

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315288	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER BARTLEY NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 175 BARTLEY RD , JACKSON, New Jersey, 08527	
(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
F0921 SS = E	<p>Safe/Functional/Sanitary/Comfortable Environ</p> <p>CFR(s): 483.90(i)</p> <p>§483.90(i) Other Environmental Conditions</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to provide an environment that is safe, functional, sanitary, and comfortable. This deficient practice was identified for two of three dining rooms (Main and Dogwood).</p> <p>This deficient practice was evidenced by the following:</p> <p>On 8/6/25 at 11:52 AM, the surveyor toured the facility's main dining room in the presence of the US FOIA (b)(6)) and observed a bug in the second drawer of the kitchenette, as well as a black, ground substance in the fourth drawer, which the US FOIA (b)(6) identified as coffee. The fourth drawer was also sticky to the touch.</p> <p>On 8/6/25 at 11:56 AM, in the presence of the US FOIA (b)(6) the surveyor observed that all five steam table wells in the Main and Dogwood dining rooms had residual water marks approximately half an inch above the water level. The wells also contained dirty water with food debris that was not consistent with the day's lunch meal.</p> <p>A review of the facility's "Monthly Cleaning List" for week one of 08/25 showed a check mark that the kitchen wells were cleaned with soap</p> <p>A review of the manufacturer's Electric Hot Food Table with Sealed-in Wells (SHT Series) "Operations Manual</p>	F0921	<p>On 8/6/2025, the kitchenette area in the main dining room was thoroughly cleaned by the housekeeping department. This included all drawers, cabinets, and surfaces. The area was then inspected by the Director of Housekeeping. On 8/6/2025 the Pest Control vendor that services the facility was called in to inspect the area. The technician reported no findings of any bugs and no sign of infestation. He did treat the area as a precaution On 8/6/2025 all 3 steam tables that are utilized in the facility were thoroughly cleaned; this includes the exterior of the equipment as well as the water wells. The steam tables were then inspected by the Regional Food Service Director. On 8/6/2025 the Food Service Director in-serviced the dietary staff on the cleaning process and the cleaning schedule for the steam tables.</p> <p>All residents have the potential to be affected by the cited deficient practice when the residents' environment is not kept safe, functional, sanitary, and comfortable. The Housekeeping Director and Administrator conducted facility wide rounds to identify any other areas that might need to be deep cleaned. The Food Service Director and the Regional Food Service Director inspected the rest of the kitchen equipment to see if any other items needed to be deep cleaned.</p> <p>On 8/7/2025, the Administrator reviewed the monthly deep cleaning schedule with the Housekeeping Director and made changes to include the dining room areas more frequently. On 8/7/2025 the Regional Food Service Director in-serviced the Dietary staff on the cleaning schedule and process for all equipment.</p> <p>The Housekeeping Director or designee will inspect 3 areas a week that are on the deep cleaning monthly calendars for 3 months. And then 1 area a week for 6 months. The Food Service Director will inspect the steam tables weekly for a month and monthly for 3 months. All findings will be presented to Administrator or designee.</p>	09/10/2025

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 reverse for further 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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F0921 SS = E	<p>Continued from page 1 and Instructions" indicated that the inside of the water compartment and outer shell should be washed daily, using a clean cloth or sponge and mild detergent.</p> <p>On 8/6/25 at 12:00 PM, the surveyor interviewed the US FOIA (b)(6), who acknowledged that the kitchenette drawers were unclean and should not contain bugs or spilled substances. The US FOIA (b)(6) confirmed that the steam table wells should be cleaned according to the manufacturer's specifications but was unable to provide cleaning records or accountability logs.</p> <p>On 8/6/25 at 12:22 PM, the surveyor interviewed the US FOIA (b)(6) who stated that staff deep clean both dining rooms monthly. However, the US FOIA (b)(6) was unable to specify when the dining rooms were last deep cleaned.</p> <p>On 8/11/2025 at 12:24 PM, the surveyor interviewed the US FOIA (b)(6). The US FOIA (b)(6) stated that there should be no bugs or spills in the dining room kitchenette drawers, that the steam table wells and water should be clean and free of food particles, and that cleaning schedules should be in place for the drawers and steam tables. The US FOIA (b)(6) emphasized that clean dining rooms are important for resident safety and for preventing illness.</p> <p>A review of the facility's "Dietary Equipment Cleaning" policy, dated 3/1/24 and revised 2/28/25 indicated that all kitchen equipment will be cleaned and sanitized regularly following manufacturer guidelines and facility-specific schedules.</p> <p>NJAC 8:39-31.4(a)</p>	F0921		
F0550 SS = D	<p>Resident Rights/Exercise of Rights</p> <p>CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights.</p> <p>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p>	F0550	<p>Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice.</p> <p>Resident #8 was immediately provided with privacy including shutting the room door, pulling the privacy curtain, and shutting the window shade while being provided with NJ Exec Ord care. The nurses involved were provided with 1:1 re-education by the Assistant Director of Nursing 8/5/2025 on the importance of maintaining resident privacy during NJ Exec Ord care, which includes shutting doors, pulling privacy curtain,</p>	09/10/2025

