STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	9 RIDGEDALE AVE FLORHAM PARK, NJ 07932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was conducted on behalf of the New Jersey Department of Health. Survey Dates: 08/14/23 through 08/17/23 Survey Census: 32 Sample Size: 17 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION SURVEY.	F 000		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure there was a Registered Nurse (RN) on duty for eight continuous hours per day. This failure had the potential to affect the	F 727	The nursing schedule that was completed for the rest of August and September was immediately reviewed by the Asst Nursing Secretary (who is in charge of staffing) to	9/20/23

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

Electronically Signed | 09/07/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	9 RIDGEDALE AVE FLORHAM PARK, NJ 07932

(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 727	Continued From page 1 residents' assessments, residents' care and treatments for all 32 residents in the facility. Findings include: Review of the facility provided "Daily Staffing" sheets for the weekends in the "Centers for Medicare and Medicaid (CMS)," quarter January, February, and March 2023, triggered on the "Payroll Based Journal (PBJ)" revealed that the facility reported no RN coverage for eight continuous hours on weekends for the following dates: 01/01/23 Sunday -- no RN coverage. 01/08/23 Sunday -- no RN coverage. 01/22/23 Sunday -- no RN coverage. 02/19/23 Sunday -- no RN coverage. 03/05/23 Sunday - no RN coverage. 03/11/23 Saturday - no RN coverage. 03/12/23 Sunday - no RN coverage. 03/19/23 Sunday - no RN coverage. Review of the "Facility Assessment" revised 09/20/22 revealed one to two RNs are required for every 24-hour period. Interview on 08/15/23 at 11:09 AM, the Director of Nursing (DON) revealed that there is always an RN on-call for emergent situations, questions, order writing, but the on-call RN does not come into the facility for an eight hour continuous shift. Interview on 08/15/23 at 11:28 AM, the DON confirmed that the staffing sheets for the days listed above had either the RN marked through, or no RN listed at all. The DON confirmed that there was not a working RN in the facility for eight consecutive hours during that 24-hour period.	F 727	ensure that an RN is scheduled for at least eight consecutive hours a day, seven days per week. All residents have the potential to be affected. Cheshire Home's Asst Nursing Secretary prepares nursing staffing schedules to include an RN for at least eight consecutive hours a day, seven days per week. In addition, an RN is scheduled to be Nurse-On-Call for each shift. To ensure the safety of all residents, the Asst Nursing Secretary will monitor the schedule on a daily basis while looking ahead in the schedule for gaps in RN scheduling. On a weekly basis, the Human Resources Director will review the entire schedule and maintain an RN Monitoring Log of these reviews. In circumstances of unexpected callouts for an RN, the Charge Nurse and Nurse-On-Call will contact other Cheshire RNs or an agency provider to provide an RN to cover. If there are no RNs available, the RN Nurse-On-Call will be required to report into the facility for eight consecutive hours. The Human Resources Director has reviewed and updated staffing policies and has inserviced the Asst Nursing Secretary, Nursing Supervisors, Charge Nurses, and Nurses-On-Call of RN staffing policies. The Human Resources Director will inservice Nursing Supervisors, Charge Nurses, Nurses-On-Call and the Asst Nursing Secretary annually and upon hire.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	9 RIDGEDALE AVE FLORHAM PARK, NJ 07932

(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 727	Continued From page 2 NJAC 8:39-25.2(h)	F 727	The Director of Nursing will review the nursing schedule on a weekly basis to ensure that adequate RN scheduling is maintained and initial the RN Monitoring Logs. The Human Resources Director will maintain inservice and RN Monitoring logs and present them to the QA Committee quarterly. In each of its quarterly meetings, the QA Committee has been addressing the current RN staffing crisis and will continue to actively recruit and hire qualified RNs. In addition, Cheshire Home has submitted an application for a waiver for RN staffing requirements.	
F 755 SS=D	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 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	F 755		9/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	9 RIDGEDALE AVE FLORHAM PARK, NJ 07932

(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 755	Continued From page 3 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 review of facility policy, record review, and staff interviews, the facility failed to ensure medication was consistently available for one (Resident (R)24 of 17 residents reviewed in the sample. NJ Exec Order 26.4b1 was not administered to the resident due to lack of availability of the medications in the facility. Findings include: Review of the facility's policy titled, "Medication System Renewal of Medications" dated revised 02/2019, read, in pertinent part, "Medication shall be renewed in a timely manner to meet residents' needs." Review of R24's "Admission Record." dated NJ Exec Order 26.4b and found in the Electronic Medical Record (EMR) under the "Admissions" Tab, indicated the resident was admitted to the facility on NJ Exec Order 26.4b with diagnoses including NJ Exec Order 26.4b1 [redacted] Review of R24's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b and found in the EMR under the "MDS" tab, indicated a Brief Interview for	F 755	The Nursing Supervisor immediately confirmed availability of NJ Exec Order 26.4b1 in the facility for Resident 24 (R24). The two Nursing Supervisors reviewed all residents prescribed medications to ensure an adequate supply was available. All residents have the potential to be affected. To ensure the safety of all residents, each Med Pass nurse is responsible for ordering medication for a resident from the pharmacy when the last column of the bingo card is started. If a Med Pass nurse is unfamiliar with the Cheshire Home ordering process, the nurse is to notify the Charge Nurse who will assist in placing the order to the pharmacy. All medication ordering will be done before the nurses end of shift. The Inservice Coordinator inserviced each nurse on these procedures. The Assistant Director of Nursing (ADON) will conduct random, bi-monthly reviews of the availability of residents medications, and will maintain a Medication Review Log of these reviews. On a twice per week basis,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	9 RIDGEDALE AVE FLORHAM PARK, NJ 07932

(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 755	Continued From page 4 Mental Status (BIMS) score of [redacted] out of 15 [redacted] The assessment also indicated R24 was receiving both scheduled and non-scheduled (as needed) medications to [redacted] Review of R24's "Pain Management Care Plan," dated [redacted] and found in the EMR under the "Care Plan" tab, indicated the resident was receiving [redacted] related to [redacted] to his [redacted] as well as for [redacted] related to his history of [redacted]. Goals included, "[R24] will be free of any [redacted] or adverse side effects from [redacted] through the review date;" and "[R24] will not have an interruptions inn in normal activities due to [redacted] through the review date;" and "[R24] will verbalize adequate [redacted] or ability to cope with [redacted] through the review date." Interventions included, "Administer ANALGESIC [redacted] as ordered by physician." Review of R24's "Order Summary Report," dated [redacted] and found in the EMR under the "Orders" tab, indicated orders for the resident to receive [redacted] by mouth every six hours as needed for [redacted] Review of R24's "Nursing Progress Notes," dated [redacted] 1:17 PM and found in the EMR under the "Notes" tab, read, "Resident verbalized having [redacted] He declined all [redacted] not available on hand. (Physician) made aware."	F 755	the Nursing Supervisors will review each residents prescriptions to ensure validity and maintain a Prescription Expiration Log of these reviews. The Inservice Coordinator will inservice each nurse on the medication ordering process annually and upon hire. The Director of Nursing has reviewed and updated medication administration and ordering policies and procedures. The ADON will review and maintain the Prescription Expiration Logs, and submit them to the QA Committee quarterly. In addition, the ADON will submit the Medication Review Logs to the QA Committee quarterly. The Inservice Coordinator will maintain inservice logs and present them to the QA Committee at each quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	9 RIDGEDALE AVE FLORHAM PARK, NJ 07932

(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 755	Continued From page 5	F 755		

Review of R24's "Nursing Progress Notes," dated NJ Exec Order 26.4b 1:30 PM and found in the EMR under the "Notes" tab, read, "Resident verbalized 'NJ Exec [redacted] Verbalized with resident that (Physician) was made aware and waiting for pharmacy delivery. He continued to refuse all NJ Exec Order 26.4b1 [redacted]. He verbalized the same and drove away in his NJ Exec Order 2 wheelchair into the hallway."

Review of R24's "Nursing Progress Notes," dated NJ Exec Order 26.4b 2:14 PM and found in the EMR under the "Notes" tab, read, "Author received a call-in nursing office. Caller verbalized he was resident's father. Caller verbalized "...my son is being abused and neclected (sic). How do you know when pharmacy is going to delivery (sic) the medication." Author verbalized the situation has been followed up and that MD [medical doctor] is made aware."

