and was evidenced by the following: An observation of the Lincoln Park Care Center building on 8/26/24 between 11:25 AM and 2:05 PM in the presence of the US FOIA (B and US FOIA (B) (6) US FOIA (B) (6) revealed the following: 1. The 1st floor boiler room door had no latch on the door hardware and hit the door frame when closed. 2. The 1st floor soiled work room door did not latch because the door strike was stuffed with material preventing it from latching.	K 363	It is the practice of the facility to ensure that smoke, fire and corridor doors will operate as designed. 1. The 1st floor boiler room door latch has been cleared of obstruction and is functioning as designed. The 1st floor soiled utility room door latch has been cleared of obstruction and is functioning as designed. The 1st floor pantry door has been adjusted and is functioning as designed. Resident room 113 door has been adjusted and is functioning as designed. The 1st floor oxygen room door has been adjusted and is functioning as designed. Resident room 104 corridor door has been adjusted and is functioning as designed. 1 West stairwell door has been adjusted and is functioning as designed. The 3rd floor Dutch Door has had an	

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K 363	Continued From page 10 3. The 1st floor pantry room (by the nurses station) corridor door did not close into its frame when held open 90 degrees and released. 4. Resident room 113 door hits its door frame, preventing the door from closing. 5. The 1st floor oxygen room (by the elevators) door did not close into its frame when open to 90 degrees and released. 6. Resident room 104 corridor door hits the floor preventing it from closing. The [redacted] repeated the test with the same results. 7. The stairwell exit door in beginning of 1 West wing was open, not latched and did not close all the way into its frame and latch when opened to 90 degrees and released. 8. The 3rd floor nursing office room 318 Dutch door had a 3/16-inch space between the top and bottom door panels that would allow the passage of smoke. 9. The 3 North wing entrance a storage room (by room 302) contained combustible boxes and papers and the door had no self closing device. 10. The 3rd floor nurses storage room for nursing storage and medical records door did not close all the way. The door stopped 2-inches from its frame when opened to 90 degrees and released. 11. Resident room 307 door hit the top of door frame preventing the door from closing. 12. Resident room 309 door hit the top of door	K 363	astragal and latch to prevent the door fromallowing passage of smoke. Storage room by 302 has had a self closer installed and is functioning as designed. The 3rd floor nurses storage closet has been adjusted and is functioning as designed. Resident room 307 and 309 doors have been adjusted and are functioning as designed. 2. Doors throughout the facility were checked to allow for closure, all resident areas are free from hazard and all systems are operating as designed. 3. Education was completed with Maintenance staff regarding monitoring doors and rating labels to ensure that the function properly. 4. Every quarter for a year, the Maintenance Director of Designee will randomly check doors throughout the facility to ensure that doors fulkly close. This information will be entered on to a log and will be presented at the quarterly QAPI meeting.	

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K 363	Continued From page 11 frame preventing the door from closing. In an interview at the time, the [redacted] and [redacted] confirmed the observations. The US FOIA (B) (6) was informed of the deficient practice during the Life Safety Code exit conference on 8/26/24 at 3:20 PM. NJAC 8:39-31.2(e)	K 363		
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	K 363		9/30/24

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K 363	Continued From page 12 materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 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 on 8/23/24 and 8/26/24 in the presence of the US FOIA (B) (6) US FOIA (B) (6) and facility staff, it was determined the facility failed to ensure corridor doors resist the passage of smoke for 20 of 53 doors observed in accordance with NFPA 101: 2012 edition, Sections 8.3.3, 8.5, 19.3.2, 19.3.6.3, 19.3.6.3.3 and NFPA 80: 2010 edition. The deficient practice had the potential to affect all residents and was evidenced by: An observation of the JDT building on 8/23/24 between 9:10 AM and 12:00 PM in the presence of the US FOIA (B) and US FOIA (B) (6) revealed the following: 1. The basement chemical storage room door did not self-close and latch. 2. The basement rear exit door by chemical storage room was open and stayed in the open position and did not close into its frame. 3. The basement medical records room was composed of a 2 leaf door system. The left leaf	K 363	It is the practice of the facility to ensure smoke, fire and corridor doors will oprate as designed. 1. The basement chemical storage room door latch has been cleared of obstruction and is functioning as designed. The basement rear exit door was adjusted and closes as designed. The basement medical records storage door bolt latch has been repaired to allow for self closing of the closet and is functioning as designed. The basement storage room has had a self closing device installed and is functioning as designed. Resident room doors in rooms 320,308,105, and 113 have been adjusted and are functioning as designed. 3. Education completed with the Maintenance staff regarding monitoring doors and rating labels to ensure	

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K 363	Continued From page 13 had a bolt on top that held the left door leaf in place so the right leaf equipped with a self closing device can close and latch to it. The bolt that held the left leaf in place was not operational and the left leaf did not have an automatic closing device. Both door leaves were open at the time of survey. The medical records storage room had combustible boxes and papers. 4. The basement storage room (by medical supplies) had combustibles stored and the door had no self-closing device. The door hit the door jamb when closed manually. 5. Resident room 320 corridor door hit the door frame and did not close into its frame. 6. Resident room 308 corridor door did not latch when closed into its frame. The US FOIA (B repeated the test with the same results. 7. Resident room 105 corridor door did not latch when closed into its frame. 8. Resident room 113 corridor door did not latch when closed into its frame. The US FOIA (B repeated the test with the same results. In an interview at the time, the US FOIA (B) and US FOIA confirmed the observations. The facility Administrator and US FOIA (B) (6) US FOIA (B) (6) were informed of the deficient practice during the Life Safety Code exit conference on 8/26/24 at 3:20 PM. NJAC 8:39-31.2(e)	K 363	proper closing. 4. Every quarter for one year, the Maintenance Director or Designee will randomly check doors throughout the facility to ensure that doors close properly. The information will be entered on a log and the results will be presented at the quarterly Quality Assurance Oerformance Improvement Committee meeting.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie	K 374		9/30/24

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K 374	Continued From page 14 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/23/24 and 8/26/24 in the presence of the US FOIA (B) (6) US FOIA (B) (6) and facility staff, it was determined that the facility failed to ensure smoke barrier doors closed into their door frame to resist the passage of smoke for 6 of 17 smoke doors observed when released from their hold open devices in accordance with NFPA 101:2012 edition, Section 19.3.6.3, 19.3.6.3.3 to 19.3.6.3.17, 8.5.4 and NFPA 80: 2010 edition. This deficient practice had the potential to affect all resident and was evidenced by the following: An observation of the fire wall door between the JDT building and the Lincoln Park Care Center (LPCC) building on 8/23/24 at 11:45 AM in the presence of the US FOIA (B and US FOIA (B) (6) US FOIA (B) revealed that the fire door did not close into its frame and latch when released from its hold open device. The test was repeated with the	K 374	It is the practice of the facility to ensure that smoke barrier doors are free to close in order to resist smoke passage. 1. All double smoke doors noted in the 2567 have mag locks installed further behind the closer. The mag lock was preventing the doors from sealing into each other. The mag locks have been moved, all doors have been inspected and adjusted for proper closure and smoke tightness. The work has been done and completed 2. All other doors were checked for sealing smoke tight. 3. Education completed with Maintenance staff regarding monitoring doors to remain	

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K 374	Continued From page 15 same results. In an interview at the time, the [redacted] and [redacted] confirmed the observation. An observation of the LPCC Building on 8/26/24 between 11:25 AM and 2:05 PM in the presence of the [redacted] and [redacted] revealed the following: 1. At the 1st floor double smoke doors located at the end of the dining room (separating the dining room from North Hall), the left door leaf did not close all the way into the door frame leaving a half inch space smoke could pass through between the 2 door leaves. In an interview at the time, the [redacted] stated the door leaf is hitting the mag lock preventing it from closing. 2. The double smoke doors located in 1 East Wing had the right door leaf did not close all the way into the door frame leaving a space between the door leaves. 3. The double smoke doors located in 1 South Wing had the door leaves not closing all the way into their proper place in the door frame leaving a space between the door leaves. 4. On the 3rd floor, the double smoke doors located in 3 North Wing had the right door leaf not closing all the way into the door frame leaving a space between the door leaves. 5. On the 3rd floor, the double smoke doors located in South Wing had the door leaves not closing all the way into the door frame leaving a	K 374	smoke tight when closed. 4. Every quarter for one year, the Maintenance Director or Designee will randomly check smoke barrier doors to ensure that doors are closing smoke tight into each other. This information will be entered on to a log and will be presented at the quarterly QAPI meeting	

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K 374	Continued From page 16 space between the door leaves. In an interview at the time, the US FOIA (B) (6) and US FOIA (B) (6) confirmed the observations. The US FOIA (B) (6) stated that it was the same issue with the mag locks preventing the doors from closing all the way and they had to be moved back. During the exit conference on 8/26/24 at 3:20 PM, the US FOIA (B) (6) was informed of the findings. NJAC 8:39-31.2 (e) NFPA 80	K 374		
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by:	K 531		9/30/24

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K 531	Continued From page 17 During record review and interview on 8/26/24, in the presence of the US FOIA (B) (6) US FOIA (B) (6), it was determined that the facility failed to produce a valid certificate of occupancy/compliance for 1 of 2 elevators in the JDT building in accordance with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division and/or AHJ and NFPA 101: 2012 edition, Sections 19.5.3, 9.4, 9.4.2, and 9.4.6. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review at 10:45 AM of the facility's NJ Uniform Construction Code elevator inspection compliance certificates, revealed that 1 of 5 of the elevator certificates for the JDT and Lincoln Park Care Center buildings was a temporary certificate that expired. The temporary certificate was for Device: UPDATE - 02 in the JDT building and was issued on 3/15/24 and expired on 5/5/24. There was no inspection report provided describing what was non compliant. There was no document of repairs completed to correct noncompliance. No further documentation was provided. In an interview at 3:20 PM the US FOIA (B) US FOIA (B) (6) and US FOIA (B) (6) confirmed the record review findings. The US FOIA (B) (6) was informed of the deficient practice at the Life Safety Code exit conference on 8/26/24. NJAC 8:39-31.2(e)	K 531	It is the practice of the facility to ensure elevatoras are inspected and certified for use. 1. The JDT elevator listed with a TCO has been updated with a CO and is filly functional. 2. All elevator paperwork has been reviewed and found to comply. All residents are safe and no hazards are present. 3. Education has been provided to the US FOIA (b)(6) to confirm that proper documentation regarding elevator inspections is maintained. 4. Every quarter for one year, the Maintenace Director or Designee will review documentation for elevator inspections. This information will be entered on to a log and will be pressented at the quarterly Quality Assurancce Performance Improvement Committee.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		9/30/24

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K 918	Continued From page 18 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and 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 observations, record review and interview on 8/22/24, 8/23/24 and 8/26/24 in the	K 918	It is the pratice of the facility to maintain proper generator transfer timess and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING **01, 02** B. WING _____	**08/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	**499 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

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K 918	Continued From page 19 presence of the US FOIA (B) (6) US FOIA (B) , it was determined the facility failed to ensure the time to transfer power from the primary power source to the secondary generator power source was within 10 seconds and the facility failed to provide a remote emergency generator shut off in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Sections 7.3, 7.3.1, 7.3.2, 8.4, 8.4.1, 8.4.2, 8.4.2.3. This deficient practice had the potential to affect all residents and was evidenced by: Record review on 8/22/24 between 10:05 AM and 11:03 AM of the monthly emergency power generator full load test logs for each of the last 12 months from July 2024 to July 2023, revealed the transfer time recorded was 15 seconds for each month the test was conducted. The generator full load tests were conducted on the following months with the following transfer time recorded: -7/30/24, transfer time 15 seconds. -6/28/24, transfer time 15 seconds. -5/31/24, transfer time 15 seconds. -4/29/24, transfer time 15 seconds. -3/27/24, transfer time 15 seconds. -2/29/24, transfer time 15 seconds. -1/31/24, transfer time 15 seconds. -12/31/23, transfer time 15 seconds. -11/23, transfer time 15 seconds. -10/31/23, transfer time 15 seconds. -9/29/23, transfer time 15 seconds. -8/31/23, transfer time 15 seconds. -7/31/23, transfer time 15 seconds. In an interview on 8/26/24 at 3:30 PM, the US FOIA (B)	K 918	remote stop. 1. The facility's emergency generator contractor has adjusted the transfer time on all transfer switches to 3 seconds and has tested functionality on 9/5/2024. The generator remote stop is installed on exterior houssing of exhaust housing. This is remote and located outside of the generator primer as specified in the code. This remote stop button has been inspected by the DOH in the previous survey and found to comly. 2. Maintenance tested the transfer time on 9/6/2024 and documented 3 second transfer. 3. Education completed with Maintenance staff regarding transfer times and logs. 4. Every quarter for one year, the Maintenance Director or Designee will check logs and test monthly for proper documentation. This information will be entered on to a log and will be presented at the quarterly Quality Assurance Performance Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING **01, 02** B. WING _____	**08/26/2024**

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LINCOLN PARK CARE CENTER	**499 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

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K 918	Continued From page 20 confirmed the record review findings. In an observation on 8/23/24 at 12:00 PM, the US FOIA (B) showed the surveyor the emergency power generator's remote shut off switch located on the side of the generator unit. The surveyor identified that the remote emergency shut off switch is not remote from the generator unit. In an interview on 8/26/24, the US FOIA (B) (6) confirmed that the remote emergency shut off switch for the power generator is located on the side of the generator unit. The US FOIA (B) (6), US FOIA (B) (6) were informed of the deficient practices during the Life Safety Code exit conference on 8/26/24 at 3:20 PM. NJAC 8:39-31.2(e) NFPA 99, 110	K 918		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided	K 921		9/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING **01, 02** B. WING _____	**08/26/2024**

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K 921	Continued From page 21 by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/26/24 in the presence of the US FOIA (B) (6) US FOIA (B) (6) and US FOIA (B) (6) [redacted] it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, and 10.5.8. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview at 3:20 PM, the [redacted] stated he did not have an annual inspection report for the PCREE and could not provide a policy or procedures for testing of the equipment or evidence of annual testing and maintenance program for PCREE.	K 921	It is the practice of the facility to maintain proper equipment testing. 1. Maintenance has created a policy and procedure for inspection of all electrical components of PCREE equipment. A sticker and master list will be maintained for annual inspection of PCREE. 2. Maintenance staff will test all equipment for proper function and safety as per specifications. 3. Education was completed with Maintenance staff regarding logs and testing of any patient use equipment. 4. Every quarter for one year, the Maintenance Director or Designee will check logs and test monthly for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING **01, 02** B. WING _____	**08/26/2024**

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K 921	Continued From page 22 The US FOIA (B) (6) was informed of the deficient practice at the Life Safety Code exit conference at 3:20 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	proper documentation. This information will be entered on to a log and will be presented at the quarterly Quality Assurance Performance Improvement committee meeting	

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
315249 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	499 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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 K0281	09/30/2024	LSC K0324	09/30/2024	LSC K0345	09/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	09/30/2024	LSC K0363	09/30/2024	LSC K0374	09/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	09/30/2024	LSC K0921	09/30/2024	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	
8/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ 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
315249 (Y1)	A. Building 02 - REHAB/SUBACUTE B. Wing (Y2)	10/8/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	499 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 09/30/2024	ID Prefix Reg. # NFPA 101 LSC K0531	Correction Completed 09/30/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			