| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315356 | A. BUILDING _____ B. WING _____ | C 07/20/2023 |

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

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| F 000 | INITIAL COMMENTS<br><br>NJ00152263<br>NJ00162461<br>NJ00163830<br>NJ00165262<br><br>Survey Date: 7/20/23<br><br>Census:59<br><br>Sample: 15 + 3 closed records<br><br>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. | F 000 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>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.<br><br>§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.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- | F 755 | | 8/18/23 |

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

Electronically Signed | 08/04/2023

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.

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| F 755 | Continued From page 1<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure that a medication was administered according to physician orders and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in 1 (one) of 7 (seven) residents during the medication observation pass (Resident #46).<br><br>This deficient practice was evidenced by the following:<br><br>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 and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by | F 755 | Plan of Correction<br>F 755 483.45 (a)(b)(1)-(3) Pharmacy Services<br>• Residents affected by deficient practice.<br><br>o There were no residents affected on the specific date noted. The surveyor stopped the Registered Nurse prior to administering the crushed *Ex Order 26. 4B1* [redacted] to resident #46.<br><br>o The RN immediately received written counseling with education by the Director of Nursing about the RN's failure to follow the physician's order stating, "*Ex Order 26. 4B1* [redacted] (1) tablet by mouth two times daily for *Ex Order 26. 4B1* with food" for resident #46 as demonstrated by the RN crushing the *Ex Order 26. 4B1* [redacted]. In addition, the RN did not comply with the cautionary label on the medication package that stated that | |

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| F 755 | Continued From page 2<br>a licensed or otherwise legally authorized physician or dentist."<br><br>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 case finding; 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."<br><br>On 07/12/23 at 9:40 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN#1) in the room of Resident #46. The surveyor observed RN#1 checking the resident's identification bracelet and informing Resident #46 that she will be administering the resident's medications. The surveyor observed the resident in bed and just finished eating breakfast.<br><br>On 07/12/23 at 9:45 AM, the surveyor observed RN#1 preparing to administer five (5) medications to Resident #46 which included *Ex Order 26. 4B1* [redacted], *Ex Order 26. 4B1* [redacted]. The surveyor observed RN #1 prepared the resident's medication and then brought it into Resident #46's room. At that time, Resident #46 | F 755 | *Ex Order 26. 4B1* [redacted] may not be crushed. The RN was counseled about the requirement to first check and subsequently adhere to the physician's medication order and cautionary instructions for administering *Ex Order 26. 4B1* [redacted] and all *Ex Order 26. 4B1* [redacted] per Policy and Procedure; "Sub-acute/Skilled Nursing Household Medication Administration-General Guidelines".<br><br>o Upon completing a root cause analysis of the deficient practice, it was determined that that the RN failed to comply with The Nurse Practice Act for the State of New Jersey which states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, 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." The RN did not prioritize and fulfill her responsibility while observed by the surveyor to check and adhere to the physician's order and medication cautionary for *Ex Order 26. 4B1* [redacted], and, as a result, crushed the tablet to address the swallowing concern expressed by resident #46. The RN along with other nurse staff had received routinely, planned education by the licensed, Pharmacist Consultant on May | |

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| F 755 | Continued From page 3<br>asked RN#1 if she could split the Ex Order 26. 4B1 in half since it was too big to swallow. The surveyor observed RN#1 take the medications to the medication cart and then scooped out the Ex Order 26. 4B1 and proceeded to crush Ex Order 26. 4B1 . After crushing the tablet, RN#1 placed it into a medication cup and then added apple sauce. RN#1 then added the remaining tablets into the medication cup containing the crushed Ex Order 26. 4B1 and apple sauce. The surveyor stopped RN#1 prior to administering the medications and asked RN#1 if she can bring the medication cup outside of the resident's room.<br><br>At that time, the surveyor interviewed RN#1 who stated that she crushed the Ex Order 26. 4B1 because the resident complained that they were unable to swallow the whole tablet. The surveyor asked RN#1 if it was recommended to crush an Ex Order 26. 4B1 . RN#1 stated that an Ex Order 26. 4B1 should not be crushed and that when the resident complained that they were unable to swallow the tablet that she should have held the medication and contacted the physician for a recommendation.<br><br>The surveyor reviewed the medical record for Resident # 46.<br><br>A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to Ex Order 26. 4B1 | F 755 | 16, 2023, called "Medication Pass In-service" that addressed that Ex Order 26. 4B1 must not be crushed and physician/APN/PA orders must be checked and adhered to along with the medication cautionary for correct medication administration. If there are discrepancies the physician/APN/PA must be contacted. There were no other variables causing the deficient practice. Upon interview, the RN subsequently stated to the surveyor that "the Ex Order 26. 4B1 should not be crushed and when the resident complained that the tablet was too large to swallow, that she should have held the medication and contacted the physician for a recommendation."<br><br>o Plans to address the underlying issues include:<br><br>All nurses are receiving an in-service from the Director of Nursing (DON) or Nurse Supervisor about the requirement under their scope of licensure and Fellowship Village Policy and Procedure; "Sub-acute/Skilled Nursing Household Medication Administration-General Guidelines" to administer Ex Order 26. 4B1 and all Ex Order 26. 4B1 as ordered by the physician/APN/PA (or dentist) which includes the process of first checking and subsequently following the physician/APN/PA order and the medication cautionary on the package. If | |

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| F 755 | Continued From page 4<br>Ex Order 26. 4B1 .<br><br>A review of the Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated NJ Exec. Order 26:4.b, reflected that the resident's Ex Order 26. 4B1 for daily decision-making score was Ex Ord out of 15, which indicated that the resident was Ex Order 26. 4B1 .<br><br>A review of the July 2023 Physician Order Sheet (POS) revealed no physician order (PO) for medications NJ Exec. Order 26:4.b.1.<br><br>Further review of the July 2023 POS revealed a PO dated NJ Exec. Order 26, for Ex Order 26. 4B1 give (1) tablet by mouth two times daily for Ex Order 26. 4B1 with food.<br><br>A review of the July 2023 Electronic Medication Administration Record (eMAR) revealed an order dated NJ Exec. Order 26, for Ex Order 26. 4B1 Ex Order 26. 4B1 give (1) tablet by mouth two times daily for Ex Order 26. 4B1 with food.<br>.<br>A review of the Manufacturer's specifications for Ex Order 26. 4B1 revealed the following: "To take each dose without crushing, chewing, or sucking the tablet. If those patients are having difficulty swallowing whole tablets, they may try one of the following alternate methods of administration:<br>a. Break the tablet in half and take each half separately with a glass of water.<br>b. Prepare an Ex Order 26. 4B1 suspension as follows:<br><br>1. Place the whole tablet (s) in approximately 1/2 | F 755 | there are discrepancies between the physician/APN/PA order and medication cautionary, the nurse must contact the physician/APN/PA and the Pharmacy for the medication manufacturer's guidelines for administration, and accordingly obtain an appropriate medication order. If a resident reports difficulty swallowing the Ex Order 26. 4B1 , a new order will be obtained from the physician that includes instructions for administering the medication per manufacturer's guidelines, to facilitate ease of swallowing.<br><br>o All physician/APN/PA medication orders that specify that the medication may be crushed will be reviewed by the DON or nurse designee to ensure Ex Order 26. 4B1 and all other Ex Order 26. 4B1 orders do not include a provision for crushing.<br><br>o All medication bingo-cards of Ex Order 26. 4B1 including Ex Order 26. 4B1 will be checked for the presence of a cautionary label that informs the nurse not to crush the tablet.<br><br>• Identify other Residents who could be affected by the deficient practice.<br><br>o All residents with physician/APN/PA orders for Ex Order 26. 4B1 and other oral, Ex Order 26. 4B1 may be affected.<br><br>• Measures or systemic changes to ensure that the deficiencies will not recur. | |

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| F 755 | Continued From page 5<br>glass of water (4-fluid ounces).<br>2. Allow approximately 2 minutes for the tablet (s) to disintegrate.<br>3. Stir for about half a minute after the tablet (s) has disintegrated.<br>4. Swirl the suspension and consume the entire contents of the glass immediately.<br>5. Add another 1 fluid ounce of water, swirl and consume immediately<br>6. Then, add an additional 1 fluid ounce of water, swirl, and consume immediately."<br><br>On 07/12/23 at 10:20 AM, the surveyor interviewed the RN/UM#2 Unit Manager (UM) who stated that the resident's *Ex Order 26. 4B1* [redacted] should not have been crushed because it was an *Ex Order 26. 4B1* [redacted]. The RN/UM#2 further stated that the facility called the resident's physician, and the order was changed after surveyor inquiry.<br><br>On 7/13/23 at 1:30 PM, the surveyor discussed the above observations and findings with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON).<br><br>There was no additional information provided.<br><br>A review of the facility's policy for "sub-acute/Skilled Nursing Household Medication Administration-General Guidelines" dated 6/25/19, which was provided by the DON included the following, "Cautionary information on the MAR or medication package/container (e.g., "don't crush, shake well, give food on an empty stomach", etc.) is checked and adhered to prior to medication administration. Nurse personnel must contact the physician/Physician assistant (PA) and Advance Nurse Practitioner (APN) when | F 755 | o A notice will be added to the *Ex Order 26. 4B1* [redacted] of each resident stating, "Each medication package must be checked for cautionary information which must be adhered to for medication administration. If a discrepancy exists between the cautionary information and medication order, the physician/APN/PA must be contacted for clarification."<br><br>o A laminated sign will be posted as a prompter to all nurses at each medication cart and medication room stating, *Ex Order 26. 4B1* [redacted] including "*Ex Order 26. 4B1* [redacted] must not be crushed. The physician/APN/PA order along with the medication cautionary must be checked first and adhered to for each medication administration. For any discrepancies, consult with the Pharmacy for manufacturer's administration guidelines and the physician/APN/PA to clarify the medication order accordingly. If the resident reports difficulty swallowing the tablet, contact the physician/APN/PA to obtain a medication order with appropriate instructions per manufacturer's administration guidelines that addresses the swallowing concern."<br><br>• Monitoring the continued effectiveness of the systemic change<br><br>o The Director of Nursing (DON) or Nurse Supervisor designee with the assistance of the licensed, Pharmacist Consultant will maintain a current list of residents who have physicians/APN/PA | |

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| F 755 | Continued From page 6<br>there is a discrepancy based on the written order or for any questions related to cautionary information."<br><br>NJAC 8:39-11.2 (b), 29.2 (d) | F 755 | orders for [redacted] and other [redacted] and complete a weekly medication pass competency of two nurses that addresses that they are demonstrating the correct knowledge and practice of thoroughly checking and adhering to physician/APN/PA orders and medication cautionaries for not crushing [redacted] including [redacted] tablets prior to administration.<br>The competency will also evaluate the nurse's demonstration of knowledge, and practice, as applicable, about contacting the physician/APN/PA if a resident reports difficulty with swallowing an [redacted] to obtain a new order with instructions for administration of the [redacted] per the manufacturer's administration guidelines. The competency evaluation for each nurse across all three shifts will be completed on an alternating basis.<br><br>o Any non-compliance observed during the medication pass competency checks will be addressed immediately through halting medication administration, providing re-education regarding checking and adhering to physician's orders and medication cautionaries for not crushing [redacted] per Policy and Procedure; "Sub-acute/Skilled Nursing Household Medication Administration-General Guidelines" and repeating the competency prior to any medication administration to ensure | |

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| F 755 | Continued From page 7 | F 755 | demonstration of full compliance. The DON will also repeat a competency evaluation of the nurse within a week or the next time the nurse is working if later than a week, to ensure demonstration of full compliance.<br><br>o The Pharmacist Consultant will also continue to complete at least annual medication pass competencies of all nurses which includes a requirement for the nurse to demonstrate the correct knowledge and practice of checking and adhering to physician/APN/PA orders and medication cautionaries for not crushing *Ex Order 26. 4B1* [redacted] including *Ex Order 26. 4B1* [redacted], and contacting the physician/APN/PA for an appropriate order per manufacturer's administration guidelines for a resident who reports a swallowing difficulty.<br><br>o The results of the weekly medication pass competency evaluations will be reported to the QAPI Committee on a quarterly basis by the DON. The weekly competency evaluations will be discontinued if 100% compliance by all nurses is achieved for six (6) consecutive months.<br><br>• Plan of Correction completion date for this deficiency<br><br>o The completion date for this deficiency, Plan of Correction is August 18, 2023. | |

New Jersey Department of Health

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| S 000 | Initial Comments<br><br>The facility is 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<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint # NJ00152263<br><br>Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was identified for CNA staffing for residents on 9 of 14-day shifts from 1/30/22 through 2/12/22 and 1 of 14-day shifts from 6/25/2023 to 7/12/2023.<br><br>The findings were as follows:<br><br>Reference: New Jersey Department of Health (DOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) | S 560 | Plan of Correction<br>S 560 8:39-5.1(a) Mandatory Access to Care<br>1) Residents affected by deficient practice.<br><br>The residents that were affected on the specific dates noted were given a choice to receive their shower on the 3-11 shift or they could receive it the next day. Other team members, including the staff nurses, and the household coordinator who is a C.N.A. helped out with breakfast and lunch during the scheduled mealtimes. The speech therapist also assisted with meals. | 8/15/23 |

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

Electronically Signed | 08/04/23

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| S 560 | Continued From page 1<br>30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/2021:<br><br>One Certified Nurse Aide (CNA) to every eight residents for the day shift.<br><br>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and<br><br>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.<br><br>A review of the "Nursing Staffing Report" completed by the facility for the weeks of 1/30/22 through 2/12/22 and 6/25/23 through 7/12/23, revealed the staffing to resident ratios did not meet the minimum requirement for one CNA to eight residents for the day shift as documented below:<br><br>-01/31/22 had 5 CNAs for 46 residents on the day shift, required 6 CNAs.<br>-02/02/22 had 5 CNAs for 45 residents on the day shift, required 6 CNAs.<br>-02/03/22 had 5 CNAs for 45 residents on the day shift, required 6 CNAs.<br>-02/04/22 had 4 CNAs for 45 residents on the day shift, required 6 CNAs.<br>-02/05/22 had 4 CNAs for 47 residents on the day | S 560 | The root cause for not having enough team members is that team members are looking to work at those places offering the highest rates and allowing the team members to determine when they want to work and not committing to specific days. On a temporary basis, we offered overtime and agencies to supplement our team members to meet the minimums. Management has determined that each day the staffing will be reviewed by the scheduler and Director of Nursing to determine how many residents we can admit. The actual number of residents in the skilled beds on these days cited was 20 fewer than capacity based upon staffing.<br><br>Plans to address these underlying issues include:<br>• Substantial increase in pay including weekend, evening, and night differentials.<br>• Creating a flexible pay system by offering non-benefit higher rates and creative hours to accommodate staffing needs.<br>• Referral bonuses for referring other team members.<br>• Offering to pay for transportation and housing.<br>• Offering tuition reimbursement<br>• On weekends Administrators are available to assist as needed as part of a Leader on Duty program.<br>• We have met with legislators in our area to lobby them for support including having a single certification for C.N.A.'s and CHHA's.<br><br>2) Identify other Residents who could be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061425 | A. BUILDING: _____ B. WING _____ | C 07/20/2023 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| S 560 | Continued From page 2<br>shift, required 6 CNAs.<br>-02/06/22 had 5 CNAs for 45 residents on the day shift, required 6 CNAs.<br>-02/07/22 had 5 CNAs for 45 residents on the day shift, required 6 CNAs.<br>-02/09/22 had 5 CNAs for 45 residents on the day shift, required 6 CNAs.<br>-02/11/22 had 5 CNAs for 46 residents on the day shift, required 6 CNAs.<br><br>-07/08/23 had 5 CNAs for 54 residents on the day shift, required 7 CNAs.<br><br>On 7/19/23 at 10:54 AM, the surveyor interviewed the Staffing Coordinator who acknowledged the state's minimum staffing ratios for each shift. She further stated that the facility is meeting the minimum ratios at times and that the facility keeps the census low so that "we can but we have call outs and I try my best to replace as much as possible."<br><br>On 7/20/23 at 11:08 AM, the surveyor team met with the administrative staff and discussed the above concerns.<br><br>There was no additional information provided. | S 560 | affected by the deficient practice.<br><br>• All residents currently residing in the skilled area have been identified as having the potential to be affected by not meeting the minimums. Upon reviewing evenings and nights we have been able to meet the minimum ratios. On those days that need additional help, the Nurse Supervisor, nurses, the household coordinator who is a C.N.A., and speech therapist will assist within their scope of practice to address residents' care needs.<br>• All shifts including evenings and nights are reviewed to ensure that the minimum of 1 direct care staff member for every 10 residents is met in the evenings and 1 direct care staff member for every 14 residents is met at night.<br>• Shift differentials and weekend differentials have been implemented to increase the pay for those team members who wish to work in the evenings and nights.<br>• Management has determined that each day the staffing will be reviewed by the scheduler and Director of Nursing to determine the number of residents we can admit to support compliance with the staffing ratios.<br><br>3) Measures or systemic changes to ensure that the deficiencies will not recur.<br><br>• Increased recruiting efforts have been implemented by Human Resources including working closely with C.N.A. schools to enhance communication with potential C.N.A.'s.<br>• Human Resources conducts exit | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SKILLED NURSING AT FELLOWSHIP VILLAGE | 8000 FELLOWSHIP DRIVE BASKING RIDGE, NJ 07920 |

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|---|---|---|---|---|
| S 560 | Continued From page 3 | S 560 | interviews with any existing C.N.A. looking to leave. Based upon the reasons, Human Resources will work with the C.N.A. to find a way to retain them.<br>• Nurse leadership has been trained and in-service to ensure that the working environment is supportive for our current C.N.A.'s, including providing supplies needed, and arranging manageable work assignments that are fair.<br>• Measures for turnover have been carefully reviewed and goals have been implemented to reduce turnover.<br>• Rewards and awards recognition of C.N.A.'s have been implemented with gift cards, free meals, closed parking spots, and a $250 bonus for team members who are recognized by supervisors and or residents monthly.<br>• Upper management including the President and CEO are in complete agreement with not having a full capacity census unless there are team members to meet the minimum ratios on all shifts. Our affiliated Hospital, Atlantic Health System, has also been informed and is in support.<br><br>4) Monitoring the continued effectiveness of the systemic change<br><br>• The Administrator on a daily basis is responsible for monitoring that staffing minimums are met and will monitor each day's staffing with the Director of Nursing or Assistant Director of Nursing 72 hours in advance to determine if the staffing ratios are met. If the ratios are not met, measures will be taken by the Director of Nursing and Scheduler to recruit CNAs including offering those not working | |

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

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|---|---|---|---|---|
| S 560 | Continued From page 4 | S 560 | shortened work hours to fill one shift, providing incentives, and overtime, as applicable, and, as a last resort, requesting support from all agencies. The ultimate goal is to exceed these minimums and those numbers are in our budget. The Administrator will monitor that the above staffing enhancement measures are offered on a monthly basis.<br>• The Administrator and Director of Nursing will closely monitor the admission referrals on a daily basis and provide direction to the case manager and Admissions to ensure that they do not bring in more residents than can be cared for per the staffing ratios.<br>• The human resources and scheduler communicate frequently with the Administrator and Director of Nursing to advise about how many trained C.N.A.'s will be available and the start time. The Administrator will monitor for at least weekly communication.<br>• Staffing patterns are provided daily per regulations and submitted to the Department of Health. The Administrator and scheduler review the staffing ratios each morning for compliance. If there are less C.N.A.'s available other team members such as nurses, rehab, and Household Coordinator C.N.A.s will provide assistance to the residents in terms of addressing their ADLs, offering changes in their shower schedule and helping in the dining room as directed by the Director of Nursing. Also, A Nurse will be re-assigned, as needed, to provide ADL support in accordance with residents' plans of care and the Nurse Supervisor will fulfill the assignment of the Nurse. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061425 | A. BUILDING: _____ B. WING _____ | C 07/20/2023 |

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

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|---|---|---|---|---|
| S 560 | Continued From page 5 | S 560 | The Administrator will monitor adherence to this adjustment in staffing support on the days when CNA staffing is needed to meet the ratios.<br>• These interventions are specific to the problem of meeting minimum ratios, measurable, attainable, relevant and time bound.<br><br>• The results of the above monitoring will be reported to the QAPI Committee on a quarterly basis. The monitoring may be discontinued if staffing ratios are met daily for twelve consecutive months.<br><br>5) The completion date for this deficiency is August 15, 2023. | |

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<br>B. Wing Y2 | 9/5/2023 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SKILLED NURSING AT FELLOWSHIP VILLAGE | 8000 FELLOWSHIP DRIVE<br>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 F0755 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 483.45(a)(b)(1)-(3) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 08/18/2023 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 7/20/2023 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 061425 Y1 | A. Building<br>B. Wing Y2 | 9/5/2023 Y3 |

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

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix S0560 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 8:39-5.1(a) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 08/15/2023 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |
|---|---|
| 7/20/2023 | ☐ YES ☐ NO |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 061425 Y1 | A. Building<br>B. Wing Y2 | 9/5/2023 Y3 |

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

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix S0560 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 8:39-5.1(a) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 08/15/2023 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |
|---|---|
| 7/20/2023 | ☐ YES ☐ NO |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315356 | A. BUILDING **01**<br>B. WING _____ | **07/20/2023** |

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

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>The nursing home building construction was stated to be 90's with no current major renovations or noted additions to the Health care center. It is a three (3) story building Type II (222) protected construction and is fully sprinklered. The exterior 600 KW diesel generator does approximately 80% of the building. The facility is divided into 10-smoke zones. The center core open staircase has a fire curtain that protects fire from extending to the upper floors.<br><br>There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life<br><br>The facility has 54 certified beds in ACO currently, The facility has added 13, so now the facility has 67 licensed beds. At the time of the survey the census was 59.<br><br>60 private<br>5 one-bedroom<br>1-semi private (2)<br>67 total | K 000 | | |
| K 111 SS=F | Building Rehabilitation<br>CFR(s): NFPA 101<br><br>Building Rehabilitation<br>Repair, Renovation, Modification, or Reconstruction<br>Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: | K 111 | | 8/11/23 |

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

Electronically Signed | 08/04/2023

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 |
|---|---|---|---|
| | 315356 | A. BUILDING **01**<br>B. WING _____ | **07/20/2023** |

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

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|---|---|---|---|---|
| K 111 | Continued From page 1<br>* Requirements of Chapter 18 and 19<br>* Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6<br>18.1.1.4.3, 19.1.1.4.3, 43.1.2.1<br>Change of Use or Change of Occupancy<br>Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2<br>18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7)<br>Additions<br>Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8.<br>18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 7/13/23, in the presence of the Housekeeping Director (HD) and Maintenance Director from a sister facility (MDSF), it was determined that the facility failed to ensure separation from different licensed wings on each floor of the facility and was provided with a 3/4-hour fire rated door in accordance with the requirements of NFPA 80 and NFPA 101, 2012 Edition, Section 19.1.1.4.3, 19.1.1.4.4, 19.1.3.10, 19.3.2, 19.3.2.1, 19.3.2.1.2 | K 111 | K111<br>1) Residents affected by the deficient practice.<br>All residents in the skilled area are protected by the fire barrier, smoke barrier, and smoke partition system.<br><br>All records will be maintained and will be readily accessible to the surveyor as needed. Household doors will be labeled | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315356 | A. BUILDING **01**<br>B. WING _____ | **07/20/2023** |

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

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| K 111 | Continued From page 2<br>8.4, 8.5, 4.6.10, 4.6.10.1. The deficient practice was observed for 3 of 3 doors by the following:<br><br>At 10:45 AM, the surveyor, HD and MDSF observed on the first floor that the center core of the building contained three (3) separate wings.<br>- Memory Care wing<br>- Assisted Living Wing<br>- Skilled Nursing Household 101<br><br>The entrance door and frame to the Skilled Nursing Household area's on all three (3) floors: identified as Skilled Nursing Household; 101;Skilled Nursing Household 201; and Skilled Nursing Household 301, were observed to not have any required door label's with the rating of the door assemblies.<br><br>The findings were verified by the HD and MDSF, at the time of the observation's the HD and MDSF confirmed the observations that the doors were not provided with any labels indicating a fire resistance rating.<br><br>The building is a three (3) story TYPE II construction and requires a 3/4-hour opening protection rating.<br><br>The Administrator and Corporate staff were informed of the finding at the Life Safety Code exit conference on 7/13/23.<br><br>NJAC 8:39-31.2(e) | K 111 | when required.<br><br>Based upon construction drawings, reviewed, and approved by the New Jersey Department of Community Affairs, Health Care Plan Review Unit, the corridor walls that each of the noted doors are located within are required to be smoke partitions. As per Chapter 7, Section 710 of the 2015 International Building Code, New Jersey Edition, these smoke partitions as well as the doors are not required to have a fire-resistance rating, however the doors shall meet the requirements for a smoke and draft control door assembly tested in accordance with UL 1784. To meet this requirement, each of these doors has fire & smoke gasketing installed, and according to the manufacturer□s product information, these gaskets are tested in accordance with UL 1784 and meet the requirements of NFPA 105.<br>To clarify, the noted doors are entrance doors to Skilled Nursing Households numbered 101, 203 & 303, not 201 & 301.<br><br>Furthermore, one-hour required smoke barrier partitions with accordion-folding fire doors (Won Doors) are located within Households 101, 203, provide the required separation between smoke compartments. These smoke barriers and the folding fire doors are located near the above-mentioned entrance doors, thereby separating the Skilled Nursing Households from the common areas of the facility with rated construction. Skilled Nursing Household 303 is located on the | |

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| K 111 | Continued From page 3 | K 111 | uppermost Third Floor with no direct access or adjacency to the common areas of the facility other than via stairs and an elevator, which are protected with two-rated shaft enclosures, thereby separating the Household from common areas.<br>2) Identifying other Residents who could be affected by the deficient practice.<br><br>All residents in the skilled area are protected by the fire barrier, smoke barrier, and smoke partition system. All of the skilled household doors including 101, 203, and 303 were examined to determine if any of the other doors required additional seals. Each of these doors has fire & smoke gasketing installed and meet the requirement of NFPA 105.<br><br>3) Measures or systemic changes to ensure that deficiencies will not recur. During the quarterly inspections done by the fire marshal, these doors will be inspected to ensure compliance. Any concerns or issues will be reported to our VP of Construction and Senior Director of Plant Operations and will be addressed immediately.<br><br>4) Monitoring the continued effectiveness of systemic change. Plant Operations as part of their Preventive Maintenance rounds will add these doors to ensure compliance. The results of these rounds will be reported quarterly at the QAPI meeting. The Corporate personnel will also make periodic rounds to ensure that we remain | |

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| K 111 | Continued From page 4 | K 111 | in compliance. This will become part of the metrics report measuring and identifying positive or negative outcomes. This report is reviewed by the Executive Director.<br><br>5) The completion date for this deficiency is August 11, 2023. | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review on 7/1/23, in the presence of the Housekeeping Director (HD), it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents in the facility and was evidenced by the findings below:<br><br>At 11:00 AM, the surveyor observed that the old main fire alarm panel located in the corridor fire alarm panel closet was in trouble mode. The facility was installing a new fire alarm panel with another vendor. The new fire alarm annunciator panel was not activated yet. The facility provided | K 345 | K 345-PLAN OF CORRECTION – Fire alarm system testing and maintenance.<br>1) Residents affected by the deficient practice.<br>All residents in the skilled area were protected by the new Honeywell fire alarm system that was 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 and is using the new main fire alarm panel located in the Plant Ops maintenance shop. The old fire alarm system (Simplex) is being converted to a new one (Honeywell) and there is no disruption of | 9/5/23 |

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| K 345 | Continued From page 5<br>a document from the new fire alarm vendor dated 7/13/23, indicating the Healthcare Center fire alarm system was working properly and has adequate coverage.<br><br>The HD provided the most recent fire alarm inspection dated 2/20/23. This inspection was from the old vendor and the document indicated, "cannot inspect report" due to "new competitor panel installed" (not on our inspection contract). The new fire alarm vendor indicated the Healthcare Center fire alarm system was working properly and had adequate coverage, but a complete inspection of the new system was not provided as of the exit date of 7/13/23, until the system was fully functional and the old system was disconnected.<br><br>On 7/12/23 at 1:35 PM, the fire marshal was called to confirm, he was aware of the fire alarm panel and new fire alarm vendor and he stated they were aware of the change and were waiting for the system to be fully completed.<br><br>The Administrator and Corporate staff were informed of the findings at the Life Safety Code Exit Conference on 7/13/23.<br><br>NFPA 70<br>NFPA 72<br>NJAC 8:39-31.2(e)<br>NFPA 101- 2012 edition 9.6.1.3- 9.6.1.5 | K 345 | service as evidenced by the activation of the system during the survey. The fire marshal is completely aware of the change in systems and agrees that fire protection is still appropriate. The reason for the trouble light on the old panel is due to the phasing out of that system.<br><br>2) Identifying other Residents who could be affected by the deficient practice.<br>All residents in the skilled area were protected by the new Honeywell fire alarm system that was 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 and is using the new main fire alarm panel located in the Plant Ops maintenance shop. The reason for the trouble light in the old panel is that it is still covering areas in the other non-skilled sections of the campus. However, this does not impact the skilled area. The old fire alarm system (Simplex) is being converted to a new one (Honeywell) and there is no disruption of service as evidenced by the activation of the system during the survey. The recent fire alarm inspection of 2/20/23 was sent to the fire marshal stating that the system was fully functional.<br><br>3) Measures or systemic changes to ensure that the deficiencies will not recur.<br>Outside vendors have been used to ensure that the conversion from an old to a new fire system is done in accordance with the state and federal regulations. | |

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| K 345 | Continued From page 6 | K 345 | Team members will be fully in-serviced upon completion of the new fire alarm system. Regular quarterly meetings with the fire marshal will be held to ensure that we are in close communication with him. Any issues or concerns will be addressed.<br>4) Monitoring the continued effectiveness of the systemic change<br>Testing of the health care fire system has been completed by FSS fire systems and the Fire Marshall has been notified it is functioning properly. All systems such as the fire dampers will be tested again as soon as new dampers have been installed. A complete test of the fire alarm system will occur as soon as this is complete and a full report for the entire campus will be given to us. Fire system inspections will then resume yearly as required by state law.<br>All fire safety inspections are completed per contract and there is a PM work order in the maintenance software system for each. Regarding the fire alarm system, FSS completed a test after all speakers / strobes were installed in the health Center. FSS will also conduct a full fire alarm test when the entire fire alarm system and panels are fully installed throughout the skilled area. Plant Operations is responsible for monitoring all contracts as well as corrective and preventive maintenance work orders. These contracts are reviewed yearly during the months of August and September to see what needs to be renewed each year. The Senior Director of Plant Ops will present at QAPI details of the conversion to the new | |

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| K 345 | Continued From page 7 | K 345 | system. Any trouble lights on the new system will be addressed immediately.<br>5) The completion date for resolving this deficiency is September 5, 2023. | |
| K 363 SS=F | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. | K 363 | | 8/18/23 |

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| K 363 | Continued From page 8<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 7/13/23, in the presence of the Housekeeping Director (HD) and Maintenance Director from a sister facility (MDSF), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.<br><br>This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in 46 of 50 resident room (RR) doors observed and was evidenced by the following:<br><br>During the building tour on 7/13/23 from 9:15 AM to 1:45 PM, the surveyor in the presence of the HD and MDSF toured the facility and observed the following split-vertical resident room doors that were not smoke resistant, due to compromised gaskets that were torn and/or missing from the meeting point of the doors when in the closed position.<br><br>RR 303-02 bottom 6"<br>RR 303-04 bottom 2"<br>RR 303-07 bottom 3"<br>RR 303-08 bottom 4"<br>RR 303-11 top 5" and bottom 5"<br>RR 303-15 bottom 4" | K 363 | K 363-<br>1) Residents affected by deficient practice.<br><br>• All 50 resident rooms were inspected by the surveyor and 46 of 50 rooms did not confine fire and smoke products and properly defend occupants in place. Upon performing a root cause analysis, it was determined that the problem was caused by wheelchairs and other devices hitting the door sides, compromising the door gaskets.<br><br>• New gaskets which will prevent the passage of smoke and allow the doors to be smoke resistant are being installed for all rooms regardless of status. Plant Operations has created a monthly preventive maintenance work order to check each of the doors throughout the skilled area. This monthly preventive work order has been created in a software system and Plant Ops will address any issues immediately after receiving the work order.<br><br>2) Identifying other Residents who could be affected by the deficient practice.<br><br>Given that all resident rooms were | |

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| K 363 | Continued From page 9<br>RR 303-17 bottom 3"<br>RR 303-19 bottom 3"<br>RR 303-21 bottom 6"<br>RR 303-23 bottom 6"<br>RR 303-25 middle 1"<br>RR 203-2 middle 2"<br>RR 203-4 middle 1"<br>RR 203-5 middle 1"<br>RR 203-7 middle and bottom 3"<br>RR 203-8 bottom 2"<br>RR 203-9 bottom 6"<br>RR 203-15 bottom 3"<br>RR 203-21 middle 2"<br>RR 203-23 middle 4"<br>RR 101-1 middle 6"<br>RR 101-2 middle 2"<br>RR 101-3 middle 8"<br>RR 101-4 middle 6"<br>RR 101-5 middle 8"<br>RR 101-6 middle 8"<br>RR 101-7 middle 8"<br>RR 101-8 middle 8"<br>RR 101-9 middle 8"<br>RR 101-10 middle 10"<br>RR 101-11 middle 10"<br>RR 101-12 middle 8"<br>RR 101-14 middle 8"<br>RR 101-15 middle 8"<br>RR 101-16 middle 8"<br>RR 101-17 middle 8"<br>RR 101-18 middle 8"<br>RR 101-19 middle 8"<br>RR 101-20 middle 8"<br>RR 101-22 middle 8"<br>RR 101-24 middle 8"<br>RR 101-26 middle 8"<br>RR 101-28 entire door<br>RR 101-30 middle 8"<br>RR 101-32 entire door | K 363 | inspected for this issue, there were no other residents impacted. Through environmental rounding by both nursing and plant operations, any issues including door closings of resident rooms will be identified and acted upon.<br><br>3) Measures or systemic changes to ensure that the deficient practice will not occur.<br><br>To actively spot this deficiency in the future, Plant Operations has created a monthly preventive maintenance work order to check each of the doors throughout the health center. This monthly PM has been created in the software system and will be completed on a monthly basis effective immediately. We are also completing in-service training for the housekeeping, household coordinators and nursing team members regarding checking the doors to the resident rooms to see that each gasket is in good shape and in place. The in-service includes notifying a supervisor when they see any type of problem with the resident door. Once a team member sees a problem, they have been instructed to complete a work order which will be repaired by Plant Operations within 24 hours.<br><br>4) Monitoring the continued effectiveness of the systemic change<br><br>Plant Operations along with Senior Management are responsible for | |

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| K 363 | Continued From page 10<br><br>At the time of observations, the surveyor interviewed the HD who confirmed the above findings.<br><br>The Administrator and Corporate staff was informed of the findings at the Life Safety Code exit conference on 7/13/23.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. | K 363 | monitoring all corrective and preventive maintenance work orders and they are checked on a daily basis by our Service Coordinator and maintenance workers that are assigned each task. The Maintenance Director from a sister facility will conduct rounds with the Senior Director of Plant Ops quarterly and any issues will be completed the same day but no later than within 24 hours. All work orders are reported on a monthly basis using a Metrics report which is a measurable method of identifying positive or negative outcomes. Timeliness of work completion will also be reviewed by QAPI committee. The Plant Ops Director or designer will report outcomes of the metrics and quarterly rounding results at the quarterly QAPI meetings. This metrics report is created by the Sr. Director of Plant Operations and Assistant Director of Plant Ops and is reviewed by the Executive Director of Fellowship Village.<br><br>5) The completion date for this deficiency is August 18, 2023. | |
| K 522 SS=F | HVAC - Any Heating Device<br>CFR(s): NFPA 101<br><br>HVAC - Any Heating Device<br>Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: | K 522 | | 9/1/23 |

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| K 522 | Continued From page 11<br>* is chimney or vent connected.<br>* takes air for combustion from outside.<br>* provides for a combustion system separate from occupied area atmosphere.<br>19.5.2.2<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview on 7/12/23, in the presence of the Housekeeping Director (HD) and Maintenance Director from a Sister Facility (MDSF), it was determined that the facility failed to ensure that 2 of 2 hot-water storage tanks were in optimal operating condition. The deficient practice was evidenced by the following:<br><br>At 10:30 AM, the HD provided documentation from the facility risk engineering services vendor dated 2/25/21 & 2/1/23, The documents indicated the following comments:<br><br>1) The hot water storage tank #1, is actively leaking. Failure of the water storage system will result in wetted equipment and potential damage to boiler equipment.<br><br>The boiler inlet and outlet piping are corroded and actively leaking. Failure of the hot water generator piping will result in a loss of service, hot water to the facility.<br><br>2) The hot water storage tank #2, was actively leaking. Failure of the water storage system will result in wetted equipment and potential damage to boiler equipment.<br><br>The tank piping was heavily corroded and at risk of catastrophic failure. Failure will result in the loss of service hot water to the facility. The piping | K 522 | 1) Residents affected by deficient practice.<br><br>There were no residents that were immediately impacted as there has been consistent hot water throughout the past year. The reason for the tanks leaking is that over time water has eroded the piping, thus causing the leaks. Within the next month the tanks will be drained individually and welded to stop leakage and all piping will be repaired to ensure there are no leaks. We have installed a bypass so that we can always have one tank available for hot water.<br><br>The tanks were repaired on 7/27 and 7/28 in 2021 and there was no longer any leaking. Based upon the boiler inspection in 2022, there was no l leaking from the tank. We have been looking into engineering and purchasing new tanks but in the meantime we will be repairing the existing tanks until the study and design is complete.<br><br>2) Identifying other Residents who could be affected by the deficient practice –<br><br>There were no residents that were immediately impacted as there has been consistent hot water throughout the past | |

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| K 522 | Continued From page 12<br>shall be repaired or replaced as soon as practical.<br><br>An interview was conducted with the HD while reviewing documentation. The HD stated that as of the document dates of 2/25/21 and 2/1/23, the hot water storage tanks were not repaired.<br><br>The Administrator and Corporate Staff was informed of the findings at the Life Safety Code exit conference on 7/13/23.<br><br>NJAC 8:39-31.2(e) | K 522 | year. Welding the tanks and replacing the water piping will stop the leaking water.<br><br>We have been looking into engineering and purchasing new tanks but in the meantime we will be repairing the existing tanks until the study and design is complete.<br><br>Nursing, Plant Ops and Household Coordinators have been in-serviced that any concerns or issues regarding the lack of hot water be directed to Plant Ops immediately via a work order.<br><br>3) Measures or systematic changes to ensure that the deficiencies will not occur –<br><br>The initial repairs will cover the immediate need to stop the tanks from leaking and ensure that there will be no catastrophic failures. An engineering company will provide the draft for a systematic analysis of the problem and ensure that the deficiency will not happen again. Plant operations will create a preventive maintenance work order to check the hot water tanks monthly and this will be monitored by the Service Coordinator as well as maintenance staff. Each maintenance team member will also have in-service training on what to look for and procedures on what to do when they find something. Measurable results will be provided by the system checks recorded in the work order system in future years. Consultants from our Corporate | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315356 | A. BUILDING **01**<br>B. WING _____ | **07/20/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SKILLED NURSING AT FELLOWSHIP VILLAGE** | **8000 FELLOWSHIP DRIVE**<br>**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 522 | Continued From page 13 | K 522 | Department will be deployed to review and inspect these tanks at least 2x a year.<br><br>4) Monitoring the continued effectiveness of the systematic change – Monitoring the system will come from the Plant Operations department via their software work order system. The Service Coordinator will be responsible for assuring the preventive maintenance work orders are completed and assigned to maintenance workers each month. All work orders are reported monthly using a Metrics report and submitted quarterly to the QAPI committee. This report is created by the Sr. Director of Plant Operations and Assistant Director of Plant Ops and is reviewed by the Executive Director of Fellowship Village.<br><br>5) Does the plan for each deficiency have its own completion date? - The completion date for the hot water tank repairs is 9/1/23. | |

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<br>B. Wing Y2 | 9/5/2023 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SKILLED NURSING AT FELLOWSHIP VILLAGE | 8000 FELLOWSHIP DRIVE<br>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 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0111 | 08/11/2023 | LSC K0345 | 09/05/2023 | LSC K0363 | 08/18/2023 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC K0522 | 09/01/2023 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| 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 | |
|---|---|
| 7/20/2023 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |