STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315288	A. BUILDING ______ B. WING ______	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARTLEY NURSING & REHAB	175 BARTLEY RD JACKSON, NJ 08527

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: 157609; 157901; 158420; 158690; 159655; 160396; 160817; 160883; 161521; 169393 Survey Date: 4/30/24 Census: 204 Sample: 40 + 3 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint NJ # 157609; 157901; 160396 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to administer medications within scheduled time parameters on various	F 658	F- TAG 658 1. Resident #213 is no longer a resident at the facility. On 4/12/2024 the Assistant Director of Nursing immediately assessed resident # 20 for any NJ Exec Order 26.4b1 and did not observe NJ Exec Order 26.4b1	6/13/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/23/2024

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

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F 658		F 658		

Continued From page 1
shifts for two residents in accordance with professional standards of practice. This deficient practice was identified for 2 of 35 residents reviewed for professional standards of practice (Resident #20 & Resident #213).

Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."

Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "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."

The evidence was as follows:

1. On 4/12/24 at 8:35 AM, during medication pass observation, the surveyor observed the US FOIA (b)(6) [redacted] on NJ Exec Ord [redacted] Unit prepare morning medications for Resident #20. The

related to cited deficient practice. The resident attending physician and the responsible party were notified regarding the medication that was administered outside the scheduled time parameter. The nurse involved was re-educated by the facility Pharmacy consultant on following medication Cautionaries. Nurse was also re-educated on utilizing the advance search tab in PCC for residents with medications that have cautionaries to ensure that medications are given within the scheduled time parameter. This Inservice was given on 4/12/2024.

2. All residents with medications that have scheduled time parameters for medication administration and residents with physician orders for anticoagulant medications have the potential to be affected by the cited deficient practice.

3. The facility Pharmacy Consultant and facility Staff Development Coordinator provided a re-education for nurses regarding facility's policy on Medication Administration with emphasis on timely medication administration and medications with schedule time parameters, and to utilize "advance search" a feature available in PCC (Point Click Care- clinical software) Electronic Medication to ensure that medications with schedule time parameters are administered within the time parameter. This was initiated on 4/12/2024 and will be completed by 5/31/2024. The same education will be given during orientation for a newly hired nurse and as deemed

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F 658	Continued From page 2 resident had medications which included an NJ ex order ... . On 4/12/24 at 8:56 AM, as the surveyor and the US FOIA entered the Resident #20's room for medication administration, the surveyor observed the US FOIA (b)(6) removing the resident's breakfast tray from the overbed table. The surveyor asked the US FOIA (b)(6) to raise the lid of the meal plate, and the surveyor observed the resident had NJ Exec Order 26.4b1 of their morning meal. The US FOIA then proceeded to administer the resident their morning medications. The surveyor reviewed the medical record for Resident #20. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that NJ ex order 26.4b1 A review of the April 2024 Medication Administration Record (MAR) included the physician's order (PO) dated NJ ex order 26.4b, to administer at 7:30 AM NJ ex order 26.4b1 A review of the corresponding NJ ex order 26.4b1 Medication Admin Audit Report revealed that on NJ ex order 26.4b the 7:30 AM dose was administered at 8:52 AM. On 4/12/24 at 11:40 AM, the surveyor interviewed	F 658	necessary. 4. The Assistant Director of Nursing, and or designee will conduct an audit of 15 medications that have scheduled time parameter weekly for 4 weeks and monthly for 3 months to assure that medications are given timely following medications schedule time parameters. Any negative findings will be addressed by giving a one on one education, and disciplinary measures if deemed appropriate. The results of the audits will be submitted during the next 3 meetings to the QA committee who meets quarterly for review and recommendations for frequency and necessity of further audits.	

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F 658	Continued From page 3 the US FOIA who stated the NJ Exec Ord Unit was served breakfast usually around 7:30 AM. At that time, the US FOIA and surveyor reviewed the NJ ex order 26.4b1 MAR, and the US FOIA acknowledged the order stated give 30 minutes before meal. The US FOIA further acknowledged she should have given the NJ ex order 26.4b before the resident had their breakfast. On 4/12/24 at 11:50 AM the surveyor interviewed the US FOIA (b)(6)) who stated breakfast on the NJ Exec Ord Unit was served at 8:00 AM. The US FOIA (b) then stated the nurses should prioritize the order in which residents were administered their medications based on residents whose medications were due earliest such as NJ Exec Order 26.4b1. At that time, the US FOIA (b) and the surveyor reviewed the MAR for Resident #20. The US FOIA (b) acknowledged the NJ Exec Order 26 should be given NJ Exec Order 26.4b1 prior to a meal. The US FOIA (b) further acknowledged the nurse should have given the NJ Exec Order 26 before the resident had eaten breakfast to ensure the NJ Exec Ord were NJ Exec Order 26.4b1 and to help prevent any NJ Exec Order 26.4b1. On 4/23/24 at 12:59 PM, the surveyor re-interviewed the US FOIA (b) who stated the allowance for medication administration time was one hour before and one hour after the scheduled medication administration time. 2. On 4/23/24 the surveyor reviewed the closed medical record for Resident #213. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that NJ ex order 26.4b1	F 658		

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F 658	Continued From page 4 NJ ex order 26.4b1 . A review of the NJ ex order 26.4b1 Order Recap Report revealed the resident had the following physician's order (PO) to be administered at 9:00 AM: NJ ex order 26.4b1 A review of the NJ Exec Order 26.4b1 Medication Admin Audit Report reflected on NJ Exec Order 26.4b, the 9:00 AM dose was administered at 10:39 AM. On 4/23/24 at 1:04 PM, the surveyor reviewed the Medication Admin Audit Report for NJ ex order 26.4b1 with the US FOIA (b) who acknowledged the NJ ex order 26.4b1 at 9:00 AM was not administered until 10:39 AM. The US FOIA (b) stated a medication can be given up to one hour before or one hour after a medication administration time and confirmed the NJ ex order 26.4 had been given outside the one-hour parameter. A review of the facility's "Medication Administration" policy dated last reviewed January 2024 included ...Medications are administered by licensed nurses... as ordered by the physician and in accordance with professional standards of practice...administer within acceptable time frame... NJAC 8:39-27.1(a)	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		6/13/24

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F 676	Continued From page 5 §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Complaint NJ# 160883	F 676	F- TAG 676	

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F 676	Continued From page 6 Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident received showers as scheduled. This deficient practice was identified for 1 of 2 residents reviewed for activities of daily living (Resident #61), and was evidenced by the following: On 4/15/24 at 11:01 AM, the surveyor interviewed Resident #61 who stated he/she did not receive their scheduled shower on Friday NJ Exec Order 26 during the 3:00 PM to 11:00 PM (3-11) shift. The resident stated their showers were scheduled weekly for Mondays and Fridays. The surveyor reviewed the medical record for Resident #61. A review of the Admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that NJ ex order 26.4b1 NJ ex order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b1 included that the resident had a Brief interview for Mental Status (BIMS) score of NJ ex order 26.4b1 out of 15, which indicated a NJ ex order 26.4b1 A further review in Section NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Abilities and Goals, indicated the resident NJ ex order 26.4b1	F 676	1. Resident #61 was immediately offered a shower on NJ ex order 26.4b1 CNA #1 was re-educated by the Director of Nursing that showers must be given in accordance with the resident bath schedule and to inform the nurse and/or the nurse supervisor if resident declines or if there is another reason the shower could not be given. This re-education was given on 4/16/2024. 2. All residents who have scheduled showers have the potential to be affected by the cited deficient practice. 3. The Director of Nursing and the facility Staff Development coordinator provided re-education to CNAs (Certified Nursing Assistant) regarding facility's policy in providing shower to residents and notifications when a resident refused scheduled shower. This education was initiated on 4/16/2024 and will be completed by 5/31/2024. The same in-service will be provided during orientation of all newly hired CNA and as deemed necessary. 4. The Unit Managers and or designee will audit 15 Showers schedules covering all shifts weekly x 4 weeks and then monthly x 3 months to assure that showers are given per the resident shower schedule. Negative findings will be addressed immediately by providing a one on one re-education of the CNA involved and/or disciplinary actions as appropriate, The results of the audits will be submitted at the next 3 meetings of the QA committee who meets quarterly for review and recommendations for	

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F 676	Continued From page 7 NJ ex order 26.4b1 . A review of the "3-11 NJ Exec Ord Six Person Assignment:E" sheet dated NJ ex order, indicated Resident #61 received a shower on Mondays and Fridays during the 3-11 shift. A review of the Progress Notes for NJ ex order 26.4b1 did not include the NJ ex order 26.4b1 On 4/17/24 at 1:15 PM, the surveyor interviewed the US FOIA (b)(6)) who stated the Certified Nursing Aides (CNA) provided resident showers on their assigned days and shifts. On 4/17/24 at 3:00 PM, the surveyor attempted to interview CNA #1 who was assigned to Resident #61 on NJ Exec Order 26 via telephone. There was no answer. On 4/18/24 at 9:00 AM, the surveyor attempted to interview CNA #1 via telephone with no answer. On 4/18/24 at 9:10 AM, the surveyor informed the US FOIA (b) they attempted to speak to CNA #1 on multiple occasions, and the US FOIA (b) stated CNA #1 had called out for their assigned shift today. On 4/18/24 at 9:15 AM, the US FOIA (b) informed the surveyor that CNA #1 who stated she had four residents to give showers to on that day, and the aide should have informed the US FOIA (b)(6) if she was unable to provide care. On 4/23/24 at 10:46 AM, the surveyor interviewed CNA #2 who stated they received their daily assignments which included which residents needed to be showered. CNA #2 stated if a resident NJ Exec Order 26 a shower, they were to notify the	F 676	frequency and/or necessity of further audits.	

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F 676	Continued From page 8 US FOIA (b)(6). On 4/23/24 at 11:00 AM, the surveyor interviewed the US FOIA (b)(6) who stated resident shower days were indicated on the CNA's assignment sheets, and if the resident refused to be showered, the US FOIA (b would notify her. On 4/24/24 at 10:02 AM, the US FOIA (b) in the presence of the US FOIA (b)(6) and survey team stated she spoke to CNA #1 on the telephone and confirmed Resident #61 NJ ex order 26.4b1 NJ ex order 26.4b. The US FOIA (b) continued that CNA #1 informed her that she ran out of time to shower the resident, and the US FOIA (b) acknowledged the aide did not inform anyone. The US FOIA (b acknowledged residents should receive showers as scheduled. A review of a facility's "Activities of Daily Living (ADL), Supporting" policy dated January 2024, included Supporting This policy indicate Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs)...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently with consent of the resident and in accordance with the plan of care... NJAC 8:39- 27.1 (a)	F 676		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		6/13/24

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F 812	Continued From page 9	F 812		

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness; b.) maintain kitchen equipment in a clean and sanitary manner; and c.) maintain cold food in acceptable temperatures during meal service. The deficient practice was evidenced by the following:

1. On 4/10/24 at 9:10 AM, the surveyor in the presence of the US FOIA (b)(6)) and the US FOIA (b)(6)) conducted a kitchen tour and observed the following:

1. In the walk-in freezer, an opened box of sliced cheese pizza. The box contained a bag with two

Provider's Plan of Correction:

F- TAG 812
1. On 4/11/24, the opened, undated Pizza and the Salisbury steak were immediately discarded. The entire walk-in-freezer was inspected by the Corporate Food Service Director and the Food Service Director to ensure there were no other opened/undated food items in the freezer. The Corporate Food Service Director provided individual in-service to the US FOIA (b)(6) regarding the policy of Storing, Preparing, Labeling and the Distribution of food in accordance with professional standards for food service safety. The cooktop catch tray, the fryer area, the double door steamer box was immediately cleaned. The oil in the fryer

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F 812	Continued From page 10 slices of pizza outside of the bag, and the box was unsealed exposing the contents to air. The surveyor observed ice crystals on all the pizza slices. There was no observed date when the box was opened. The US FOIA (b) was unsure when the box was opened. 2. In the walk-in freezer, an opened box of Salisbury steaks. The box contained a bag that was opened exposing the contents to air. The surveyor observed ice crystals on the food product. There was no observed date of when the box was opened. The US FOIA (b) was unsure when the box was opened. 3. The cooktop catch tray had hard, thick, flaky black sediment on the pan and soiled aluminum foil on top of the sediment. The US FOIA (b) and US FOIA acknowledged that it needed to be thoroughly cleaned. The US FOIA (also stated, "it did not meet expectations on his staff." 4. The fryer had sediment around the cook top area and the oil was dark brown in color with sediment floating on the surface. The US FOIA (and US FOIA acknowledged that it needed to be thoroughly cleaned. The US FOIA (also stated, "it did not meet expectations on his staff." 5. The double door steamer box had sediment in the catch tray and built-up debris in the filter on the right side of the tray. The US FOIA (b and US FOIA acknowledged that it needed to be thoroughly cleaned. The US FOIA (also stated, "it did not meet expectations on his staff." On 4/11/24 at 8:52 AM, the surveyor interviewed the US FOIA who stated the freezer items should have been labeled with an opened date. The US FOIA also	F 812	was discarded. On 4/17/2024 the Corporate Food Service Director reviewed the policy for "Food Temperatures" with the US FOIA (b)(6) and all dietary staff. The pudding, cantaloupe and remaining sandwiches were checked for temperature compliance. 2. All residents have the potential to be affected when food items are not stored according to regulatory guidelines as this may produce food borne pathogens. A facility wide inspection was conducted by the Food Service Director to determine if any areas that store food had any opened/undated items, there were none found. All residents have the potential to be affected by this deficient practice when kitchen appliances are not maintained in a clean and sanitary manner. All residents have the potential to be affected by this deficient practice when food is not at the proper temperature. 3. On 4/11/24, the Corporate Food Service Director re-educated the US FOIA (b) and all dietary staff on the policy and procedure for safe storage, preparation, labeling and distribution of food in accordance with standards for food service safety. On 4/11/2024 the Corporate Food Service Director re-educated the US FOIA (b)(6) and the dietary staff on cleanliness in the kitchen including the freezer, appliances, and all cooking areas. On 4/17/2024 The Corporate Food Service Director initiated an in-service for the US FOIA (b)(6) as well as the dietary staff on facility policy for 'Food Temperatures'. 4.The Corporate Food Service Director or	