Review of R24's "Medication Administration Record (MAR)," dated NJ Exec Order 26.4b and found in the EMR under the "Orders" tab, confirmed R24 was not able to receive his requested NJ Exec Order 26.4b1 as it was not available in the facility. The MAR indicated the resident's reported NJ Exec Order 26.4b1 [redacted]

During an interview with R24 on NJ Exec Order 26.4b at 2:27 PM, he stated, "They (the facility) run out of my NJ Exec Order 26.4b1. Last was (approximately) two weeks ago. They (staff) tell me it's (the resident's NJ Exec Order 26.4b1 out at the pharmacy or it's my insurance (causing the medication to be unavailable) but I think they (staff) are ordering it (the resident's NJ Exec Order 26.4b1) too late.

During an interview with the Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE FLORHAM PARK, NJ 07932**

(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 755	Continued From page 6 (DON) on 08/15/23 at 2:00 PM, she confirmed the facility did have problems with not having controlled medication available for residents. She stated her expectation was all medication was to be ordered in a timely manner so that it would be available for administration. The DON confirmed her expectation was residents were to be given as needed (prn) medication as ordered to control reported [NJ Exec O] NJAC 8:39-29.2(d)	F 755		

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
315383 Y1	A. Building B. Wing Y2	9/26/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	9 RIDGEDALE AVE FLORHAM PARK, NJ 07932

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 F0727	Correction	ID Prefix F0755	Correction	ID Prefix	Correction
Reg. # 483.35(b)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. #	Completed
LSC	09/20/2023	LSC	09/20/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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?
8/18/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health from 08/17/23 through 08/18/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/17/23 through 08/18/23 and was found to be in non-compliance 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. Cheshire Home is a one-story building that was built in 1981 with an addition that was built in the late 1990s. It is composed of Type II protected construction. The generator does approximately 100 % of the building as per the Administrator. The current occupied beds are 32 of 35.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type	K 161		9/20/23

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

Electronically Signed | 09/07/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(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 161	Continued From page 1 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure a Life Safety Floor Plan was provided to identify the location of smoke barriers and construction type in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 19.1.6.1. This deficient practice had the	K 161	The Maintenance Director updated the Cheshire Home floor plan to include the building construction type in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 19.1.6.1 and to identify the location of the smoke barriers. See	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(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 161	Continued From page 2 potential to affect 32 residents. Findings include: A document review of the facility floor plan provided by the Administrator revealed the floor plan did not include the facility construction type or location of the smoke barriers. During an interview on 08/17/23 at 12:25 PM the Administrator stated he did not have a floor plan that indicated the construction type or the location of the smoke barriers. NJAC 8:39-31.2(e)	K 161	Attachment 1. All residents and staff have the potential to be affected. To ensure the safety of all residents and staff, the Maintenance Director appropriately updated all floor plans that are displayed throughout the building and in the Cheshire Home Emergency Operation Plan. The Social Services Director gave a copy of the updated Cheshire Home floor plan to each resident in the facility. Each resident acknowledged receipt in writing. The floor plan was added to the Admission Packet given to each new resident and reviewed upon admission by the Admissions Director. The Inservice Coordinator inserviced all staff on the updated floor plan. The Inservice Coordinator will inservice all staff on the updated floor plan upon hire, annually, and as needed. The Inservice Coordinator will maintain inservice logs. The Social Services Director will distribute floor plans to each resident annually and upon any changes made to the floor plan and maintain written receipts of acknowledgement. The Inservice Coordinator will present inservice logs to the QA Committee at each quarterly meeting. The Social Services Director will provide records of receipt to the QA Committee at each quarterly meeting.	
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101	K 331		9/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(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 331	Continued From page 3 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure interior wall finishes had a flame spread rating in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 19.3.3. This deficient practice had the potential to affect 32 residents. Findings include: An observation on 08/17/23 at 1:51 PM revealed the interior wall, located in the exit hallway near the Boiler Room, was covered with wood paneling with an unknown flame spread rating. During an interview at the time of the observation, the Administrator stated he did not know the flame spread rating and was unable to provide documentation to indicate the rating. NJAC 8:39-31.2(e)	K 331	The Maintenance Director and his assistant removed and replaced the interior wall surface, located in the exit hallway near the Boiler Room, with Type X fire rated gypsum drywall that is 5/8-inch thick to ensure the safety of all residents and staff (see photo of corridor in attachment 7). All residents and staff have the potential to be affected. To ensure the safety of all residents and staff, an inspection of the building was completed by the Maintenance Director and certified that all other interior walls were rated in accordance with NFPA 101. Any construction material to be used in the facility, including drywall, in the future will be inspected by the Maintenance Director to ensure compliance with NFPA 101 prior to installation. Cheshire Home became a member of the NFPA to ensure receipt of new and updated regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(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 331	Continued From page 4	K 331	The Maintenance Director and his staff will attend NFPA accredited training on at least a yearly basis to ensure compliance with current regulations. All new construction installations will be logged by the Maintenance Director and submitted to the QA Committee quarterly. The Maintenance Director will report on training received to the QA Committee annually.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure in an area not continuously occupied, smoke detection was installed at the main fire alarm control panel in accordance NFPA	K 341	A smoke detection unit was installed at the main fire alarm control panel, located in the fire alarm room. The smoke detection system was installed by a	9/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 5 101 (Life Safety Code) 2012 Edition, Section 9.6.1.8. This deficient practice had the potential to affect 32 residents. Findings include: AN observation on 08/17/23 at 1:16 PM revealed the main fire alarm control panel, located in the fire alarm room, was not equipped with smoke detection. During an interview at the time of the observation, the Assistant Maintenance Director confirmed the room was not equipped with smoke detection. NJAC 8:39-31.2(e) NFPA 70, 72	K 341	licensed electrician on 8/25/2023. See Attachment 2. All residents and staff have the potential to be affected. To ensure the safety of all residents and staff, the Maintenance Director inspected all other areas in the facility that are not continuously occupied to ensure a smoke detection system was present. An inspection of the entire facility was done by the local Fire Safety Inspector to determine that all non-continuously occupied areas are adequately protected with appropriate smoke detection systems. See attachment 3. The newly added smoke detection system was added to the list of regularly tested smoke detection systems that are tested by a licensed electrician twice per year. The electrician will maintain logs of testing and submit a copy of each log to the Maintenance Director. The Maintenance Director will review any future construction or building modification with the local Fire Safety Inspector to determine the need for additional smoke detection systems. The Maintenance Director will maintain logs of these meetings. The Inservice Coordinator inserviced all staff on the newly added smoke detection system. The Inservice Coordinator inservices all staff upon hire and annually on fire safety. The Inservice Coordinator will maintain inservice logs. The Maintenance Director will present the letter of confirmation of compliance from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 6	K 341	the local Fire Safety Inspector to the QA Committee at the quarterly meeting. The Maintenance Director will submit logs of meetings with the local Fire Safety Inspector and testing of smoke detection systems to the QA Committee at each quarterly meeting. The Inservice Coordinator will present inservice logs to the QA Committee at each quarterly meeting.	
K 371 SS=F	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on document review, observations, and interview, the facility failed to ensure smoke barriers were provided to form at least two smoke compartments in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 19.3.7.1. This deficient practice had the potential to affect 32 residents. Findings include: A document review of the facility floor plan	K 371	The Administrator employed the services of a licensed architect and licensed building contractor. The architect confirmed the existence of two smoke compartments within the building. Attached is a letter and diagram, dated August 30, 2023, provided and endorsed by the architect (see Attachment 4). In the same letter, the architect also confirmed that all doors and openings to the living and dining areas were equipped	9/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(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 371	Continued From page 7 provided by the Administrator revealed the floor plan did not include the location of the smoke barriers. An observation on 08/17/23 at 1:07 PM revealed a set of double doors located between the facility and a newer addition. The doors were held open with magnetic hold open devices which indicated they were part of a smoke barrier wall. An observation of the area above the doors and the wall revealed the wall did not extend from outside wall to outside wall and had numerous unsealed openings and penetrations. During an interview on 08/17/23 at 1:40 PM, the Administrator stated areas had been sealed above the ceiling tiles at the living and dining areas and the doors closed upon activation of the fire alarm. An observation on 08/17/23 at 1:45 PM of the area above the doors and the walls, located at the living and dining area,s revealed the walls did not extend from outside wall to outside wall and had numerous unsealed openings and penetrations. Two of five doors were equipped with magnetic hold open devices. NJAC 8:39-31.1(c), 31.2(e)	K 371	with a magnetic hold open, electronic release and multipoint hold open, or roll-down shutters that are activated by the building□s fire alarm system. The Maintenance Director and Maintenance Assistant checked for and sealed any openings or penetrations that existed to compromise the existing smoke barriers. All residents and staff have the potential to be affected. To ensure the safety of all residents and staff, the Maintenance Director completed a thorough inspection of the smoke barrier walls of the smoke compartment for openings and penetrations. All findings were properly sealed. To ensure no penetrations exist, the Maintenance Director contracted the services of a Fire Protection Company to do an independent inspection of the smoke barrier walls of the smoke compartment. A letter certified by the Fire Protection Company confirmed smoke compartment walls to be free from any unsealed openings and/or penetrations. See Attachment 5. The Maintenance Director updated the Cheshire Home floor plan to identify the location of the smoke barriers. The Social Services Director gave a copy of the updated Cheshire Home floor plan to each resident in the facility. Each resident acknowledged receipt in writing. The floor plan was added to the Admission Packet given to each new resident and reviewed upon admission by the Admissions Director. Any future work done that involves the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(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 371	Continued From page 8	K 371	smoke barriers will be inspected by the Maintenance Director to ensure there are no openings or penetrations. All such work will be logged on the Smoke Barrier Log by the Maintenance Director and submitted to the QA Committee quarterly. The Inservice Coordinator inserviced all staff members on the smoke compartments and updated floor plan. The Inservice Coordinator will inservice all staff upon hire, annually, and as needed on smoke compartments and the floor plan, and maintain inservice logs. The Social Services Director will distribute floor plans to each resident annually and upon any changes made to the floor plan and maintain written receipts of acknowledgement. The Inservice Coordinator will submit the inservice logs to the QA Committee at each quarterly meeting. The Social Services Director will provide records of receipt to the QA Committee at each quarterly meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		9/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(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 918	Continued From page 9 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Emergency Power Supply (EPS) was equipped with a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the EPS where so installed, or elsewhere on the premises where the prime mover is located outside the building in accordance with NFPA 110 Emergency and Standby Systems (2010 Edition) 5.6.5.6. This deficient practice had the potential to affect 32 residents. Findings include:	K 918	The Maintenance Director contracted a licensed electrician to install a remote manual stop station for the Emergency Power Supply (EPS) on the outside of the generator transfer switch, which is located near an exit door of the building. See Attachment 6 and photos in Attachment 7. All residents and staff have the potential to be affected. To ensure the safety of all residents and staff, two signs were installed identifying the remote manual stop station for the EPS. One sign was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(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 918	Continued From page 10 An observation on 08/17/23 at 1:31 PM revealed there was not a remote manual stop station installed for the EPS on the premises where the prime mover was located outside of the building. At the time of the observation of the EPS, the Assistant Maintenance Director confirmed the EPS did not have a remote manual stop station. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	installed immediately above the remote manual stop station on the outside of the generator transfer switch and another sign inside the building near the exit door close to the remote manual stop station. The Maintenance Director updated the floor plan to identify the remote manual stop station. The Social Services Director gave a copy of the updated Cheshire Home floor plan to each resident in the facility. Each resident acknowledged receipt in writing. The floor plan was added to the Admission Packet given to each new resident and reviewed upon admission by the Admissions Director. The Inservice Coordinator inserviced all staff on the remote manual stop for the EPS and updated floor plan. The Inservice Coordinator will inservice all staff upon hire, annually, and as needed. The Inservice Coordinator will maintain inservice logs. The Maintenance Director will test the remote manual stop once per month and maintain a Remote Manual Stop Test Log. The Social Services Director will distribute floor plans to each resident annually and upon any changes made to the floor plan and maintain written receipts of acknowledgement. The Maintenance Director will submit the Remote Manual Stop Test Logs to the QA Committee at each quarterly meeting. The Inservice Coordinator will submit inservice logs to the QA Committee quarterly. The Social Services Director will provide records of receipt to the QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	**9 RIDGEDALE AVE** **FLORHAM PARK, NJ 07932**

(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 918	Continued From page 11	K 918	Committee at each quarterly 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
315383 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/26/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESHIRE HOME	9 RIDGEDALE AVE FLORHAM PARK, NJ 07932

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 K0161	09/20/2023	LSC K0331	09/20/2023	LSC K0341	09/20/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0371	09/20/2023	LSC K0918	09/20/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO