STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315356	A. BUILDING _____ B. WING _____	C 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED NURSING AT FELLOWSHIP VILLAGE	**8000 FELLOWSHIP DRIVE BASKING RIDGE, NJ 07920**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint NJ #: 174415, 173702 Survey Date: 10/30/24 to 11/4/24 Census: 58 Sample: 15 + 3 closed records THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES.	F 000		

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

Electronically Signed | 11/18/2024

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

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations from 10/30/24 through 10/31/24. The facility was found to be not in compliance with 42 CFR 483.73.	E 000		
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the	E 030		11/22/24

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

Electronically Signed | 11/18/2024

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED NURSING AT FELLOWSHIP VILLAGE	**8000 FELLOWSHIP DRIVE** **BASKING RIDGE, NJ 07920**

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E 030	Continued From page 1 following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication	E 030		

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E 030	Continued From page 2 plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complied with Federal, State, and Local laws. This deficient practice had the potential to affect all staff and 58 residents. Findings include: A review of the facility's "Emergency Preparedness Plan [EPP]" revealed the plan lacked a communication plan which contained contact information for staff, service provider entities, residents' physicians, other facilities, and volunteers. During an interview on 10/31/24 at 10:40 AM, the US FOIA (b)(6) confirmed the facility was not able to locate the communication plan during the	E 030	Residents affected by the deficient practice 1) Included in the emergency preparededness commmunication plan that complies with Federal, State, and local laws, is a communication plan that has been updated to include the following: A) Names and contact information of staff B)Entities providing services under arrangement C) Residents' physicians D) Other facilities that are part of our organization. E) Volunteers The plan will be reviewed and updated at least annually.	

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E 030	Continued From page 3 survey. NJAC 8:39-31.2(e)	E 030	Identifying other Residents who could be affected by the deficient practice. 2) All other sections of the emergency plan were reviewed to ensure that all sections were in compliance with Federal, State, and local laws. Measures or systemic changes to ensure that deficiencies will not recur. 3) Every quarter the communications plan will be reviewed by the Administrator, Plant Operatons, and the Executive Director to ensure that the plan remains up to date. All changes to the staff, other entities, physicians, volunteers, and other entities will be updated. Monitoring the continued effectiveness of systemic change 4) The communications plan will be submitted at every quarterly QAPI meeting for review to ensure that all content is updated and included. Any concerns will be addressed.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations from 10/30/24 through 10/31/24 and the 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	K 000		

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K 000	Continued From page 4 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Skilled Nursing at Fellowship is located inside a three-story building constructed in 1998 with renovations and a 13-bed addition constructed in 2018 with plan approval in June of 2016. It is composed of Type II (111) construction and is divided into ten smoke compartments. The facility has a complete automatic sprinkler system (wet with antifreeze). The bi-fuel (diesel, natural gas) generator provides emergency power to 100% of the building. The number of occupied beds was 58 out of 67. The skilled nursing facility is located on the first floor (Wing 101), second floor (wing 203), and third floor (wing 303). The piped in medical gas system (oxygen and vacuum) is supplied to the first floor (Wing 101). Access controlled locks are located throughout the facility at designated exits. The facility does not have life support equipment.	K 000		
K 342 SS=F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2,	K 342		12/13/24

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K 342	Continued From page 5 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a manual means to activate the fire alarm system in the path of egress as required by NFPA 101 (Life Safety Code) 2012 Edition, Section 9.6.2.3 and 19.3.4.2.1. This deficient practice had the potential to affect 20 residents. Findings include: An observation on 10/30/24 at 11:14 AM revealed the designated exit from the skilled nursing facility, located on the third floor (Wing 303) near the Day Room, was not provided with a means to manually activate the fire alarm system in the natural path of travel. The closest pull station in the healthcare facility was located by the stairwell at the other end of the wing and required traveling through two smoke compartments to reach it. A manual means of activating the fire alarm system was also not provided at the Nurses' Station or a continuously monitored location. The door at the Day Room was equipped with access-controlled magnetic locks, impeding access to manual pull stations located on the other side of the door in the assisted living facility. The fire alarm system was currently being replaced with a new system. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and stated the facility was not aware that a manual means to activate the fire alarm was required at the designated exit. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 342	Residents affected by the deficient practice 1) A new pull station will be installed in the front of the household NJ Exec O door to provide a manual means to activate the fire alarm system. This has been completed as of 12/13. I have attached pictures of the new pull stations and a letter from our Fire Company attesting to the work that has been done. Identifying other Residents who could be affected by the deficient practice. 2) The other areas of the skilled unit will be reviewed to determine the location of the pull stations. Any area requiring a pull station will be addressed. Pull stations have been installed in these areas. I have attached pictures in the attachments that support this and the fire company has sent a letter stating that the work has been done. This is in the attachments. Measures or systemic changes to ensure that deficiencies will not recur. 3) The plant operations team as part of their preventative program will make formal weekly rounds to make sure that pull stations are in place in accordance with NFPA 101. During monthly inspections by NJ exec order 2 and the inspections done by the Fire Marshal and Fire protection company, this issue will be part	

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K 342	Continued From page 6	K 342	of the inspection for these parties to review. Any concerns or issues will be addressed. Monitoring the continued effectiveness of systemic change. 4) This issue will be presented by Plant Ops at the quarterly QAPI meeting and any further results from discussion will be reviewed.	
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 observation, record review, and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 9.6.1.3. This deficient practice had the potential to affect all 58 residents. Findings include: Observations on 10/30/24 at 1:30 PM and 7:19 PM of the fire alarm control panel revealed the following active trouble signals:	K 345	Residents affected by the deficient practice. 1) All residents in the skilled area are protected by the new [NJ Exec Order 26.4b1] Fire alarm system that is operating according to the requirements of NFPA 70 and National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. The skilled area fire alarm system is working properly as communicated by the Managing Director of the new fire alarm system to the surveyor. The fire marshal is aware of the change in systems. The	12/13/24

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K 345	Continued From page 7 "Healthcare Ground Fault Booster 1 2nd Floor 10/26/24 11:31 PM" During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and revealed the facility was aware of the trouble signal. According to the US FOIA (b)(6), the facility was currently replacing the fire alarm system and that was why there were trouble signals at the control panel. A review of the facility's untitled fire alarm inspection reports revealed annual tests of the entire system and sensitivity tests of the smoke detectors had not been conducted in the previous two years prior to the survey. The most recent report was from 2022 and indicated over 600 trouble signals were indicated at the fire alarm control panel. During an interview conducted at the time of the observation, the US FOIA (b)(6) confirmed the finding and revealed the facility could not locate any other documentation indicating the deficiencies in the report had been corrected and that the fire alarm system had been tested since then. During an interview on 10/30/24 at 5:05 PM, the NJ Exec Order 26.4b1 stated a complete test of the fire alarm system had not been conducted since 2022 due to the renovations and replacing of the entire fire alarm system. Only partial tests were conducted as new devices were installed. Documentation was requested in writing from the fire alarm company stating the system was functional was requested. As a precaution, the facility implemented a fire watch policy on	K 345	reason for the trouble signal "Healthcare Ground Fault Booster 1 2nd Floor will be corrected once the completion of the installation of the new fire alarm system. The testing includes the functionality of the devices in every portion on each Fire Alarm Panel reported to central station and to dispatch. This includes the sensitivity test for the smoke detectors. 2) Identifying other Residents who could be affected by the deficient practice. All residents in the skilled area are protected by the new fire alarm system. The fire alarm company sent documentation verifying that the system is functional and has provided the inspection. This testing includes the sensitivity test. 3) Measures or systemic changes to ensure that the deficiencies will not recur. A completed annual inspection will be done by December 6. The Plant Ops Director and Administrator will work with the Managing Director of the fire company to ensure that this is complete. All issues not in compliance will be addressed in a timely fashion. Once the test is conducted including the sensitivity test, this will be sent to the department. 4) Monitoring the continued effectiveness of the systemic changes The Plant Operations Director will submit this report annually at the QAPI meeting. The Excutive Director and the Regional Director for NJ Exec Order 26.4b1 will review this to ensure completion.	

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K 345	Continued From page 8 10/30/24 at 7:35 PM. According to documentation provided by the facility on 10/31/24 at 10:25 AM from the fire alarm installation company, the fire alarm system was functional. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	Please see attachment that shows the actual inspection that was completed	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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, record review, and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection	K 353	Residents affected by the deficient practice 1) The escutcheon plate on the sprinklered head was installed to ensure	12/6/24

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K 353	Continued From page 9 Systems (2011 Edition). This deficient practice had the potential to affect all 58 residents who resided at the facility. Findings include: An observation on 10/30/24 at 1:30 PM of the sprinkler in the Maintenance Shop revealed the escutcheon plate was missing. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and stated the facility was unaware the escutcheon plate was missing prior to the survey. A review of the facility's sprinkler maintenance records revealed the facility failed to provide documentation of weekly inspections of the gauges for the dry sprinkler system, quarterly inspections of the sprinkler system, and three-year trip test for the dry system. According to documentation, the most recent inspection and test of the sprinkler system was conducted in October 2023. The most recent 3-year trip test was conducted in 2020. During an interview on 10/30/24 at 8:30 PM, the US FOIA (b)(6) confirmed the findings and stated the facility was unable to locate documentation of the weekly inspections of the sprinkler gauges, the quarterly inspections, or the annual inspection and test. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	protection of the sprinklered head for proper functioning. All other sprinklered heads were checked and all escutcheon plates were in place. Weekly inspections of the gauges for the dry sprinkler system, quarterly inspections of the sprinkler system, and three year trip test for the dry system will be completed. Identifying other Residents who could be affected by the deficient practice 2) Plant ops team will review in other skilled households to ensure that all the escutcheon plates are in place around the sprinklered heads. All inspections to meet NFPA 25 Standard for inspection, testing and Maintenance of Water-Based Fire Protection Systems (2011 Edition) will be maintained in a timely manner. Measures or systemic changes to ensure that deficiencies will not recur. 3) The escutcheon plates, and the weekly, quarterly, and three year trip test will all become part of the preventative maintenance program to ensure compliance. These inspections will be reviewed monthly by Plant Ops Assistant Director,and the Regional Director of NJ Exec Order 26.4b1 as a check and balance to ensure compliance. Any issues will be addressed immediately. Monitoring the ocntinued effectiveness of systemic changes. 4) These reports will be submitted to the	

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K 353	Continued From page 10	K 353	QAPI committee quarterly for their review. The Administrator, Plant Ops Director and the Regional Director for [NJ Exec Order 26.4b1] will review this as well. Evidence of this work being completed will be sent to the Department including inspection reports and photos of the plate. Please see attachment that shows the three year trip test that was completed	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6.2. This deficient practice had the potential to affect all 58 residents.	K 372	1) Residents affected by the deficient practice Plant Operations reviewed the locations of the smoke penetrations with the surveyor and are sealing all penetrations with fire rated caulking. 2) Identifying other Residents who could	12/13/24

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	315356	A. BUILDING **01** B. WING _____	**11/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED NURSING AT FELLOWSHIP VILLAGE	**8000 FELLOWSHIP DRIVE** **BASKING RIDGE, NJ 07920**

(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 372	Continued From page 11 Findings include: Observations on 10/30/24 at 11:16 AM of the smoke barrier located by the Day Room and the 303 Bath revealed a four-inch unsealed overcut around a group of wires and a two-inch overcut around conduits above the ceiling and won-door. An observation on 10/30/24 at 11:51 AM of the smoke barrier located in the Soiled Utility in 303 revealed a six-inch unsealed overcut around a pipe penetration above the ceiling tile and cabinets. Observations on 10/30/24 at 12:05 PM of the smoke barrier located inside Soiled Utility in 203 revealed a five-inch by eight-inch hole in the wall above the sink and a three-inch overcut around a group of wire penetrations. Observations on 10/30/24 at 12:15 PM of the smoke barrier located in the 203 Corridor by the Bath revealed a six-inch overcut at a conduit penetration and red wire penetration above the ceiling tile. An observation on 10/30/24 at 1:05 PM of the smoke barrier located inside the Linen Room in 101 revealed a two-inch unsealed overcut above the ceiling tile. An observation on 10/30/24 at 1:10 PM of the smoke barrier located by the Elevator at the 101 Entrance revealed an unsealed three-inch hole in the wall above the ceiling. During an interview at the time of the observations, the US FOIA (b)(6)	K 372	be affected by the deficient practice. Plant Ops are including as part of their preventative maintenance program regular inspections in all areas of the skilled household. Any holes that are found will be immediately corrected. 3) Measures or systemic changes to ensure that deficiencies will not recur. Plant Ops will do Weekly walkthrough of skilled areas for 4 weeks and then once per quarter and there will be follow up by Plant Ops once a contractor is in the building to ensure that they have not left holes in these areas. The Corework regional director and Administrator will review these reports on a quarterly basis. Labels of photos and evidence will be provided of the sealant used to ensure it has either elastomeric, intumescent or endothermic caulking properties. 4) Monitoring the continued effectiveness of systemic change. Plant Ops will report this as part of the QAPI presentation on a quarterly basis. Attached is evidence of the work completed. There are pictures of the 6 areas addressed and please see the attachment of the Fire Barrier Sealant with intunescent properties	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315356	A. BUILDING **01** B. WING _____	**11/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED NURSING AT FELLOWSHIP VILLAGE	**8000 FELLOWSHIP DRIVE** **BASKING RIDGE, NJ 07920**

(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 372	Continued From page 12 confirmed the unsealed gaps and penetrations. The US FOIA (b) (6) stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers.	K 372		
K 918 SS=F	NJAC 8:39-31.2(e) 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 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	K 918		11/22/24

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	315356	A. BUILDING **01** B. WING _____	**11/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED NURSING AT FELLOWSHIP VILLAGE	**8000 FELLOWSHIP DRIVE** **BASKING RIDGE, NJ 07920**

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K 918	Continued From page 13 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 record review and interview, the facility failed to maintain the generator in accordance with NFPA 110 Emergency Power and Standby Power Systems (2010 Edition), Section 8. This deficient practice had the potential to affect all 58 residents. Findings include: A review of the facility's "Generator Inspection & Testing Records," provided by the facility revealed weekly inspections of the generator were not conducted between 01/10/24 and 01/24/24, between 03/21/24 and 04/10/24, and between 05/01/24 and 05/22/24. During an interview on 10/30/24 at 3:20 PM, the US FOIA (b)(6) confirmed the findings and stated the facility was unaware of the missing documentation of the weekly generator inspections. NJAC 8:39-31.2(g). 31.2(g) NFPA 99, 110	K 918	1) Residents affected by the deficient practice The Plant Operations team will ensure that the generator log book is maintained for both weekly and monthly inspections. 2) Identifying other Residents who could be affected by the deficient practice Regular work orders are tracked in a ticketing system (NJ Exec Order 26.4b1). All dates will be entered into the log book. The generators will be inspected and a reconciliation will be done between the log books and the inspections to ensure that they match . 3) Measures or systemic changes to ensure that deficiencies will not recur Reports will be pulled from the NJ Exec Order 26.4b1 system to ensure that all inspections were done. Generator reports will be reviewed by the Administrator once a month along with the Plant Ops Director and NJ Exec Order 26.4b1 personnel. 4) Monitoring the continued effectiveness	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315356	A. BUILDING **01** B. WING _____	**11/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED NURSING AT FELLOWSHIP VILLAGE	**8000 FELLOWSHIP DRIVE** **BASKING RIDGE, NJ 07920**

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K 918	Continued From page 14	K 918	of systemic change. Reports will be presented at the quarterly QAPI meetings. Any negative findings will be immmediately acted upon to correct. The results of this will be provided to the Executive Director or designee quarterly.	

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
315356 Y1	A. Building B. Wing Y2	1/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED NURSING AT FELLOWSHIP VILLAGE	8000 FELLOWSHIP DRIVE BASKING RIDGE, NJ 07920

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 E0030	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(c)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/22/2024	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	
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?
11/4/2024	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315356 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED NURSING AT FELLOWSHIP VILLAGE	8000 FELLOWSHIP DRIVE BASKING RIDGE, NJ 07920

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0342	12/13/2024	LSC K0345	12/13/2024	LSC K0353	12/06/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0372	12/13/2024	LSC K0918	11/22/2024	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	
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?
11/4/2024	☐ YES ☐ NO