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F 812	Continued From page 11 acknowledged that once a product was opened, if all the content in the bag was not used, it should be resealed and dated. The US FOIA further stated that the cooking equipment should have been cleaned and maintained in a sanitary manner to prevent food borne illness and contamination. On 4/11/24 at 9:11 AM, the surveyor interviewed the US FOIA (b) who stated the facility's process and policy was to seal any opened packaging that was partially used and label the packaging with an opened date to ensure the product was used in a timely fashion to prevent waste and sealing to prevent exposure to air which caused contamination, ice crystal formation, and food born illnesses. The US FOIA (also acknowledged the cooking equipment should have been cleaned and maintained in a sanitary manner to prevent food borne illness and contamination according to regulations. On 4/22/24 at 11:44 AM, the US FOIA (b)(6) in the presence of the US FOIA (b)(6)) acknowledged the above concerns. A review of the facility's undated "Food Storage: Cold Foods" policy included...all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination... A review of the facility's "Environment" policy dated revised July 2023, included it is the center policy that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. Action Steps: 1. The FSD will ensure that the physical plant is maintained in a clean and sanitary manner,	F 812	designee will conduct a full inspection of kitchen appliances and all food items in the walk-in freezer monthly x 6 months. The Food Service Director or designee will do a temperature audit at least 1 meal a day for one month, and at least once a week for 3 months. Negative findings will be address immediately by providing education to dietary staff or providing disciplinary actions as appropriate. All findings will be reported at the next 3 Quality Assurance meting who meets quarterly for review and recommendations for frequency and further audits.	

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	315288	A. BUILDING ______ B. WING ______	C 04/30/2024

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F 812	Continued From page 12 including floors, walls, ceilings, lighting, and ventilation; 2. The FSD will ensure that all employees are knowledgeable in the proper procedures for cleaning all food services equipment and services; 3. The FSD will ensure that all food contact surfaces are cleaned and sanitized after each use; 4. The FSD will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces... 2. On 4/17/24 at 11:07 AM, the surveyor informed the US FOIA (b)(6)) that they wanted to observe food temperatures for the lunch trayline. At this time, the US FOIA (b) calibrated a thin probe thermometer in an ice bath to 32 degrees Fahrenheit (F). The US FOIA (informed the surveyor that cold food should be maintained at 41 F or below. The surveyor observed the following food items held above 41 F: Cantaloupe 43 F. The cantaloupe was in a portion control (PC) cup with a label that indicated prepared 4/17/24 at 6:08 AM. The containers were directly on a tray with no measures to maintain coldness. Pudding 44 F. The pudding was in a PC cup with a label that indicated prepared 4/17/24 at 6:57 AM. The containers were being held directly on a tray with no measure to maintain coldness. Ham and cheese sandwich 51 F. The sandwich had a label that indicated prepared 4/17/24 at 7:03 AM. The sandwich was being held directly on the trayline with no measure for maintaining coldness. Turkey sandwich 49 F. The sandwich was being	F 812		

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F 812	Continued From page 13 held directly on the trayline with no measure for maintaining coldness. On 4/17/24 at 11:15 AM, the surveyor interviewed Dietary Aide (DA#1) who stated another US FO prepared the cold items, and she printed the label at the time the other US FO prepared the items and placed them in the refrigerator. On 4/17/24 at 11:20 AM, the surveyor interviewed DA #2 who stated he removed the sandwiches from the refrigerator at approximately 11:05 AM, and placed them on the trayline. On 4/17/24 at 11:21 AM, the US FOIA (b acknowledged that the cantaloupe, pudding, and sandwiches were not being held at 41 F or below. On 4/24/24 at 10:02 AM, the US FOIA (b)(6) in the presence of the US FOIA (b)(6) and survey team acknowledged the cold food items were not being held at the appropriate temperature. A review of the facility's "Food Temperatures" policy dated reviewed August 2023, included the temperature of hot foods at the point of service (steamtable) during tray assembly will be 135 degrees Fahrenheit or above for hot foods and 40 or below for cold foods...the cook is responsible to see all food is at proper temperature...chilled food and beverages recommended temperature range 40 F or below... NJAC 8:39-17.2(g)	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		6/13/24

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F 842	Continued From page 14	F 842		

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 15 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review pertinent facility documents, it was determined that the facility failed to maintain complete and accurate NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 35 resident medical records reviewed (Resident #61), and was evidenced by the following: On 4/15/24 at 11:01 AM, the surveyor interviewed Resident #61 who stated he/she NJ ex order 26.4b1 on Friday NJ ex order 26.4b1.	F 842	F-TAG 842 1. On NJ ex order 26.4b1, the Director of Nursing NJ ex order 26.4b1 on resident #61. On NJ ex order 26.4b1, the Director of Nursing provided individual counseling to the Unit Manager (NJ Exec Ord Unit) regarding the facility policy for completing weekly NJ Exec O assessments and the NJ Exec O assessment documentation. A review of the policy titled "NJ Exec Order 26.4b1" was reviewed with the US FOIA (b)(6). 2. All residents have the potential to be	

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F 842	Continued From page 16 The surveyor reviewed the medical record for Resident #61. A review of the Admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that NJ ex order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4 included that the resident had a Brief interview for Mental Status (BIMS) score of NJ ex out of 15, which indicated a NJ ex order 26.4b1 . On 4/15/24 at 11:01 AM, the surveyor received from the US FOIA (b)(6) Resident #61's "NJ ex order 26.4b which were dated NJ ex order 26.4b NJ ex order 26.4b1 A review of the assessment sheet indicated on NJ Exe the nurse documented NJ ex and signed their initials. There initials for the US FOIA (b)(6) initials were blank. For the dates of NJ ex order 26.4b1 and NJ ex order there was NJ ex order 26.4b1 , and/or initials for the US FOIA (b)(6) . A review of the "3-11 NJ Exec Ord Six Person Assignment: E" indicated, sign the NJ Exec Order 26.4b1 assessment form Monday through Friday. On 4/17/24 at 9:37 AM, the US FOIA (b)(6)	F 842	affected by the cited deficient practice when the policy for "Weekly Skin Assessments" is not followed. A facility wide review was done by the Assistant Director of Nursing and Unit Managers to ensure all residents have a current skin assessment record. All residents have the potential to be affected when documents are not completed properly. 3. An in-service was initiated on 4/17/2024 and will be completed by 5/31/2024 by the Facility Staff Development coordinator with nurses regarding "Weekly Skin Assessments with emphasis in completing the weekly skin Assessments and signing timely. A similar education will be given during orientation for all new hired nurses, and will be repeated as deemed necessary. The Skin Assessment Form was reviewed and revised and a new streamlined "Weekly Skin Observation" will be utilized effective June 1st, 2024, for all residents for weekly skin inspection documentation. The old "Skin Assessment" form will be retired effective 6/1/24. 4.The Unit managers or desgnee will conduct a weekly audit for 15 residents covering all shifts to assure that the weekly skin inspection is completed, documented and signed x 4 weeks and then monthly x 3 months. Negative findings will be corrected immediately by providing a one on one re-education for nurse involved and disciplinary actions will be given if appropriate. The findings of the audits will be submitted to QA committee (who meets quarterly) for the next 3 quarters for review and recommendation	

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F 842	Continued From page 17	F 842		

(US FOIA (b)(6)) provided the surveyor with copies of the resident's "NJ ex order 26.4b1" dated NJ ex ord The assessments were now completed for all the dates, as well as NJ ex order 26.4b1 and NJ ex orde were added. The surveyor showed the US FOIA (b) the NJ Exec O assessment copies they received on NJ Exec Order 26, and asked why they were different from the copies the US FOIA (b) just provided. The US FOIA (b) stated after the surveyor spoke to the US FOIA (b)(6) on NJ Exec Order 26, the US FOIA (b)(6) informed the US FOIA (b about the missing documentation, so she had staff go back and change the forms to add the incomplete documentation.

On 4/22/24 at 12:00 PM, the US FOIA (b) provided the surveyor with a statement from the US FOIA (b)(6) that indicated on NJ ex order 26.4 during the 3:00 PM to 11:00 PM (3-11) shift, a NJ Exec O assessment was completed on Resident #61 with NJ Exec Order 26.4b1.

On 4/23/24 at 10:46 AM, the surveyor interviewed the US FOIA (b who stated after a resident received a shower, the aide notified the nurse to complete a NJ Exec Order 26.4b1.

On 4/24/24 at 10:02 AM, the US FOIA (b) in the presence of the US FOIA (b)(6), US FOIA (b)(6), and survey team acknowledged that the were not complete at the time of survey, and she had staff change the documentation. The US FOIA (b) confirmed she did not had staff date the assessment at the time the documentation was updated, and acknowledged staff should not back date assessments that were not completed. The US FOIA (b) acknowledged records were to be maintained accurately and complete.

Provider's plan of correction (F 842): for frequency and further audits.

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F 842	Continued From page 18 A review of a facility's "Activities of Daily Living (ADL), Supporting" policy dated January 2024, included residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs)...Appropriate care and services will be provided for residents who are unable to carry out ADLs... A review of a facility's "Weekly Skin Checks" policy dated 12/10/23, included the nurse will inspect the resident skin once weekly during bath days for sign of skin breakdown or injury....Will complete the Weekly Skin Check form after performing skin inspections.... NJAC 8:39-35.2(d)	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		6/13/24

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F 880	Continued From page 19 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 20 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure appropriate storage for NJ Exec Order 26.4b1 equipment for NJ Exec Order 26.4 prevention. This deficient practice was identified for 1 of 4 residents reviewed for NJ Exec Order 26.4b1 care (Resident #61), and was evidenced by the following: On 4/15/24 at 11:01 AM, the surveyor observed Resident #61 in bed and their NJ ex order 26.4b1 and NJ ex order 26.4b1 Resident #61 informed the surveyor that NJ ex order 26.4 On 4/15/24 at 11:15 AM, the surveyor interviewed the resident's US FOIA (b)(6)) who stated she had administered the resident's NJ ex order 26.4b1 earlier, but she never went back to the resident's room to verify if the treatment was completed. At that time, the US FOIA accompanied by the surveyor went into Resident #61's room, and the US FOIA took the resident's NJ ex order 26.4b1 The surveyor observed	F 880	F-TAG 880 Infection Control 1. O NJ ex order 26.4b1 for resident #61. The Director of Nursing provided individual counseling for the nurse involved regarding facility's policy for Cleaning NJ Exec Order 26.4b1 equipment after administration of NJ Exec Order 26.4b treatment and proper storage for NJ Exec Order 26.4 control practice. This individual in-service was completed on 4/15/2024. 2. All residents with a physician order for Nebulization treatment have the potential to be affected by the cited deficient practice. 3. The Infection Preventionist provided an in-service to licensed nurses on 4/15/24 regarding facility's policy for Cleaning Respiratory Equipment after administration of nebulizer treatment and its proper storage. This in-service will be completed by 5/31/2024 and will be given during orientation for all newly hired nurse and repeated as deemed necessary. 4. Facility Infection Preventionist and/or nurse designee will complete a weekly observation audit for five residents on nebulizer treatments covering all shifts x 4	

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F 880	Continued From page 21 no disinfecting of the NJ ex order 26.4b1. The surveyor asked the US FOIA what the facility's policy was for US FOIA (b)(6) equipment cleaning and storage, and the US FOIA stated the NJ Exec Ord and NJ Exec Orde was placed into a bag for storage after use. On 4/15/24 at 11:20 AM, the surveyor interviewed the US FOIA (b)(6) regarding the facility's policy for usage and storage of NJ Exec Order 26.4b equipment. The US FOIA (b)(6) stated when the resident's treatment was complete, the nurse placed the NJ Exec Ord and NJ Exec Orde into a storage bag. On 4/15/24 at 11:35 AM, the surveyor interviewed the US FOIA (b)(6) who stated the nurse was expected to administer the NJ Exec Order 26.4b treatment per physician's order; staying with the resident until the treatment was completed. The nurse then cleaned the NJ Exec Order 26.4b with water and dried it with a paper towel prior to placing it in a bag for storage.. The surveyor reviewed the medical record for Resident #61. A review of the Admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that NJ ex order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ ex order 26, included that the resident had a Brief interview for Mental Status (BIMS) score of NJ ex out	F 880	weeks and then monthly x three months to assure that nurses are following facility's policy for Cleaning Respiratory Equipment after administration of nebulizer treatment and its proper storage for infection control. Negative results will be corrected immediately through re-education, nebulizer competencies and or disciplinary action if deemed appropriate. Results of the audits will be submitted during the next 3 QA meetings to the QA committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.	

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F 880	Continued From page 22 of 15, which indicated a NJ ex order 26.4b1 . A review of the current Physician's Orders included a physician's order (PO) dated NJ ex order 26.4b1, NJ ex order 26.4b1 An additional PO dated NJ ex order 26.4b1, indicated NJ ex order 26.4b1 . On 4/22/24 at 9:45 AM, the surveyor interviewed the US FOIA (b)(6) who stated stated the nurse administered the NJ ex order 26.4b1 to order, and stayed with the resident until the treatment was complete. The nurse then removed the medication dispenser and rinsed the chamber, as well as rinsed the NJ Exec Ord with water and placed the equipment on a clean paper towel to dry. When the equipment was dry, the nurse placed it in a bag for storage. On 4/24/24 at 10:02 AM, the US FOIA (b) in the presence of the US FOIA (b)(6) , and survey team who stated the nurse should have rinsed the NJ ex order 26.4b1 and medication dispenser under running water after the resident's treatment was complete, and placed it on a clean paper to dry prior to placing in the bag for storage. A review of the facility's "Cleaning Respiratory Equipment" policy dated last revised 2/1/24, included supplies...when not in use, store masks and cannulae in plastic bags labeled with the resident's name and date...small volume nebulizers:..cleaning a. begin with a sterile (disposable) nebulizer for each resident; b. rinse with water and air dry small volume medication	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 nebulizers between treatments on same residents... A review of the undated facility provided "Medication Nebulization (AARC # 2720)" policy included this policy is to instruct the proper use of aerosolized medication to the lower airways via small volume nebulizer...Disassemble parts after ever treatment. Remove tubing from the compressor and set it aside. The tubing should not be washed or rinsed. Rinse the nebulizer cup and mouthpiece with either sterile or distilled water after each use and shake dry. Store in zippered or drawstring bag... NJAC 8:39-19.1(a)	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation it was determined that the facility failed to maintain the resident's environment, equipment, and living areas in a safe, sanitary, and homelike manner. This deficient practice was identified for 1 of 4 nursing units ([NJ Exec Ord] Unit) and was evidenced by the following: On 4/10/24 at 10:35 AM, the surveyor entered resident room [NJ Exec Ord] #17 and observed the doorknob backplate was not secured properly to	F 921	F tag- 921 Safe/Functional/Comfortable Environment 1. On 4/18/2024, the doorknob plate in room #1, room #15 and room # 17 (Birch Unit) was immediately repaired by the Maintenance Director. The PTAC unit cover in room # 11 was replaced by the Maintenance Director on 4/11/2024 and again on 4/18/2024 as it had become detached again. An in-service was done by the Administrator and the Maintenance Director with all staff (management and	6/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315288	A. BUILDING ______ B. WING ______	C 04/30/2024

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F 921	Continued From page 24 the resident's entrance door or bathroom door, which resulted in the backplate hanging loosely with a gap between the doorknob and the door. On 4/10/24 at 10:37 AM, the surveyor entered resident room NJ Exec Ord #15 and observed the doorknob backplate was not secured properly to the resident's entrance door which resulted in the backplate hanging loosely with a gap between the doorknob and the door. On 4/10/24 at 11:02 AM, the surveyor observed in resident room NJ Exec Ord #11, the packaged terminal air unit (PTAC) (a self-contained through-the-wall air conditioning and heating unit) with the cover detached and was placed next to the unit, which left the internal components of the unit exposed. The resident stated that the PTAC unit had been in this condition for a couple days. On that same date and time, the surveyor observed two holes in the wall, one to the left of the PTAC unit and one on the far wall between the residents' beds. On 4/12/24 at 11:33 AM, the surveyor entered resident room NJ Exec Ord #1 and observed the doorknob backplate was not secured properly to the resident's entrance door which resulted in the backplate hanging loosely with a gap between the doorknob and the door. On 4/12/24 at 11:36 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that broken items or building issues were to be reported to the US FOIA (b)(6) who entered the concerns into the computer system. When asked who was responsible for the overall appearance of the building, CNA #1 responded, everyone.	F 921	frontline) on the process of reporting any repairs that need to be performed in the facility on 4/18/2024 . A review of the computer system to inform maintenance of repairs needed was done by the Maintenance Director on 4/18/2024. 2. All residents have the potential to be affected by the cited deficient practice when the resident's environment is not kept safe, functional, sanitary, and comfortable. The Maintenance Director and Administrator conducted facility wide rounds to identify any other items that might need repair or replacement. 3. On 4/18/2024, the Maintenance Director re-educated the maintenance team, Department Heads, and Unit Managers, on the policy to report resident items that need repair or replacement to ensure that all repairs will be made with speed and efficiency. 4. The Maintenance director and/or maintenance staff will review the computer entries for any need of repair or replacement. Walking rounds will be done twice a week in at least 4 rooms per unit for 30 days by the Maintenance Director or designee and Unit Manager or designee to examine all components of the rooms. Then once a week for 30 days, then twice a month for 30 days. All findings will be reported at the Quality Assurance meeting (who meets quarterly) for the next 3 quarters.	

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F 921	Continued From page 25	F 921		

On 4/18/24 at 10:10 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that broken items and building issues were reported to Maintenance through the computer system. LPN #1 explained that everyone on the floor was responsible to identify and report any building issues that may be a safety concern.

On 4/18/24 at 10:36 AM, the surveyor interviewed the US FOIA (b)(6) who stated that any concerns with the building were to be reported right away to Maintenance through the computer system. The US FOIA (b)(6) confirmed that regularly scheduled floor staff, supervisors, clerks, and/or unit managers had access to the system and could directly enter their concerns. At this time, the surveyor and US FOIA (b)(6) toured the unit and the US FOIA (b)(6) confirmed that the doorknobs should not be loosely attached to the door. When the surveyor showed the US FOIA (b)(6) pictures of the PTAC unit with the cover removed and interior components exposed, the US FOIA (b)(6) confirmed that it should have been addressed immediately. The US FOIA (b)(6) also confirmed that resident rooms should not have holes in the wall.

On 4/18/24 at 10:50 AM, the surveyor interviewed the US FOIA (b)(6)) who stated that the Maintenance Department had a maintenance care application on their computer that identified building concerns and their location. The US FOIA (b) explained that the issues were addressed as soon as possible dependent on the situation, and confirmed that everyone in the building had the responsibility to ensure that the building was maintained in a safe and homelike environment. The US FOIA (b further confirmed that the doorknobs, the PTAC unit, and holes in the

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F 921	Continued From page 26 resident room should not have been in that condition. On 4/24/24 at 10:02 AM, the US FOIA (b)(6), in the presence of the US FOIA (b)(6) confirmed that the doorknobs, PTAC unit, and holes should have been previously identified and addressed and that they should not have been found in that condition. A review of the facility provided "Resident Rights" policy, with dated January 2023 included...the resident has a right to a safe, clean, comfortable and Homelike environment.... NJAC 8:39-4.1 (a), 11	F 921		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315288		6/18/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARTLEY NURSING & REHAB	175 BARTLEY RD JACKSON, NJ 08527

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 06/13/2024	ID Prefix F0676 Reg. # 483.24(a)(1)(b)(1)-(5)(i)-(iii) LSC	Correction Completed 06/13/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
4/30/2024	

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

POST-CERTIFICATION REVISIT REPORT

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315288		6/18/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 06/13/2024	ID Prefix F0676 Reg. # 483.24(a)(1)(b)(1)-(5)(i)-(iii) LSC	Correction Completed 06/13/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 06/13/2024
ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 06/13/2024	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 06/13/2024	ID Prefix F0921 Reg. # 483.90(i) LSC	Correction Completed 06/13/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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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? ☐ YES ☐ NO
4/30/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315288	A. BUILDING **02** B. WING ______	**04/30/2024**

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BARTLEY NURSING & REHAB	**175 BARTLEY RD** **JACKSON, NJ 08527**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/29/24 and 4/30/24, and Bartley Nursing and Rehab. was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility was originally constructed in 1985 as a one-story building Type II (000). There is supervised smoke detection in the corridors and in resident rooms. There are two (2) emergency generators inside the facility 1. Generac 200 KW Diesel. 2. Onan 55 KW Natural Gas. The generators supply emergency power to the fire alarm control panel, cross corridor doors hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for privation of life. The facility is divided into 16- smoke zones.	K 000		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit	K 293		6/13/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/23/2024

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

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K 293	Continued From page 1 travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation on 4/29/24 and 4/30/24, in the presence of facility management, it was determined that the facility failed to provide seven illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was identified had the potential to affect 204 residents who reside in the facility, and was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge."	K 293	1. An outside vendor was contacted and came in to install 6 illuminated exit signs. Aspen Court (2) outside enclosed courtyard, Cedar Unit (2) outside courtyard and Birch Unit (2) outside courtyard. The sign above the corridor double smoke doors near the resident's Salon was installed by Director of Maintenance. 2. All residents and staff have the potential to be affected by this deficient practice when there is an insufficient number of illuminated exit signs throughout the facility that clearly identify routes to reach an exit. 3. On 5/3/2024 the Administrator re-educated the US FOIA (b)(6) and the maintenance staff on proper placement of exit and directional signage with continuous illumination. 4. The Maintenance Director or designee will audit exit sign placement and functionality on at least 5 corridors/areas once a week for a month and then once a month for six months. All findings will be reported at the next 3 meetings of the Quality Assurance committee which meets quarterly.	

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K 293	Continued From page 2	K 293		

2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign."

On 4/29/24, during the survey entrance at approximately 8:41 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility was a single-story building with three enclosed (surrounded by the building) outside courtyards that residents, staff and visitors could use.

Starting at approximately 9:01 AM on 4/29/24 and continued on 4/30/24, in the presence of the US FOIA (b)(6) a tour of the building was conducted.

During the two day building tour the of the facility, the surveyor observed seven locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations:

1. On 4/29/24 at approximately 9:58 AM, the surveyor observed in the Aspen Unit outside enclosed courtyard, that the facility failed the have two illuminated exit signs above the two

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K 293	Continued From page 3 designated exit access doors that clearly identified the exit access routes to reach an exit. 2. On 4/29/24 at approximately 10:03 AM, the surveyor observed no evidence of one illuminated exit sign above the corridor double smoke doors near the residents' Salon. When the fire alarm was activated the corridor double smoke doors automatically released and closed, you would not be able to see the illuminated exit sign on the other side of the doors. 3. On 4/30/24 at approximately 10:16 AM, the surveyor observed in the Cedar Unit outside enclosed courtyard, that the facility failed the have two illuminated exit signs above the two designated exit access doors that clearly identified the exit access routes to reach an exit. 4. On 4/30/24 at approximately 11:10 AM, the surveyor observed in the Birch Unit outside enclosed courtyard, that the facility failed the have two illuminated exit signs above the two designated exit access doors that clearly identified the exit access routes to reach an exit. The US FOIA (b) confirmed the findings at the time of observations. The US FOIA (b)(6) were informed of these findings during the life safety code exit on 4/30/24 at approximately 12:40 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		

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K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility provided documentation on 4/29/24 and 4/30/24, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in	K 321	1. On 5/1/24, the Maintenance Director installed a door closure on the corridor door leading to the Finance Office. This allows for the door to self-close. 2. All residents as well as staff members have the potential to be affected by this	6/13/24

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BARTLEY NURSING & REHAB	**175 BARTLEY RD** **JACKSON, NJ 08527**

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K 321	Continued From page 5 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 was identified and had the potential to affect 204 residents who reside in the facility, and was evidenced by the following: During survey entrance conference on 4/29/24 at approximately 8:41 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a single-story building with 144 resident sleeping rooms and common areas that resident, staff, and visitors could use. Starting at approximately 9:01 AM on 4/29/24 and continued on 4/30/24, in the presence of the US FOIA (b)(6) a tour of the building was conducted. During the two day building tour the surveyor observed the following hazardous area that failed to have smoke resisting doors: 1. On 4/30/24 at approximately 9:32 AM, during an inspection of the Finance office, when the corridor door leading to the Finance office was opened to a 90 degree opening to the frame, the door did not self-close. The surveyor observed the door had no means to self-close. The surveyor observed inside the room the contained the following combustible products: 51 banker size boxes filled with resident medical records; four drawer filing cabinets filled with paper records; eight-five drawer filing cabinets filled with paper records; cardboard boxes and other	K 321	deficient practice when fire doors do not meet regulatory requirements. A facility wide inspection was conducted by the Administrator and Maintenance Director to ensure all fire doors met regulatory guidelines. None were found to be deficient. 3. An in-service was done on 5/3/2024 by the Administrator for the US FOIA (b)(6) and all maintenance staff regarding regulatory compliance for Fire Safety pertaining to enclosed areas. 4. 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 reported at the next 3 meetings of the Quality Assurance committee who meet quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315288	A. BUILDING **02** B. WING ______	**04/30/2024**

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BARTLEY NURSING & REHAB	**175 BARTLEY RD** **JACKSON, NJ 08527**

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K 321	Continued From page 6 combustible products. This Finance office was utilized as a medical records storage room. At this time the surveyor counted the 2 foot by 4 foot (2' by 4') drop ceiling tiles which the room measured 28' by 24' which was 672 square feet which was larger than 50 square feet. With this corridor door not smoke resistant, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted in the corridor identified you would need to pass by this room as the primary and/or secondary exit access route to reach an exit. The US FOIA (b) confirmed the findings at the time of observations. The US FOIA (b)(6) were informed of the finding during the life safety code exit on 4/30/24 at approximately 12:40 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING 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. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state	K 351		6/13/24

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K 351	Continued From page 7 or local regulations prohibit sprinklers. 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. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/29/24 and 4/30/24, in the presence of facility management, it was determined that the facility failed to install sprinklers to all areas in accordance with the requirements of 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 Systems 2012 Edition. This deficient practice was identified for 1 of 17 exit discharge door over hangs that exceeded four feet, and was evidenced by the following: During the survey entrance on 4/29/24 at approximately 8:41 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a single-story building with 144 resident sleeping rooms and common area that resident, staff, and visitors could use. Starting at approximately 9:01 AM on 4/29/24 and continued on 4/30/24, in the presence of the US FOIA (b)(6) a tour of the building was conducted. Along the two day tour of the facility, the surveyor	K 351	1. An outside vendor was contacted to install a new sprinkler head outside the overhang adjacent to the Main Dining room. The vendor did a site visit to take measurements and put together a proposal for the scope of work as well as plans to submit for a permit. The proposal was approved by the Administrator. Sprinkler was installed on 6/13/2024. 2. 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 Administrator with the Maintenance Director made facility wide rounds to ensure that all other areas had the sprinklers within the regulatory requirements. 3. 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 by an overhang that measures greater than 4 feet. 4. New sprinkler head will be included in future sprinkler inspections. All findings will be reported at the next 3 Quality	

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K 351	Continued From page 8 observed the following location that failed to provide proper fire sprinkler coverage: On 4/29/24 at approximately 10:15 AM, the surveyor observed no evidence of a fire sprinkler for the outside overhang adjacent to the Main Dining room. At this time the surveyor asked the US FOIA (b) if they saw a fire sprinkler for the overhang, and the US FOIA (b) stated, no. At this time the surveyor measured and recorded the unprotected overhang which was 5 feet by 5 feet; which was move than four feet from the building. The US FOIA (b) confirmed the findings at the time of observations. The US FOIA (b)(6) were informed of the finding during the life safety code exit on 4/30/24 at approximately 12:40 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	Assurance Committee meetings which are conducted quarterly.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These	K 363		6/13/24

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K 363	Continued From page 9 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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 4/29/24 and 4/30/24, in the presence of facility management, it was determined that the facility failed to ensure 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. This deficient practice was identified for 2 of 32 corridor doors inspected, and was evidenced by the following:	K 363	1. On 5/2/24 the Door on Aspen Unit Nourishment room and the door on Cedar Unit by the Bathing room corridor were immediately repaired by the Maintenance Director. The Administrator along with the Maintenance Director conducted a facility wide inspection of all doors to ensure all doors met regulatory requirements preventing fire, smoke and poisonous gases from passing into the exit. 2. All residents and staff members have the potential to be affected by this	

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K 363	Continued From page 10	K 363		

During survey entrance on 4/29/24 at approximately 8:41 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility was a single-story building with 144 resident sleeping rooms and common area that resident, staff, and visitors could use.

Starting at approximately 9:01 AM on 4/29/24 and continued on 4/30/24, in the presence of the US FOIA (b)(6) a tour of the building was conducted. During the two day tour of the facility the surveyor performed closure tests of the thirty-two doors in the corridors with the following results:

1. On 4/29/24 at approximately 9:49 AM, during a closure test of the Aspen Unit Nourishment room corridor door, the surveyor observed, measured, and recorded a 5/8 inch (5/8)" gap along the top of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.

A review of an Emergency Evacuation diagram posted in the corridor identified to pass this Aspen Unit Nourishment room would be the primary and/or secondary exit access route to reach an exit.

2. On 4/30/24 at approximately 10:10 AM, during a closure test of the Cedar Unit Central Bathing room corridor door, the surveyor observed, measured, and recorded a 3/8" gap along the top of the door. This would allow fire, smoke and poisonous gases to pass into the exit access

deficient practice when doors are not properly set and fire, smoke or poisonous gases can exit.

3. On 5/2/2024 Administrator provided in-service to the US FOIA (b)(6) as well as the maintenance staff regarding the proper regulatory guidelines for doors and the prevention of fire, smoke and poisonous gases from passing into the exit.

4. The Maintenance Director or designee will check at least 10 doors weekly for one month and then monthly for six months for any gaps that would allow fire, smoke, or poisonous gas to pass through to the exit. All findings will be reported at the next 3 meetings of the Quality Assurance committee who meet quarterly.

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K 363	Continued From page 11 corridor in the event of a fire. A review of an Emergency Evacuation diagram posted in the corridor identified to pass this Central Bathing room would be the primary and/or secondary exit access route to reach an exit. The US FOIA (b) confirmed the findings at the time of observations. The US FOIA (b)(6) were informed of the findings during the survey exit on 4/30/24 at approximately 12:40 PM. NJAC 8:39-31.1(c), 31.2(e) 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		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility	K 372	1. All penetrations above the ceiling tiles	6/13/24

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provided documentation on 4/29/24 and 4/30/24 in the presence of facility management, it was determined that the facility failed to maintain the integrity of smoke barrier partitions. This deficient practice was identified for 5 of 8 smoke barrier walls inspected, and was evidenced by the following:

During entrance conference on 4/29/24 at approximately 8:41 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility was a single-story building with fifteen smoke barrier walls for the sixteen smoke compartments.

Starting at approximately 9:01 AM on 4/29/24 and continued on 4/30/24, in the presence of the US FOIA (b)(6) an inspection of the above the corridor ceiling tiles of eight smoke barrier walls was performed. The surveyor observed the following smoke barrier wall failed to maintain the 1/2 hour fire rated construction as required by code in the following locations:

1. On 4/29/24 at approximately 9:10 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors going into the Aspen Unit (next to Resident Room #A-1) had one approximately one and a half inch (1-1/2") penetration with wires running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, which indicated that it would not seal closed to prevent smoke, fumes, and fire from passing through to

K 372

(Aspen Unit) next to room #A-1, above the ceiling tiles of the double smoke doors on the (Aspen Unit) next to resident room #A-7, double smoke doors on the (Aspen Unit) near room #A-23 and #A-25, above the ceiling tiles of the double corridor smoke doors next to room #A-30, and above the ceiling tiles of the double smoke doors on the (Cedar Unit) next to room #C-28 running through the barrier walls were sealed to prevent smoke, fumes and fire from passing through to the other compartments.

2. All residents have the potential to be affected by this deficient practice when wires through the barrier wall are not sealed. A facility wide inspection was conducted by the Administrator and Maintenance Director to ensure there were no other barrier walls with unsealed wires or other penetrations. None were found to be deficient.

3. An in-service was conducted by the Administrator for the US FOIA (b)(6) and all maintenance staff regarding the importance of sealing penetrations through a barrier wall.

4. The Maintenance Director or designee will inspect at least 5 barrier walls weekly for 4 weeks and then monthly for 6 months to ensure all barrier walls are sealed properly. All findings will be reported at the next 3 meetings of the Quality Assurance Committee who meet quarterly.

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K 372	Continued From page 13 the other smoke compartment. 2. On 4/29/24 at approximately 9:22 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors on the Aspen Unit (next to Resident Room #A-7) had one approximately 1" penetration with three white wires and one red wire running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, which indicated that it would not seal closed to prevent smoke, fumes, and fire from passing through to the other smoke compartment. 3. On 4/29/24 at approximately 9:39 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors on the Aspen Unit (between Resident Rooms #A-23 and #A-25) had one approximately 3" by 3-1/2" penetrations with three white wires and one red wire running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, which indicated that it would not seal closed to prevent smoke, fumes, and fire from passing through to the other smoke compartment. 4. On 4/29/24 at approximately 9:44 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors (next to Resident Room #A-30) had one approximately 1-1/2" penetration with wires running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, which indicated that it would not seal closed to prevent smoke, fumes, and fire from passing through to the other smoke compartment. 5. On 4/30/24 at approximately 9:48 AM, the	K 372		

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K 372	Continued From page 14 surveyor observed above the ceiling tiles of the corridor double smoke doors on the Cedar Unit (near to Resident Room #C-28) had one approximately 2" by 3" penetration with wires running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, which indicated that it would not seal closed to prevent smoke, fumes, and fire from passing through to the other smoke compartment. The US FOIA (b) confirmed the findings at the time of observations. The US FOIA (b)(6) were informed of the findings during the life safety code exit on 4/30/24 at approximately 12:40 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 4/29/24 and 4/30/24, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 9 electrical outlets located next to a water source (with-in 6 feet) was equipped with	K 911	1. The GFCI electrical outlet in resident room #C-21 located 12 inches from the sink was immediately replaced by the Maintenance Director. The Classroom/Staff Lounge duplex electrical	6/13/24

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K 911

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ground-fault circuit interrupter (GFCI) protection as required. This deficient practice was evidenced by the following:

Reference:
National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.

NFPA 70,
210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location.

(B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal.
(5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink.

During entrance conference on 4/29/24 at approximately 8:41 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility was a single-story building with 144 resident sleeping rooms and common area that resident, staff and visitors could use.

K 911

outlet located 10 inches to the left of the sink was immediately replaced by the Maintenance Director.
2. All residents have the potential to be affected by this efficient practice when electrical outlets do not meet regulatory requirements. The Administrator and Maintenance Director conducted a facility wide inspection of all GFCI electrical outlets to ensure all meet regulatory guidelines. None were found to be deficient.
3. On 5/2/24 an in-service was conducted by the Administrator for the US FOIA (b)(6) and all maintenance staff regarding the testing of the GFCI outlets to ensure they are functioning correctly.
4. An audit of at least 5 GFCI outlets will be tested weekly for a month by the Maintenance Director or designee to ensure they are in proper working condition and meet compliance for life safety. Audit will be repeated monthly for 6 months. All findings will be reported at the next 3 meetings of the QA committee which meets quarterly.

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BARTLEY NURSING & REHAB	**175 BARTLEY RD** **JACKSON, NJ 08527**

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K 911	Continued From page 16 Starting at approximately 9:01 AM on 4/29/24 and continued on 4/30/24, in the presence of the US FOIA (b)(6) a tour of the building was conducted. During the two day tour of the facility, the surveyor observed and tested nine electrical outlets in wet (with-in six feet of a sink) locations with two electrical outlets that failed to de-energize when tested in the following location: 1. On 4/30/24 at approximately 9:56 AM, the surveyor observed, measured and recorded in the inside Resident Room #C-21 bathroom one GFCI electrical outlet located approximately 12 inches from the sinks edge when tested with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. 2. On 4/30/24 at approximately 10:17 AM, the surveyor observed, measured and recorded in the "Class room/ Staff Lounge" one duplex electrical outlet located 10 inches to the left of the sink when tested with a GFCI tester to de-energize, the duplex electrical outlet did not de-energize as required by code. The US FOIA (b) confirmed the findings at the time of observations. The US FOIA (b)(6) were informed of the deficiency during the life safety code survey exit on 4/30/24 at approximately 12:40 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=F	Electrical Systems - Essential Electric Syste	K 918		6/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315288	A. BUILDING **02** B. WING ___	**04/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARTLEY NURSING & REHAB	**175 BARTLEY RD** **JACKSON, NJ 08527**

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K 918	Continued From page 17 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/29/24	K 918	1. The Administrator immediately	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315288	A. BUILDING **02** B. WING ___	**04/30/2024**

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BARTLEY NURSING & REHAB	**175 BARTLEY RD** **JACKSON, NJ 08527**

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K 918	Continued From page 18 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 2 of 2 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: During entrance conference on 4/29/24 at approximately 8:41 AM, the surveyor asked the US FOIA (b)(6)) if the facility had an emergency generator, and the US FOIA (b) stated the facility had two; one was a 200 kilowatt (KW) diesel emergency generator and one was a 55 KW natural gas emergency generator. Starting at approximately 9:01 AM on 4/29/24 in the presence of the US FOIA (b)(6) a tour of the building was conducted. During the building tour the of the facility the surveyor at approximately 10:10 AM, an inspection of the two emergency generators was performed. The surveyor observed that the two emergency generators had the stop buttons located on the control panels of the generators. The surveyor observed no evidence of remote top buttons for the 200 KW diesel emergency generator and the 55 KW natural gas emergency generator. The US FOIA (b) told the surveyor that there are no remote stop buttons for the two emergency generators. The US FOIA (b) confirmed the findings at the time of observations.	K 918	contacted an outside vendor to install the NJ Ex Order 26.4b1) and Generator 55 KW (Natural Gas). The vendor did a site visit to obtain information of what parts/equipment is necessary. Vendor sent proposal of work to Administrator. Proposal was approved immediately. Emergency stop buttons were installed for both generators. 2. All residents have the potential to be affected by this deficient practice when the Stop Station remote has not been installed. 3. The Administrator reviewed the regulatory guidelines with the US FOIA (b)(6) to ensure there was knowledge of the regulatory requirements and the need for compliance, specifically the need for a remote manual stop button for each generator that is placed away from the actual unit. 4. The Administrator will ensure that facility staff is educated on how to use the emergency stop buttons if necessary. All findings will be reported at the next 2 meetings of the Quality Assurance committee who meet quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315288	A. BUILDING **02** B. WING ______	**04/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARTLEY NURSING & REHAB	**175 BARTLEY RD** **JACKSON, NJ 08527**

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K 918	Continued From page 19 The US FOIA (b)(6) were informed of the findings during the life safety code exit on 4/30/24 at approximately 12:40 PM. NJAC 8:39-31.2(e), 31.2(G) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315288	A. Building 02 - BUILDING B. Wing	7/1/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARTLEY NURSING & REHAB	175 BARTLEY RD JACKSON, NJ 08527

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 Reg. # NFPA 101 LSC K0293	Correction Completed 06/13/2024	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 06/13/2024	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 06/13/2024
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 06/13/2024	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 06/13/2024	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 06/13/2024
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 06/14/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
4/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO