STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315262	A. BUILDING _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARROGATE	400 LOCUST STREET LAKEWOOD, NJ 08701

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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 #: NJ00163358, NJ00174088 Survey Date: 08/15/2024 Census: 63 Sample: 17 plus 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately assess the status of a resident in the Minimum Data Set (MDS), an assessment tool. This deficient practice was identified for 1 of 2 sampled residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #16) and was evidenced by the following: On 08/08/2024 at 10:00 AM, the surveyor	F 641	It is the practice of this facility to have the assessment accurately reflect the resident's status. One resident was found to have been affected by the alleged deficient practice. Resident #16 was observed to have a NJ Ex Order 26.4(b)(1) on his/her NJ Ex Order 26.4(b). A review of Section P0200 for NJ Exec Order was coded as NJ indicating there	10/15/24

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

Electronically Signed | 08/30/2024

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 641	Continued From page 1 observed Resident #16 in the bed with a NJ Ex Order 26.4 [redacted] on his/her NJ Ex Order 26.4(b)(1) According to the Admission Record, Resident #16 was admitted to the facility with diagnoses including of but not limited to NJ Ex Order 26.4(b)(and NJ Ex Orde [redacted] Resident #16 had a Physician Order (PO) dated NJ Ex Order 26.4(b)(1) to apply a NJ Ex Order 26.4(b)(1). A review of the Admission MDS dated NJ Ex Order 26.4(b)(1) for Resident # 16, indicated under Section NJ Exec Order 2 for NJ Exec Order 2 was coded as NJ indicating there was NJ Ex Order 26.4(b)(1). During an interview on 8/12/2024 at 11:37 AM, the U.S. FOIA (b) (6) acknowledged that Resident #16's Admission MDS dated NJ Ex Order 26.4(b)(1) should have been coded as having a NJ Ex Order 26.4(b)(1). NJAC 8:39-27.1(a)	F 641	was NJ Ex Order 26.4(b)(1). On discovery Section P0200 was modified immediately by the US FOIA (b)(6) and coded as having a NJ Ex Order 26.4(b)(1). Education was provided the U.S. FOIA (b) (6) from the Director of Nursing and the corporate MDS specialist. NJ Ex Order 26.4(b)(1) was caused from this deficient practice. All residents identified as a risk for elopement have the potential to be affected by the alleged deficient practice. The Director of Nursing or designee will conduct weekly audits on all MDS P0200 in the look back period for accurate coding to reflect the resident status. The completion of audits will be monitored by the Administrator, Director of Nursing, or designee weekly for 4 weeks, every two weeks for 2 months, and monthly for 2 months. Audit findings will be discussed during monthly QAPI meetings. Adverse findings will be immediately addressed.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		10/15/24

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F 656	Continued From page 2 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 656	It is the practice of this facility to develop	

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F 656	Continued From page 3 and review of pertinent facility documentation, it was determined that the facility failed to A.) reevaluate and update a resident-centered Care Plan (CP) upon readmission, to include the use of an NJ Ex Order 26.4(b)(1), B.) failed to develop and implement a comprehensive person-centered care plan that include the use of an NJ Ex Order 26.4(b)(1) and use of a NJ Ex Order 26.4(b)(1), and C.) failed to reevaluate and update a resident-centered CP to include NJ Ex Order 26.4(b)(1). The deficient practice was identified for 4 of 4 residents (Resident # 15, # 17, #43, # 3) reviewed for Care Plans. A.) On 08/08/2024 at 9:24 AM, Surveyor # 1 observed Resident #15 in bed. The resident responded when Surveyor # 1 spoke to them. The resident had covers over them and Surveyor # 1 was unable to observe the resident's NJ Ex Ord A review of the Admission Record indicated that Resident #15 had diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A review of the Annual Minimum Data Set (MDS) an assessment tool used to facility resident care dated NJ Ex Order 26.4(b)(1), included but was not limited to; Section N0415 - NJ Ex Order 26.4(b)(1) Classes: Use and Indication, documented that Resident #15 was taking NJ Ex Order 26.4(b)(1) medication. A review of the Order Summary Report active orders as of NJ Exec Order 26.4b1 included but was not limited to; a physician's order dated NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) Oral Tablet NJ Ex Order 26.4(b)(1)) NJ Ex Order 26.4(b)(1) Give 1 tablet by mouth every 12 hours related to NJ Ex Order 26.4(b)(1). Monitor for NJ Ex Order 26.4(b)(1) such as NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).	F 656	and implement comprehensive person-centered care plans for each resident. 4 residents were found to have been affected by the alleged deficient practice. Resident #15: Care plan was updated to reflect the use of NJ Ex Order 26.4(b)(1) medications including goals with target dates, interventions, and tasks. Resident #17: Care plan was updated to reflect the NJ Ex Order 26.4(b)(1) including goals with target dates, interventions, and tasks. Resident #43: Care plan was updated to reflect the NJ Ex Order 26.4(b)(1) including goals with target dates, interventions, and tasks. Resident # 3: Care plan was updated to reflect the NJ Ex Order 26.4(b)(1) that was identified to the NJ Ex and NJ Exec Or NJ Exec Order 26 including goals with target dates, interventions, and tasks. All floor nurses, charge nurses, unit managers, and supervisors will be reeducated on proper development of comprehensive care plans by the DON and ADON, Staff Educator, at the staff meeting on September 24th. NJ Ex Order 26.4(b)(1) was caused by this deficient practice. All residents have the potential to be affected by the alleged deficient practice.	

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F 656	Continued From page 4 A review of the NJ Ex Ord Evaluation dated NJ Ex Order 26.4(b)(1), included but was not limited to documentation that Resident #15 had NJ Ex Order 26.4(b)(1). A review of the facility provided resident-centered care plan failed to include the following: problem/focus area for the use of NJ Ex Order 26.4(b)(1) goals with target dates, or any interventions/tasks for the use of the NJ Ex Order 26.4(b)(1) medication. On 08/08/24 at 1:45 PM, the U.S. FOIA (b) (6) stated the process was to initiate a care plan on admission by the supervisor on duty. The next day each department would review and add their information to the care plan. The U.S. FOIA (b) (6 stated, "I'm responsible for nursing." and stated that would include things such as NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) medications. When asked about NJ Ex Order 26.4(b)(1) the U.S. FOIA (b) (6) stated, "We definitely would care plan NJ Ex Order 26 used for NJ Ex Order 26.4(b)(1)." On 08/09/24 at 9:50 AM, the U.S. FOIA (b) (6) stated all staff were responsible for areas of the resident's care plan. She further stated that each department does their own assessment for the care plans. The U.S. FOIA stated that the information would be gathered from face-to-face assessments and identified needs, and that the electronic medical record would trigger things like medications, cardiac care plan, etc. The surveyor inquired about NJ Ex Order 26.4(b)(1) use being on the care plan and the U.S. FOIA stated, "probably yes because the resident is NJ Ex Order 26.4(b)(1), and we need everyone to be aware of what could happen." The U.S. FOIA accessed Resident #15's medical record with the surveyor and showed the surveyor the most current care plan. The U.S. FOIA acknowledged that the use of the NJ Ex Order 26.4(b)(1)	F 656	An audit will be done on 10 resident charts by the Director of Nursing or designee weekly for 4 weeks, and then monthly for 3 months to ensure proper comprehensive care plans are in place addressing the residents specific care/needs. Findings of the audits will be shared at monthly QAPI meetings for review. Ongoing need for continuation of audits will be determined at the end of the 4 months.	

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F 656	Continued From page 5 medication was not documented in the care plan. On 08/09/24 at 10:17 AM, the [U.S. FOIA] stated that in [NJ Ex Order 26.4(b)(1)], the facility had a conversion of care plan programs and did not realize until the survey team brought it to their attention, that the care plans were not complete or comprehensive. The [U.S. FOIA] further stated that Resident #15's previous care plan included the use of [NJ Ex Order 26.4b1] but the facility did not identify that it was not carried over to the current comprehensive care plan. Surveyor # 1 inquired about the quarterly resident interdisciplinary team meetings, and the [U.S. FOIA] stated that the facility never realized at the meetings that the care plans were not complete. A review of the facility provided policy, "Care Plans - Baseline" revised March 2022, included but was not limited to; Policy "A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission." Interpretation and Implementation "1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. initial goals based on admission orders ... b. physician orders ... 2. ... The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. ... 4. ... the baseline care plan ... that includes, but is not limited to the following: a. the stated goals and objectives of the resident; b. a summary of the resident's medications and dietary instructions; ..."	F 656		

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F 656	Continued From page 6	F 656		

A review of the facility provided policy, "Care Plans, Comprehensive Person-Centered" revised March 2022, included but was not limited to; Policy "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented or each resident." Interpretation "1. The interdisciplinary team (IDT), ... develops and implements a comprehensive, person-centered care plan for each resident. ... 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. ... 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, ... e. reflects currently recognized standards of practice for problem areas and conditions. ... 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; ... c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required MDS assessment."

B.) A review of the Electronic Medical Record (EMR) under, "Diagnoses" revealed that Resident # 17 was diagnosed with but not limited to [redacted] and NJ Ex Order 26.4(b)(1) [redacted].

A review of the EMR revealed orders to but not limited to monitoring [redacted] and [redacted] every shift.

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F 656	Continued From page 7	F 656		

A review of the EMR under Care Plans did not reveal a specific focus or interventions for an NJ Ex Order 26.4(b)(1).

A review of the quarterly Minimum Data Set (An assessment tool) dated NJ Ex Order 26.4(b)(1 revealed under section, "H" that Resident # 17 had an NJ Ex Order 26.4(b)(1

On 08/08/2024 at 9:55 AM during the initial tour of the facility, Surveyor # 2 observed Resident # 17 in their room. At that time, Resident # 17 confirmed to the surveyor that he/she had a NJ Ex Order 26.4(b

On 08/12/2024 at 9:39 AM during an interview with the U.S. FOIA (b) (6) , Surveyor # 2 asked if someone has a NJ Ex Order 26.4(b)(1), should they have a specific care plan focus for it. The U.S. FOIA (b) (6) replied, "Yes."

On 08/13/2024 at 12:07 PM during an interview with the U.S. FOIA (b) (6)), Surveyor # 2 asked should a care plan focus for an NJ Ex Order 26.4(b)(1 care have been initiated. The U.S. FOIA replied, "Yes." Surveyor # 2 then asked when should the care plan have been initiated. The U.S. FOIA replied, "When [he/she] was readmitted."

A review of Resident # 43's Physician's Orders located in the EMR revealed that he/she had an order for a NJ Ex Order 26.4(b)(1 to the NJ Ex Order 26.4(b)(1) and to check placement and function every shift for monitoring.

A review of Resident # 43's Care Plans located in

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F 656	Continued From page 8	F 656		

the EMR did not reveal a Care Plan focus or interventions for a NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) .

A review of Resident # 43's diagnoses located in the EMR revealed diagnoses of but not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) .

On 08/08/2024 at 10:06 AM during the initial tour, Surveyor # 2 observed Resident # 43 in their bed. At that time, Surveyor # 2 observed a NJ Ex Order 26.4 attached to Resident # 43's NJ Ex Order 26.4(b)(1). At that time, Resident # 43 told Surveyor # 2 that it is used in NJ Ex Order 26.4b1 .

Another review of Resident # 43's Care Plans located in the EMR revealed a focus for NJ Exec Order 26.4b1 The focus included an intervention to check function and placement every shift for a NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b). The focus and intervention were initiated on NJ Ex Order 26.4(b)(1).

On 08/13/2024 at 12:07 PM during an interview with the U.S. FOIA (b) (6)), Surveyor # 2 asked when should a care plan for NJ Ex Order 26.4b1 been initiated. The U.S. FOIA replied, "It should have been initiated the day that the NJ Ex Order 26.4(b)(1) went on. We saw that it was not on there so we added it."

A review of the facility policy titled, "Care Plans, Comprehensive Person-Centered" with a revised date of March 2022 revealed under, "Policy

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Interpretation and Implementation" that, "2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Minimum Data Set] assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission."

C.) On 08/08/2024 at 10:10 AM, Surveyor # 3 observed Resident # 3 in bed, with NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1).

A review of the Admission Record revealed that Resident #3 had diagnoses which included but not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

A review of the Order Summary Report revealed a physicians order dated NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), pat dry, apply NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)) and a clean dry NJ Ex Order 26.4(b)(1) daily. NJ Ex Order 26.4(b)(1) is NJ Ex Order 26.4(b)(1) every NJ Ex Order 26.4(b)(1). There was also a physician's order dated NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), apply NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) daily.

A review of Resident # 3 resident-centered care plan failed to include the NJ Ex Order 26.4(b)(1) identified on NJ Ex Order 26.4(b)(1) for the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) for the NJ Ex Order 26.4(b)(1).

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F 656	Continued From page 10 On 08/14/2024 at 09:09 AM during an interview with Surveyor # 3, the U.S. FOIA (b) (6) [redacted]) said that we work as a team to get care plans done. The U.S. FOIA (b) (6) also stated, "When an admission comes in, they are started by nursing, and then all disciplines come in and update. We then review quarterly." When asked what if something new is identified, the U.S. FOIA (b) (6) stated, "If something new is going on, it should be added that day or the next." On 08/14/2024 at 12:42 PM during an interview with Surveyor # 3 the U.S. FOIA (b) (6) [redacted]) stated, "It depends on the resident and what it was" when asked if NJ Ex Order 26.4(b)(1) should be added to the care plan. When the surveyor asked about Resident #3's NJ Ex Or [redacted], the U.S. FOIA [redacted] replied, "That just happened on the NJ Ex Ord[redacted] When the surveyor asked, should that be on the care plan now, the U.S. FOIA [redacted] replied, "I would hope so."	F 656		
F 690 SS=D	NJAC 8:39-11.2 (d)(e)(h) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		10/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315262	A. BUILDING _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARROGATE	400 LOCUST STREET LAKEWOOD, NJ 08701

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F 690	Continued From page 11 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to A.) ensure that a resident received appropriate treatment and services to prevent NJ Ex Order 26.4(b)(1)) to the extent possible specifically by failing to clean and store a NJ Ex Order 26.4(b)(1) according to facility policy and B.) failed to obtain a physician's order to NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). The deficient practice was identified for 2 of 2 Residents (Resident # 17 and 42) investigated for NJ Ex Order 26.4(b)(1).	F 690	It is the practice of this facility to clean and store NJ Ex Order 26.4(b)(1) according to facility policy and obtaining an MD order before NJ Ex Order 26.4(b)(1) per the facility's policy and procedure. 2 residents were found to have NJ Ex Order 26.4(b)(1) by the deficient practice. Resident #42 an order was immediately given by the MD to have the NJ Ex Order 26.4(b)(1) as needed for NJ Ex Order 26.4(b)(1) A audit of all indwelling catheter residents was immediately done to ensure all order included as needed flushing. New order	

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F 690	Continued From page 12 The deficient practice was evidenced by the following: A review of the Electronic Medical Record (EMR) under, "Diagnoses" revealed that Resident # 17 was diagnosed with but not limited to NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted]. A review of the EMR revealed physician's orders to but not limited to monitoring NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) every shift. A review of the EMR under Care Plans revealed a Care Plan focus titled, "Risk for NJ Ex Order 26.4(b)(1) [redacted] Risk for NJ Ex Ord initiated on NJ Ex Order 26.4(b)(1). The Care Plan also revealed a focus titled, "Potential for the spread of NJ Ex Order 26.4(b)(1) [redacted]) to other residents or staff during high contact related to: history of NJ Ex Order [redacted] and [tradename] NJ Ex Order [redacted] That focus was initiated on NJ Ex Order 26.4(b)(1) [redacted]. A review of the quarterly Minimum Data Set (An assessment tool) dated NJ Ex Order 26.4(b)(1) revealed under section, "H" that Resident # 17 had an NJ Ex Order 26.4(b)(1) [redacted] On 08/08/2024 at 09:55 AM during the initial tour, Surveyor # 1 observed Resident # 17 in his/her wheelchair in their room. At that time, he/she confirmed they use an NJ Ex Order 26.4(b)(1) [redacted] On 08/12/2024 at 9:39 AM during an interview with Surveyor # 1, the U.S. FOIA (b) (6)	F 690	sets were immediately implemented to ensure that proper orders are on every new resident admitted with an indwelling catheter. Residents #17 and #42: The facility is updating its current NJ Ex Order 26.4(b)(1) [redacted] to reflect that if a change of NJ Ex Order 26.4(b)(1) are needed, a NJ Ex Order 26.4(b) [redacted] will be used every time. A section will be added to the CNA task list to ensure that NJ Ex Order 26.4(b)(1) are being changed daily. With the use of NJ Ex Order 26.4(b)(each time, this will eliminate the need for NJ Ex Order 26.4(b) [redacted] at night and also eliminating the problem of NJ Ex Ord not being NJ Ex Order 26.4(b)(1) that were being stored for future use. No actual harm was caused from this deficient practice. All indwelling catheter residents have the potential to be affected by the alleged deficient practice. The Indwelling catheter policy will be updated with the new practices and the Nurses and CNA's will be educated at the September 24th Staff meeting by the DON and the ADON, Staff Educator. The goal is with staff education and diligent auditing of the charts, this problem will not reoccur. The Director of Nursing or designee will conduct weekly audits of all indwelling catheter residents to ensure that proper orders are on every resident along with tasks being completed each day. Audits will be done weekly for 4 weeks, and then	