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F0550 SS = D	<p>Continued from page 2</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights.</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, interview, record review, and review of pertinent facility documents it was determined that the facility failed to interact with residents in a dignified and respectful manner by failing to provide privacy to Resident #8 during NJ Exec Ord care. This deficient practice was identified for 1 of 44 residents reviewed for dignity and was evidenced by the following:</p> <p>During a tour of the Dogwood Unit on 8/5/2025 at 11:53 AM, the surveyor observed Room # NJ with the door open and two nurses inside performing NJ Ex Order 26,451 to Resident #8 whose bed was next to the window. The surveyor noted that resident's privacy curtain was not pulled and the window shades were not pulled down for privacy. The surveyor continued to observe the room and at no time</p>	F0550	<p>Continued from page 2</p> <p>and/or shutting shades on windows (if resident is on the window side of the room).</p> <p>Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents with a physician's order for wound care have the potential to be affected by the cited practice.</p> <p>Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Licensed nurses were provided with re-education by the facility educator and Assistant Director of Nursing regarding the importance of maintaining resident privacy while providing wound care and that this includes shutting the door, pulling the privacy curtain, and/or shutting the window shades (if resident is on the window side of the room) on 8/5/2025 and ongoing. This in-service education will be given during orientation for newly hired licensed nurses, annually and as deemed necessary. An audit form has been developed that will be utilized in auditing resident privacy during wound care.</p> <p>Element 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Assistant Director of Nursing, and/or designee will perform a weekly audit on five residents, covering all shifts, being provided with wound care to assure compliance with staff maintaining privacy during wound care. This audit will be done for four weeks and then monthly for four months to assure compliance with maintaining resident privacy during wound care. Negative findings will be corrected through one-on-one re-education by the Assistant Director of Nursing or the nurse supervisors.</p>	

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<p>F0550 SS = D</p>	<p>Continued from page 3 was Resident #8's privacy maintained.</p> <p>On the same date at 12:01 PM, the surveyor approached the US FOIA (b)(6) who was seated at the nursing station. The US FOIA (b)(6) stated that during NJ Exec Order care, privacy was to be maintained by either closing the door or pulling the privacy curtain. When asked about the window bed, the US FOIA (b)(6) confirmed that the window shade should be pulled down to maintain privacy. The surveyor requested that the US FOIA (b)(6) accompany them to Room # NJ EX. Upon approaching room # NJ EX one of the nurses stated that the door was closed. When the surveyor stated that they have been standing at the doorway the nurse stated that she believed the door was closed. The second nurse then approached the treatment cart and while the US FOIA (b)(6) was providing education, it was confirmed that the door was not closed.</p> <p>On 8/6/2015 at 10:56 AM, the surveyor spoke with Resident #8 who confirmed that the nurses did not pull the curtain, shut the door, or pulled the window shade during NJ Ex Order 26.4b1.</p> <p>The surveyor reviewed Resident #8's medical record:</p> <p>A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included NJ Exec Order [REDACTED]</p> <p>A review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1, reflected a brief interview for mental status (BIMS) score of NJ EX out of 15, which indicated that the resident was NJ Exec Order 26.4b1.</p> <p>During an interview with the surveyor on 8/11/2025 at 9:48 AM, the US FOIA (b)(6) confirmed that privacy was to be maintained during NJ Exec Order care by closing the door, pulling the privacy curtain, and pulling the window shades if the resident is in a window bed.</p> <p>During an interview with the surveyor on 8/11/2025 at 12:20 PM, the US FOIA (b)(6), in the presence of the US FOIA (b)(6) in Training, confirmed that privacy was to be maintained during NJ Exec Order care by closing the door, pulling the privacy curtain, and pulling the window shades if the resident is in a window bed.</p> <p>A review the facility policy titled,</p>	<p>F0550</p>		

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F0550 SS = D	Continued from page 4 "Promoting/Maintaining Resident Dignity", last revised 11/2024, revealed that: "It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident 's quality of life by recogniziing each residents individuality". The policy further revealed the following under Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights [...]; 12. Maintain resident privacy [...]. A review the facility policy titled, "Wound Care", last revised 12/20205, revealed the following under Procedures: [...] 8. Ensure privacy by pulling the privacy curtain or shutting the door if in a private room [...]. NJAC 8:39-4.1(a)12	F0550		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F0690	Element 1: Corrective action accomplished for those residents found to have been affected by the alleged deficient practice. Resident #13's NJ Exec Order 26.4b1 was removed off of the resident's footboard, disinfected, put inside the NJ Exec Order 26.4b1 and placed on the bed frame NJ Exec Or the NJ Exec Order 26.4b1 . The US FOIA (b)(6) involved was provided with 1:1 re-education by the facility infection preventionist on 8/5/2025 on the importance of NJ Exec Order 26.4b1 being maintained NJ Exec Order 26.4b1 , off of the floor, and inside a NJ Exec Order 26.4b1 . Element 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who have an indwelling urinary catheter have the potential to be affected by the cited practice. Element 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. CNA's and license nurses were provided with re-education by the facility educator and infection preventionist regarding the importance of indwelling urinary catheter drainage bags being maintained below the bladder, off of the floor and inside a privacy bag	09/10/2025

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F0690 SS = D	<p>Continued from page 6</p> <p>A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [redacted] that the resident "required [redacted] of NJ Exec Order 26.4b1 due [redacted] and "has [redacted]". Interventions included, but were not limited to: Position [redacted] and NJ Exec Order 26.4b1 and away from entrance room door and [redacted]...</p> <p>On 8/7/2024 at 10:10 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that [redacted] should be fully encased in the [redacted], not touching the floor, and that they should be secured on the side of the bed with the provided hook.</p> <p>On 8/7/2024 at 10:15 AM., the surveyor interviewed the Registered Nurse/Charge Nurse (RN/CN #1) who confirmed that [redacted] were to be secured on the side bed frame fully inside the [redacted]. Upon review of the picture obtained of Resident #18's [redacted] on initial tour of the facility, the RN/CN #1 acknowledged that the [redacted] should have been parallel to the resident to allow [redacted]. RN/CN #1 further explained that the [redacted] being positioned at the end of the bed could potentially cause a [redacted] and [redacted] to the [redacted].</p> <p>On 8/11/2025 at 9:48 AM, the surveyor interviewed the [redacted] US FOIA (b)(6), who upon review of the picture, confirmed that the [redacted] should have been fully contained within the [redacted], placed parallel to the resident, and secured with the provided hook to allow [redacted].</p> <p>On 8/11/2025 at 12:20 PM, the survey team interviewed the [redacted] US FOIA (b)(6), in the presence of the [redacted] US FOIA (b)(6), acknowledged that it is the expectation of the facility that [redacted] should be fully contained within the [redacted], placed parallel to the resident, and secured with the provided hook on the bed frame.</p> <p>A review the facility policy titled, "Urinary Catheters", last revised 2/4/2025, revealed the following under Procedures: [...] 6. Indwelling catheters should be properly secured to prevent movement and urethral traction; [...] 15. Keep the collection bag below the level of the bladder and place in a privacy bag [...].</p>	F0690		

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F0690 SS = D	Continued from page 7 N.J.A.C. 8:39-19.4 (a)	F0690		
F0000	INITIAL COMMENTS Complaints: NJ # 175797; 179695; 182607; 184551; 185467; 185838; 185035; 186956; 186951 Survey Date: 8/12/2025 Census: 212 Sample Size: 44+3 closed records 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. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		09/10/2025

New Jersey State Department of Health

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S0000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S0000		09/10/2025

Office of Primary Care and Health Systems Management

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F0000	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 9/22/2025 in relation to the 8/12/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		

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K0324 SS = F	<p>Cooking Facilities</p> <p>CFR(s): NFPA 101</p> <p>Cooking Facilities</p> <p>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on interview and review of facility provided documentation on 08/04/2025 and 08/05/2025 in the presence of the facility US FOIA (b)(6), it was determined that the facility failed to inspect the kitchen range-hood fire suppression system semi-annually in accordance with the requirements NFPA 96. This deficient practice had the potential to affect all 212 residents and was evidenced by the following:</p> <p>A review of the facility's range-hood fire suppression system inspections at approximately 12:20 PM for the previous 19 months, revealed the system had two (2) semi-annual inspections on the following dates, 03/21/2025 and 08/13/2024. A request was made to the US FOIA (b)(6) to provide the previous year semi-annual fire</p>	K0324	<p>The facility immediately confirmed with fire protection vendor that the most recent inspection was completed on 3/21/2025 and the system is currently up to date and fully operational.</p> <p>All residents as well as staff have the potential to be affected by this deficient practice when the Fire Safety Code for timely inspections for the kitchen range-hood fire suppression system is not in compliance. The Administrator with the Maintenance Director made facility wide rounds on 8/5/2025 to ensure that all other fire protection systems inspections were up to date. All systems were found to be up to date with the necessary inspections.</p> <p>The Administrator in-serviced the US FOIA (b)(6) on the regulatory requirements presented by the Environmental Inspector. Specifically, the requirement to follow the guidance regarding timely inspections of all fire safety systems. The maintenance director will schedule all inspections 30 days prior to the due date to prevent lapses.</p> <p>The Administrator or designee will audit the life safety inspections binder monthly for three months and quarterly for a year. All findings will be presented to Administrator or designee at the next 3 Quality Assurance Committee meetings which are conducted quarterly.</p>	09/10/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315288	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER BARTLEY NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 175 BARTLEY RD , JACKSON, New Jersey, 08527	
(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
K0324 SS = F	Continued from page 1 suppression system inspections. On 08/05/2025 the US FOIA provided semi-annual inspections dated 12/12/2023 and 06/16/2023. The facility went 8 months between the 12/12/2023 and 08/13/2024 semi-annual inspections and 7 months between the 08/13/2024 and 03/12/2025. In an interview, US FOIA told the surveyor that there was a billing issue with the vendor and the inspections were late and confirmed the findings at the time. The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code Survey exit at approximately 1:15 PM on 08/05/2025. NJAC 8:39-31.2 (e) NFPA 96	K0324		
K0353 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 STANDARD is NOT MET as evidenced by:	K0353	The facility immediately confirmed with fire protection vendor that the most recent inspection was completed and the system is currently up to date and fully operational. All residents as well as staff have the potential to be affected by this deficient practice when the Fire Safety Code for timely inspections for the sprinkler system is not in compliance. The Administrator with the Maintenance Director made facility wide rounds on 8/5/2025 to ensure that all other fire protection systems inspections were up to date. All systems were found to be up to date with the necessary inspections. The Administrator in-serviced the US FOIA (b)(6) on the regulatory requirements presented by the Environmental Inspector. Specifically, the requirement to follow the guidance regarding timely inspections of all fire safety systems. The maintenance director will schedule all inspections 30 days prior to the due date to prevent lapses. The Administrator or designee will audit the life safety inspections binder monthly for three months and quarterly for a year. All findings will be presented to Administrator or designee at the next 3 Quality Assurance Committee meetings which are conducted quarterly.	09/10/2025

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K0353 SS = F	<p>Continued from page 2</p> <p>Based on interview and review of facility provided documentation on 08/04/2025 and 08/05/2025 in the presence of the facility US FOIA (b)(6), it was determined that the facility failed to inspect the Fire Sprinkler system quarterly in accordance with NFPA 25. This deficient practice had the potential to affect all 212 residents and was evidenced by the following:</p> <p>A review of the facility's Quarterly Fire Sprinkler Inspections (every 3 months) for the previous 19 months on 08/04/2025 during the survey entrance at approximately 12:20 PM, revealed the fire sprinkler system on the following dates:</p> <p>05/02/2025, 01/23/2025, 10/15/2024, 08/08/2024 and 03/20/2024.</p> <p>The facility went 4 months between 05/02/2025 and 01/23/2025. The facility went 5 months between 08/08/2024 and 03/20/2024.</p> <p>In an interview at the time, the US FOIA told the surveyor that there was a billing issue with the vendor and the inspections were late.</p> <p>The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code Survey exit at approximately 1:15 PM on 08/05/2025.</p> <p>NJAC 8:39-31.1 (c), 31.2 (e)</p> <p>NFPA 25</p>	K0353		
K0321 SS = D	<p>Hazardous Areas - Enclosure</p> <p>CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure</p> <p>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p>	K0321	<p>On 8/7/25, the Maintenance Director installed a door closure on the door leading to the Central Supply storage room. This allows for the door to self-close.</p> <p>All residents as well as staff members have the potential to be affected by this deficient practice when fire doors do not meet regulatory requirements. A facility wide inspection was conducted by the Maintenance Director and maintenance staff to ensure all fire doors met regulatory guidelines. None were found to be deficient.</p> <p>An in-service was done on 8/5/2025 by the Administrator for the US FOIA (b)(6) and all maintenance staff regarding regulatory compliance for Fire Safety pertaining to enclosed areas.</p>	09/10/2025

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K0321 SS = D	<p>Continued from page 3</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p> <p>19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms</p> <p>b. Laundries (larger than 100 square feet)</p> <p>c. Repair, Maintenance, and Paint Shops</p> <p>d. Soiled Linen Rooms (exceeding 64 gallons)</p> <p>e. Trash Collection Rooms (exceeding 64 gallons)</p> <p>f. Combustible Storage Rooms/Spaces (over 50 square feet)</p> <p>g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interview on 08/04/2025 and 08/05/2025 in the presence of the facility ^{US FOIA (b)(6)} it was determined that the facility failed to ensure that 1 of 8 fire-rated doors inspected to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice had the potential to affect limited residents and was evidenced by the following:</p> <p>Observations on 08/05/2025 at approximately 10:05 AM during an inspection of the Central Supply (Personal Protective Equipment) room, the corridor door was opened to a 90 degree opening to the frame but the door did not self-close. The surveyor observed that the corridor door had no means to self-close.</p> <p>The surveyor observed inside the room the following combustible products:</p> <p>-28 cardboard cases of vinyl gloves</p>	K0321	<p>Continued from page 3</p> <p>The Maintenance Director or designee will perform weekly rounds for a month and then monthly for six months checking at least 10 doors in enclosed areas for Fire Safety compliance. All findings will be presented to Administrator or designee at the next 3 meetings of the Quality Assurance committee who meet quarterly.</p>	

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K0321 SS = D	<p>Continued from page 4</p> <ul style="list-style-type: none"> -20 cardboard cases of surgical masks -22 cardboard cases of gloves -12 cardboard cases of gel foam cushions -18 cardboard cases of gowns -10 other cases of gowns -22 cardboard cases of adult briefs. <p>The room was larger than 50 square feet.</p> <p>In an interview, the US FOIA (b)(6) confirmed the finding at the time of observation.</p> <p>The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code Survey exit at approximately 1:15 PM on 08/05/2025.</p> <p>NJAC 8;39 -31.2 (e)</p>	K0321		
K0351 SS = D	<p>Sprinkler System - Installation</p> <p>CFR(s): NFPA 101</p> <p>Sprinkler System - Installation</p> <p>2012 EXISTING</p> <p>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.</p> <p>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5,</p>	K0351	<p>An outside vendor was contacted to install a new sprinkler head inside of the Heating, Ventilation and Air Conditioning closet in the Cedar Unit of the facility. The vendor did a site visit on 8/21/2025 to take measurements and put together a proposal for the scope of work as well as plans to submit for a permit. The vendor submitted the necessary application for a permit to Jackson Township on 8/26/2025. Permits were approved. On September 4th the vendor installed the new sprinkler head.</p> <p>All residents as well as staff have the potential to be affected by this deficient practice when the Fire Safety Code for placement of sprinkler heads is not in compliance. The Maintenance Director and maintenance staff made facility wide rounds to ensure that all other areas have sprinklers within the regulatory requirements.</p> <p>The Administrator in-serviced the US FOIA (b)(6) on the regulatory requirements presented by the Environmental Inspector. Specifically, the requirement to have a sprinkler head in a closet or room unless it meets the specified exceptions as outlined by the regulatory guidance.</p> <p>Maintenance Director will audit all required areas. All</p>	09/04/2025

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K0351 SS = D	<p>Continued from page 5 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Base on observation and interview on 08/05/2025 in the presence of the facility's US FOIA (b)(6) it was determined that the facility failed to install fire sprinklers as required by CMS regulation 483.90 (a) Physical Environment to all areas in accordance with NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systema 2012 Edition. This deficient practice had the potential to affect all residents who resided on the Cedar Unit and was evidenced by the following:</p> <p>An observation on 08/05/2025 during the building tour in the presence of the US FOIA (b)(6) at approximately 10:440 AM, revealed no evidence of fire sprinkler protection inside the 3 foot-6 inch by 5 foot Heating, Ventilation and Air Conditioning (HVAC) closet in the Cedar Unit Serving area.</p> <p>In an interview at this time, the surveyor asked the US FOIA (b)(6) "Do you see and sprinklers inside the HVAC closet." The US FOIA (b)(6) looked inside and said, "No I don't." and confirmed the finding.</p> <p>The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code Survey exit at approximately 1:15 PM on 08/05/2025.</p> <p>NJAC 8:39-31.1 (c), 31.2 (e)</p> <p>NFPA 13</p>	K0351	<p>Continued from page 5 findings will be presented to Administrator or designee at the next 3 Quality Assurance Committee meetings which are conducted quarterly.</p>	
K0355 SS = D	<p>Portable Fire Extinguishers</p> <p>CFR(s): NFPA 101</p> <p>Portable Fire Extinguishers</p> <p>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</p> <p>18.3.5.12, 19.3.5.12, NFPA 10</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations on 08/04/2025 in the presence of</p>	K0355	<p>On 8/4/25, the Maintenance Director removed the fire extinguisher that had been previously discharged and replaced it with a fire extinguisher that had the pressure indicating needle pointed in the green area of the gauge which indicates that it is full and the break away tag was intact as well.</p> <p>All residents as well as staff members have the potential to be affected by this deficient practice when fire extinguishers do not meet regulatory requirements. A facility wide inspection was conducted by the Maintenance Director and maintenance staff to ensure all extinguishers in the facility met regulatory guidelines. None were found to be deficient.</p>	09/10/2025

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K0355 SS = D	<p>Continued from page 6 the facility US FOIA (b)(6), it was determined that the facility failed to maintain 1 of 33 portable fire extinguishers observed in accordance with the National Fire Protection Association (NFPA) 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10, 2010 Edition Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3, 4-3.3, 4- 4.3 and 7.3.1.1. This deficient practice had the potential to affect limited residents and was evidenced by the following:</p> <p>Observations on 08/04/2025 at approximately 11:22 AM, revealed one (1) ABC type fire extinguisher located in the Activities room where the pressure indicating needle on the pressure gauge was in the RED discharge zone on the pressure gauge. The surveyor also observed that the break-away tag was missing indicating the fire extinguisher had been discharged.</p> <p>In an interview at this time, the US FOIA confirmed the finding at the time of observation.</p> <p>The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code Survey exit at approximately 1:15 PM on 08/05/2025.</p> <p>NJAC 8:39-31.1 (c), 31.2 (e)</p> <p>NFPA 10</p>	K0355	<p>Continued from page 6 An in-service was done on 8/5/2025 by the Administrator for the maintenance director and all maintenance staff regarding regulatory compliance for Fire Safety pertaining to fire extinguishers.</p> <p>The Administrator or designee will perform weekly rounds for a month and then monthly for six months checking at least 10 fire extinguishers in the facility for Fire Safety compliance. This is on top of the required monthly inspections that are performed by the Maintenance staff. All findings will be presented to Administrator or designee at the next 3 meetings of the Quality Assurance committee who meet quarterly.</p>	
K0000 Bldg. 02	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted on 08/04/2025 and 08/05/2025 and Bartley Nursing and Rehab was found to be in non-compliance with the requirements for participation in Medicare/ Medicaid at 42 CFR 483.90 (a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.</p> <p>The facility was originally constructed in 1985 as a one-story Type II (000) building.</p> <p>There is a supervised smoke detection in the corridors and in resident rooms. There are two emergency generators inside the facility, a 200 KW Diesel and a 55 KW Natural Gas. The generators supply emergency power to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency lighting and life safety components utilized for privation of life. The facility is divided into 16-</p>	K0000		09/10/2025

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K0000 Bldg. 02	Continued from page 7 smoke zones. The census was 212.	K0000		

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E0000	Initial Comments An Emergency Preparedness Survey was conducted at Bartley Nursing and Rehab on 08/05/2025. The facility was found to be in compliance with 42 CFR 483.73	E0000		09/10/2025

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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K0000 Bldg. 02	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 11/24/2025 in relation to the 8/12/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.</p>	K0000		

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