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F 690	Continued From page 13 replied, "They [staff] should be getting alcohol wipes to clean [redacted]. They then store the [redacted] in a [redacted] with [redacted] when Surveyor # 1 asked how the [redacted] are to be stored. The U.S. FOIA (b) (6) also said that the [redacted] and then stored in the [redacted]. On 08/13/2024 at 10:04 AM during an interview with Surveyor # 1, the Certified Nurse Aide (CNA) # 1 assigned to Resident # 17 confirmed that the [redacted] itself and the [redacted] are cleaned. The surveyor then asked if a bleach solution is used to clean the [redacted]. CNA # 1 stated, "No bleach." A review of an [redacted] of the [redacted] revealed a [redacted] at the [redacted]. On 08/13/2024 at 10:51 AM, Surveyor # 1 observed Resident # 17's [redacted] in a [redacted] secured to the hand rail in the resident's bathroom. At that time, Surveyor # 1 could observe that there was [redacted] secured to the [redacted]. The [redacted] also [redacted]. On the same date at 11:01 AM in the presence of Surveyor # 1, the U.S. FOIA (b) (6) confirmed the [redacted] did not have a [redacted] secured to the [redacted]. On 08/13/24 at 10:59 AM, the surveyor observed Resident # 42's [redacted] in a [redacted] in the bathroom. The surveyor did not observe a [redacted] secured to the [redacted]. When asked at that time the U.S. FOIA (b) (6) confirmed there was no	F 690	monthly for 3 months. Audit finding will be discussed during the monthly QAPI meetings.	

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F 690	Continued From page 14	F 690		

NJ Ex C and stated the NJ Ex Order 2 should have NJ Ex Order 2.

A review of the facility policy titled, "Catheter Care, Urinary" revised August of 2022 revealed under, "Cleaning and Disinfecting Drainage Bags" to, "1. Disconnect the drainage bag from the catheter; replace with a clean bag. 2. Use a soft, plastic squirt bottle to rinse the used bag with tap water and drain. 3. Cleanse the drainage bag with a dilute solution of 1 part regular household bleach (5.25 % concentration) mixed with 10 parts tap water (i.e., 15 mL bleach diluted with 150mL tap water). a. Instill the diluted bleach solution through the drainage tubing or top of the bag, and agitate the solution in the bag for 30 seconds. b. Drain the bleach solution, and allow the bag to air dry with the clamp open. c. Use bleach that is not scented or concentrated. d. When using a bleach solution, use gloves, aprons, and goggles to protect from fumes and irritation cause by contact. 4. After cleaning, air-dry the bag. After disinfection, cap the drainage bag tubing between uses, and disinfect the end of the tubing before reconnecting it to the catheter."

B.) On initial tour of the facility on 08/08/2024 at 10:20 AM, Surveyor # 2 observed Resident # 42 in their wheelchair.

According to the admission record, Resident # 42 was admitted with diagnoses which include but are not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

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F 690	Continued From page 15	F 690		

A review of the Quarterly Minimum Data Set, an assessment tool dated [redacted] reflected that Resident # 42 had [redacted] and utilized an [redacted].

On 08/09/2024 at 09:06 AM, Surveyor # 2 reviewed the Physician's Orders for Resident # 42 which reflected an order dated [redacted] for [redacted] care every shift.

On 08/12/2024 at 9:32 AM, Surveyor # 2 reviewed health status notes in the electric health record for Resident # 42. The health status notes dated [redacted], [redacted], and [redacted] reflected that Resident # 42's [redacted] was [redacted] to prevent [redacted] in the [redacted]. The treatment administration records for Resident # 42 dated [redacted] and [redacted] were reviewed and no documentation was observed to [redacted] the [redacted].

During an interview on 08/12/2024 at 11:23 AM, the U.S. FOIA (b) (6) stated that she is pretty sure that NJ Ex Order 26.4(b)(1) is part of the policy. She stated that sometimes we have an order to [redacted], but we don't have one for Resident #42.

During an interview on 08/12/2024 at 11:30 AM, the U.S. FOIA (b) (6) stated that there should be an order to NJ Ex Order 26.4(b)(1).

A review of the facility-provided policy titled, "Catheter Care, Urinary", revised August 2022 reflected that, "5. Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction."

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F 690	Continued From page 16 NJAC 8:39-11.2(b)	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 record review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 08/08/2024 from 09:24 AM until 10:00 AM, the surveyor observed the following in the kitchen in the presence of the Dietary Director #1 (DD#1): 1.The DD and the Food Service Worker (FSW#1)	F 812	No residents were identified as affected by the deficient practice. An audit was conducted of all kitchens and kitchenettes immediately. Any items without appropriate date and/or label were immediately discarded. All residents have the potential to be affected by the same deficient practice. All dietary staff were inserviced on proper handling and storage or potentially	10/15/24

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F 812	Continued From page 17 had facial hair and were not wearing beard guards. The DD#1 stated the beard guard is only used when on the line or direct handling of food. 2. In the walk-in freezer a frozen strawberry cream pie and a cookies and cream pie had no label and no date. The DD#1 stated it should be dated and he threw them away. On 08/13/2024 from 09:11 AM until 09:26 AM the surveyor observed the following in the satellite kitchen in the presence of the FSW#2 and DD#2: 3. In the refrigerator, a glass of orange juice, 2 glasses of white milk, 4 glasses of honey thick milk, and 4 glasses of honey thickened apple juice were covered. They had no label and no date. The FSW#2 stated I guess they should be dated. 4. In the refrigerator, 4 pieces of sheet cake wrapped in clear plastic wrap on glass dishes had no label and no date. The FSW#2 stated they should be dated. The DD#2 stated she will get rid of them. 5. In the refrigerator, individual pieces of cut watermelon were wrapped in clear plastic on glass dishes. The watermelon had no label and no date. The FSW#2 stated they should be dated. The DD#2 stated she will get rid of them. 6. In the small refrigerator, a prepared ham and cheese and tuna sandwich was on a glass plate wrapped with clear plastic wrap with no label and no date. The FSW#2 stated they should be dated. 7. In the small refrigerator, a container of egg salad and a container of tuna salad had a use by	F 812	hazardous foods in a manner that is intended to prevent the spread of food borne illnesses. All dietary staff were inserviced on the use of hair nets and beard guards. Food Service Director or designee will conduct kitchen observation audits to ensure proper labeling and dating and and use of hair nets and beard guards daily for 7 days, weekly for 1 month, and then monthly thereafter. Any issues identified in the audits will be rectified immediately. Findings will be reviewed at monthly QAPI meetings. Food Service Director will be responsible for ongoing compliance.	

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F 812	Continued From page 18	F 812		

date of 8/12/24. The DD#2 stated they should have been thrown out last night.

On 08/13/24 09:26 AM until 09:36 AM the surveyor observed the following in the kitchen with the DD#1.

The DD#1 had facial hair and was not wearing a beard guard. The FSW#1 was wearing a beard guard however the mustache was exposed. The DD#1 stated the beard guard should be over mustache.

The surveyor reviewed the facility provided policy titled, "Food Storage" with a revision date of 3/31/20 which reflected: all food items will be tightly covered and clearly labeled and identified. Leftover foods are labeled, dated, immediately placed under refrigeration.

The surveyor reviewed the facility provided policy titled, "Personal Cleanliness and Personal Hygiene" with a revision date of 3/31/20 reflected that food production and dietary staff shall wear hair restraints such as hats, hair coverings or nets that effectively prevent cross contamination of all exposed foods, equipment, and supplies.

The surveyor reviewed the facility provided policy titled, Labeling and Dating" with a revision date of 5/5/22 which reflected 1. all perishables will be covered so no portion of the item is exposed, labeled with the item name, current date, and use by date. The use by date for perishable items is the current date plus three days or less. 2. Pre-portioned service tray items will be dated with current date and discarded in three days or less.

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F 812	Continued From page 19 NJAC 8:39-17.2(g)	F 812		
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, 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	F 880		10/15/24

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F 880	Continued From page 20 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. §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 observation, interviews, and record review, it was determined that the facility failed a.) to perform hand hygiene as indicated during NJ Ex Order 26.4(b)(1) for 1 of 1 resident, (Resident # 265) reviewed for NJ Ex Order 26.4(b)(1), and b.) the facility failed to maintain a sanitary environment for 1 of 9 residents, (Resident # 3), observed for infection control.	F 880	It is the practice of Harrogate to establish and maintain an infection prevention and control policy to provide a safe, sanitary environment and prevent the development and transmission of communicable diseases and infections. Resident #265: The nurse performing	

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F 880	Continued From page 21 The deficient practice was evidenced by the following: a.) On 08/08/2024 at 09:50 AM, Resident # 265 was observed sleeping in bed. Resident # 265 was observed to be on an NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1). A review of the Admission Record revealed that Resident #265 was admitted with diagnoses including but not limited to, NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the Minimum Data Set (an assessment tool) dated NJ Ex Order 26.4(b)(1), revealed that Resident # 265 had a NJ Ex Order 26.4(b)(1) A review of the Order Summary Report with active orders as of NJ Ex Order 26.4(b)(1) revealed a physician's order dated NJ Ex Order 26.4(b)(1) to cleanse the NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), pat dry, apply NJ Ex Order 26.4(b)(1)) and a NJ Ex Order 26.4(b)(1) daily. On 08/12/2024 at 11:28 AM the surveyor observed Licensed Practical Nurse (LPN) # 1 preform NJ Ex Order 26.4(b)(1) for Resident # 265. The surveyor observed the LPN #1 remove her gloves after NJ Ex Order 26.4(b)(1) and she donned a new pair of gloves without preforming hand hygiene. At that time, when asked about hand hygiene by the surveyor LPN replied, "I forgot to sanitize my hands."	F 880	NJ Ex Order 26.4(b)(1) was immediately reeducated on the importance of hand sanitizing between changing gloves during NJ Ex Order 26 Resident #3: The nursing staff were immediately reeducated on infection control precautions and the importance of changing soiled sheets immediately. No actual harm was caused from this deficient practice. All residents requiring wound care have the potential to be affected by the alleged deficient practice. The Infection Preventionist or designee will conduct weekly audits of 5 residents that wound care is being done for 4 weeks. In addition, the Infection Preventionist or designee will conduct weekly audits of infection control rounds on 10 residents for 4 weeks. Both audits will be done monthly for 3 months. Results will be brought to the monthly QAPI meetings. Ongoing need for continuation of audits will be determined at the end of 4 months. Continuing education will be ongoing regarding Infection Control.	

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	315262	A. BUILDING _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARROGATE	400 LOCUST STREET LAKEWOOD, NJ 08701

(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 22	F 880		

On 08/14/2024 at 09:09 AM during an interview with the surveyor, the U.S. FOIA (b) (6)) stated, "Every time you take off gloves you should wash your hands."

On 08/14/2024 at 12:00 PM during an interview with the surveyor the U.S. FOIA (b) (6)) stated, "You should perform hand hygiene before and after wearing gloves."

On 08/14/2024 at 12:42 PM during an interview with the surveyor the U.S. FOIA (b) (6)) replied, "Yes, that is part of protocol", when asked if hand hygiene should be performed between glove changes.

b.) A review of the Admission Record revealed that Resident # 3 had diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1)) and long-

A review of the Order Summary Report revealed a physician's order dated t) on with , pat dry, apply NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) and a daily. is every There was also a physician's order dated to NJ Ex Order 26.4(b)(1) on , apply and NJ Ex Order 26.4(b)(1) daily.

On 08/08/2024 at 10:10 AM during initial tour, the

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	315262	A. BUILDING _____ B. WING _____	C 08/15/2024

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F 880	Continued From page 23	F 880		

surveyor observed Resident # 3 sleeping in bed with NJ Ex Order 26.4(b)(1) . The surveyor observed what appeared to a NJ Ex Order 26.4(b)(1) on the sheets on the left side of the bed.

On 08/12/2024 during an interview with the surveyor, the U.S. was asked if the bed should look like that. The U.S. replied, "No the sheets should have been changed, [he/she] NJ Exec Order 26.4b1 [he/she] NJ Ex Order 26.4(b)(1) all the time causing NJ Ex Order 26.4(b)(1)."

On 08/14/2024 during an interview with the surveyor, the U.S. FOIA was showed the picture taken on NJ Ex Order 26.4(b)(1) and, the U.S. FOIA replied, "No, there should have been a NJ Exec Order down to protect that NJ Exec Order 26.4 until the sheet was able to be changed."

A review of a facility provided policy titled "Handwashing/Hand Hygiene" revised August 2019 revealed under the "Policy Interpretation and Implementation" that, "2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. ... 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: m: after removing gloves." Also revealed under the "Applying and Removing Gloves" that, "1. Preform hand hygiene before applying non-sterile gloves."

A review of a facility provided policy titled "Infection Prevention and Control Program" revised on October 2018 revealed under the "Policy Statement" that, "An infection prevention and control program (IPCP) is established and

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F 880	Continued From page 24 maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." N.J.A.C. 8:39-19.4(n)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061528	A. BUILDING: _____ B. WING _____	C 08/15/2024

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HARROGATE	400 LOCUST STREET LAKEWOOD, NJ 08701

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S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

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

Electronically Signed | 08/30/24

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315262 Y1	A. Building B. Wing Y2	10/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARROGATE	400 LOCUST STREET LAKEWOOD, NJ 08701

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 F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0690	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	10/15/2024	LSC	10/15/2024	LSC	10/15/2024
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	10/15/2024	LSC	10/15/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/15/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315262	A. BUILDING **01** B. WING _____	**08/15/2024**

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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 08/14/2024 and 08/15/2024. Harrogate 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 Occupancies. Harrogate is a Single-story, Type V Protected building that was built in January 1985. The facility is divided into 5 smoke zones.	K 000		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health	K 131		10/15/24

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

Electronically Signed | 08/30/2024

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 131	Continued From page 1 Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/15/2024 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) it was determined that the facility failed to ensure that sections of health care facilities classified as other occupancies were separated from areas of healthcare occupancies by construction having two hour fire resistance rating in accordance with NFPA 101:2012 Edition, Section 19.1.3.3, 42 CFR 482.41, and 42 CFR 485.623. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 8/14/2024 at 1:54 PM of the nearest physical separation (residential dining exit) of the 2 occupancies, revealed that holes were made for wires and conduit and were left unsealed. There was also an approximately 1-inch gap around the penetrating duct work and the use of non-rated spray foam around other pipe penetrations. An observation on 8/14/2024 at 2:23 PM of the nearest physical separation of the 2 occupancies(carpeted corridor), revealed that due to sprinkler repairs the fire barrier had unprotected penetrations on both sides of the barrier wall. A space approximately 12-inches x 20-inches on one side and 3-inches x 6-inches on the other side. Pipes were penetrating both sides. In an interview on 8/15/2024, the surveyor asked the U.S. FOIA (b) (6) if they could find out where the points of separations between the healthcare and	K 131	It is the practice of the facility to abide by all NFPA regulations. A barrier door was identified as not meeting code. All residents had the potential to be affected. All penetrations within the barrier wall were repaired. A new set of double doors has been ordered and will be installed by 10/4/2024 to ensure required 2-hour fired rated separation is achieved. All maintenance staff were inserviced by the Administrator on the topic of separation of occupancies. All maintenance staff were inserviced by 8/30/2024. Maintenance Director or designee will audit condition of barrier doors separating occupancies monthly. Ocean County Fire Marshal will audit compliance of door quarterly. Results of these inspections will be reviewed at monthly QAPI meeting. Maintenance Director will be responsible for sustained compliance.	

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K 131	Continued From page 2 residential occupancies were according to their license. The U.S. FOIA (b) (6) stated that they would find out and let me know. In an interview at 12:15 PM the U.S. FOIA (b) (6) drew a line on the floor plans indicating the separation points as we stood in front of them. At the first point, the U.S. FOIA (b) (6) stated "healthcare ends where the wooden floor ends and residential begins where the carpet begins". The transition point between the two spaces was a doorless corridor entrance. At the second point, the U.S. FOIA (b) (6) stated that the license indicates that everything before the kitchen doors is healthcare and everything after the kitchen doors is residential. The was no separation between the two spaces. The required 2-hour fire rated separation could not be identified or verified by staff. The U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 08/15/2024 at 2:00 PM.	K 131		
K 211 SS=F	N.J.A.C 8:39-31.2(e) Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.	K 211		10/15/24

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K 211	Continued From page 3 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/14/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that the means of egress was continuously maintained free of all obstruction to full use in case of emergency in accordance with NFPA 101:2012 Edition, Section 7.1.10.1 . This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:30 PM on the Sandy Cove unit, revealed that a table approximately 8-feet long was in front of exit door 36 impeding access. In an interview at the time of the observation, the U.S. FO [redacted] confirmed the observation and stated they would have someone move the table right away. The facility's U.S. FOIA (b) (6) was notified of the deficient practice during the Life Safety Code exit conference on 8/15/2024 at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 211	It is the practice of the facility to ensure all egress doors are free of obstacles. No individuals were directly affected by the deficient practice. All residents had the potential to be affected. The table in front of exit door 36 has been removed. All maintenance and security staff have been inserviced by the Administrator on the topic of means of egress. All maintenance and security staff were inserviced by 8/30/2024. Security Director or designee will audit all exit doors for means of egress daily. Results of these inspections will be reviewed monthly at QAPI. Security Director will be responsible for sustained compliance.	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the	K 222		10/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 4 clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.	K 222		

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K 222	Continued From page 5 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/14/2024 and 08/15/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure doors that were installed with delayed-egress systems were properly labeled and functioning in accordance with NFPA 101:2012 Edition, Sections 19.2.2.2.4, 19.2.2.5 and 7.2.1.6. This deficient practice was observed for 4 of 5 tested doors, had the potential to affect all residents and was evidenced by the following. An observation on 08/14/2024 at 1:13 PM, revealed that the main entrance door to the Sandy Cove unit did not release after 15 seconds when tested by the U.S. FO and was not provided with a readily visible sign that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". The door did release with the access code. In an interview at the time of the observation, the U.S. FO confirmed that there was no sign and stated that the door previously released after 15 seconds and was not sure why it was not functioning.	K 222	It is the best practice of the facility to provide an environment where people can safely exit during an emergency. All residents had the potential to be affected. Signage for 15 second emergency release on exit doors posted next to all exit doors on 8/19/2024. Vendor scheduled to fix 15 second release on entrance door to Sandy Cove. Part is ordered and the Vendor is scheduled to complete the project by 9/30/2024. All maintenance and security staff inserviced by the Administrator on topic of means of egress. All maintenance and security staff were inserviced by 8/30/2024. Security Director or designee will audit functionality of delayed egress for all exit doors daily. All audits will be reviewed monthly at QAPI. Security Director will be responsible for sustained compliance.	

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K 222	Continued From page 6 An observation at 1:30 PM, revealed that exit door 36 on the Sandy Cove unit was not provided with a readily visible sign that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". The door did release after 15 seconds when tested by the U.S. FOIA An observation at 1:40 PM, revealed that exit door 37 on the Sandy Cove unit was not provided with a readily visible sign that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". The door did release after 15 seconds when tested by the U.S. FOIA An observation on 08/15/2024 at 9:00 AM, revealed that the exit door near room 24 was not provided with a readily visible sign that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". The door did release after 15 seconds when tested by the U.S. FOIA In interviews at the time of the observations, the U.S. FO confirmed the observations The facility's U.S. FOIA (b) (6) was notified of the deficient practice during the Life Safety Code exit conference on 8/15/2024 at 2:00 PM.	K 222		
K 324 SS=F	N.J.A.C 8:39-31.2(e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small	K 324		10/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315262	A. BUILDING **01** B. WING _____	**08/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARROGATE	**400 LOCUST STREET** **LAKEWOOD, NJ 08701**

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K 324	Continued From page 7 appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 08/14/2024 and 8/15/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that commercial cooking equipment was maintained in accordance with NFPA 101:2012 Edition, Sections 19.3.2.5, 9.2.3 and NFPA 96:2011 Edition Standard for Ventilation Control and Fire Protection of Commercial Operations. This deficient practice had the potential to affect all residents and was evidenced by the following: Documentation review on 08/14/2024, revealed that the semi annual kitchen hood inspections dated 02/20/2023, 08/06/2023, 02/26/2024 and 06/30/2024 all identified deficiencies on the reports.	K 324	It is the practice of the facility to maintain its commercial cooking equipment in accordance to local, state, and federal regulations. All residents had the potential to be affected. Vendor scheduled to make all necessary repairs per findings on recent hood inspection. Parts have been ordered and Vendor will complete repairs by 10/11/2024. U.S. FOIA (b) (6) and U.S. FOIA (b) (6) educated by the Administrator on 8/23/2024 on the topic of maintaining commercial cooking equipment.	

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K 324	Continued From page 8 In an interview with the U.S. FOIA on 08/15/2024, a request was made by the surveyor for service reports to correct the identified deficiencies that were found during the semi annual inspections. The U.S. FOIA stated that they would contact the service company and get back to me. In an interview with the U.S. FOIA at 1:00 PM, the U.S. FOIA stated that they contacted the service company and was informed that the repairs had not been made yet, but they were put on on the schedule so that the repairs can be made as soon as possible. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 08/15/2024 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 96	K 324	Food Service Director will retain all reports for hood inspections. All reports will be reviewed at monthly QAPI meeting to monitor compliance. Food Service Director will be responsible for sustained compliance.	
K 342 SS=F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5	K 342		10/15/24

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K 342	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/14/2024 in the presence of the U.S. FOIA (b) (6) [redacted]) it was determined that the facility failed to ensure that manual alarm boxes were continuously accessible in accordance with NFPA 101:2012 Edition, Sections 19.3.4.2.1 and 9.6.2 . This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:40 PM, revealed that the manual alarm box on the Sandy Cove unit near exit door 37 was equipped with a keyed lock box. In an interview at the time of the observation, the U.S. FO [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 08/15/2024 at 2:00 PM N.J.A.C 8:39-31.2(e)	K 342	It is the practice of the facility to ensure that all manual alarm boxes are accessible at all times. All residents had the potential be affected. Lock box cover immediately removed from manual alarm box. All maintenance and security staff inserviced by the Administrator on topic of fire alarm pull stations. All maintenance and security staff were inserviced by 8/30/2024. Security Director or designee will audit all manual alarm boxes daily to ensure all are accessible. Log of daily audits will be reviewed monthly at QAPI. Security Director will be responsible for sustained compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		10/15/24

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K 353	Continued From page 10 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 08/14/2024 and 08/15/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to make repairs and take corrective actions to correct deficiencies identified to the fire sprinkler systems in accordance with NFPA 25 . This deficient practice had the potential to affect all residents and was evidenced by the following: Documentation review on 08/14/2024, revealed that the fire sprinkler report on 04/14/23 marked a deficiency for not having a hydraulic placard on the dry sprinkler system. In an interview with the U.S. FO on 08/14/2024, the U.S. FO was unaware that there was a deficiency on the report. No further information was provided on the removal of the deficiency cited by licensed fire sprinkler inspection company. Documentation review on 8/14/2024, revealed that the backflow preventer was marked as deficient on the annual report dated 05/16/2024. An observation on 8/15/2024 at 9:27 AM, revealed that the backflow preventer had an attached 2024 inspection tag with a hole punched	K 353	It is the practice of the facility to keep its fire sprinkler system in accordance to NFPA 25. All residents had the potential to be affected. Hydraulic placard signage placed near dry sprinkler system on 8/20/2024. Backflow preventer fixed and passed inspection by licensed fire sprinkler inspection company on 8/29/2024. Maintenance staff inserviced by the Administrator on topic of fire sprinkler inspection requirements. All maintenance staff were inserviced by 8/30/2024. Administrator will receive a copy of all documentation provided from inspections regarding the fire sprinkler system. Maintenance Director or designee will review all reports monthly and will bring them to monthly QAPI to review completion of recommendations. Maintenance Director will be responsible for sustained compliance.	

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K 353	Continued From page 11 through the month of May and "Annual inspection failed" was written on it. In an interview at the time of observation, the [redacted] confirmed the observation and stated that they were unaware that the backflow preventer failed the annual inspection. The facility's [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 08/15/2024 at 2:00 PM. N.J.A.C 8:39--31.2(e) NFPA 25	K 353		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/15/2024 in the presence of the [redacted], it was determined that the facility failed to ensure that penetrations through smoke/fire barriers are protected by a system or	K 372	It is the practice of the facility to maintain all smoke barrier doors in order to restrict the transfer of smoke. All residents had the potential to be	10/15/24

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K 372	Continued From page 12 materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105, and NFPA 80:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on at 8:40 AM, revealed that the smoke/fire barrier wall near room 16 had an unprotected penetration for flexible electrical conduit and other wires. The penetration was approximately 4-inches by 4-inches. An observation at 8:40 AM, revealed that the swinging pair of smoke barrier doors did not fully close when tested by the U.S. FOI One of the 2 doors was stopped by the door frame. There was also a 1 and 1/8-inch gap under the door. In an interview at the time of the observations, the U.S. FO confirmed the findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice during the Life Safety Code exit conference on 08/15/2024 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 80, 105	K 372	affected. All penetrations within the barrier wall repaired. Swinging pair of smoke doors adjusted and corrected to address the issue of the doors not completely closing and the 1 and 1/8-inch gap under the door. All maintenance staff have been inserviced by the Administrator on the topic of smoke barrier rated doors. All maintenance staff inserviced by 8/30/2024. Maintenance or designee will conduct testing of all smoke barrier doors monthly and will bring documentation to monthly QAPI meetings for review. Maintenance Director will be responsible for sustained compliance.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		10/15/24

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K 521	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/14/2024 and 08/15/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that resident bathrooms were provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2, 9.2.1 and NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/14/2024 at 1:13 PM, revealed that the ventilation in room 6 was not functioning when tested by the U.S. FOIA An observation at 1:35 PM, revealed that the ventilation in room 3 was not functioning when tested by the U.S. FO An observation on 08/15/2024 at 8:50 AM, revealed that the ventilation in room 9 was not functioning when tested by the U.S. FO An observation at 9:15 AM, revealed that the ventilation in room 28 was not functioning when tested by the U.S. FO The facility's U.S. FOIA (b) (6) was notified of the deficient practice during the Life Safety Code exit conference on 08/15/2024 at 2:00 PM N.J.A.C 8:30-31.2(e) NFPA 90A	K 521	It is the best practice of the facility to ensure ventilation throughout the community is in proper working condition. All residents had the potential to be affected. Ventilation in resident bathrooms 3, 6, 9, and 28 were repaired on 8/16/2024. Audit done of all bathrooms to ensure proper working condition. Maintenance Director or designee will audit ventilation in resident bathrooms weekly for 4 weeks and monthly thereafter. Maintenance Director or designee will bring copies of reports to monthly QAPI meeting for review. Maintenance Director will be responsible for sustained compliance.	

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K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 08/14/2024 and 08/15/2024 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that Inspections, Testing and Maintenance (ITM) of fire/smoke door assemblies were in accordance with NFPA 101:2012 Edition, Section 7.2.1.15, NFPA 105: 2010 Edition, Sections 4.1.1, 5.2.1 and NFPA 80: 2010 Edition, Sections 5.2.1, 5.2.4.2 . This deficient practice had the potential to affect all residents and is evidenced by the following: In an interview on 08/14/2025 at 8:30 AM during the Life Safety Code entrance conference, a request was made for fire/smoke door ITM to the U.S. FOIA Documentation review at 10:00 AM, revealed that there was no documentation regarding fire or smoke door assembly inspections.	K 761	It is the best practice of the facility to conduct regular Maintenance, Inspection & Testing of its fire/smoke assemblies. All residents had the potential to be affected. Ocean County Fire Marshal visited on to do an audit of all fire/smoke door assemblies to ensure compliance. All maintenance staff have been inserviced by the Administrator on the topic of barrier rated doors. All maintenance staff inserviced by 8/30/2024. Ocean County Fire Marshal will conduct Maintenance, Inspection & Testing of fire/smoke door assemblies on a quarterly basis and will provide documentation that will be brought to monthly QAPI meetings	10/15/24

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K 761	Continued From page 15 In an interview at 2:42 PM, a request was made to have fire/smoke door assembly ITM available for review the following morning. No documentation was provided regarding fire/smoke door assembly ITM. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 08/15/2024 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 80, 105	K 761	for review. Maintenance Director will be responsible for sustained compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance 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	K 918		10/15/24

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K 918	Continued From page 16 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 documentation review and interview on 08/14/2024 and 08/15/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that corrective actions were taken to correct deficient conditions identified for the emergency electrical generator in accordance with NFPA 110: 2010 Edition, Section 8.3.4.1 and NFPA 99: 2012 Edition, section 6.5.4.2 . This deficient practice had the potential to affect all residents and was evidenced by the following: Documentation review on 8/14/2024, revealed that the generator had an unsatisfactory remark on the 5/10/2024 quarterly inspection stating " Radiator has debris, should be cleaned" In an interview at 2:40 PM, the U.S. FO stated that they were not aware that there was a problem and would contact the generator company to figure it out. In an interview on 08/15/2024 at 9:00 AM, the U.S. FO stated that the generator company was contacted	K 918	It is the best practice of the facility to ensure the emergency electrical generator meets all local, state, and federal regulations. All residents had the potential to be affected. Generator serviced on 8/20/2024 and deemed to be in full compliance by licensed Vendor. All maintenance staff were inserviced by the Administrator on the topic of generator maintenance and testing requirements. All maintenance staff were inserviced by 8/30/2024. Administrator will receive a copy of all documentation provided from inspections regarding the generator. Maintenance Director will audit reports monthly and will bring them to monthly QAPI for review. Maintenance Director will be responsible for sustained compliance.	

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K 918	Continued From page 17 and they would be out tomorrow to make the necessary repairs. The U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 8/15/2024 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 99, 110	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315262 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARROGATE	400 LOCUST STREET LAKEWOOD, NJ 08701

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0131	10/15/2024	LSC K0211	10/15/2024	LSC K0222	10/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	10/15/2024	LSC K0342	10/15/2024	LSC K0353	10/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	10/15/2024	LSC K0521	10/15/2024	LSC K0761	10/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	10/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/15/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO