STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. BUILDING _____ B. WING _____	C 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	**249 HIGH STREET NEWTON, NJ 07860**

(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
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 #s NJ 153633, 154221, 156303,156873, 156875, 157505, 159374, 163096, 165583, 169091, 174420, 175555 STANDARD SURVEY: 8/1-8/9/24 CENSUS: 139 SAMPLE SIZE: 28+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. 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 the interview and record review, it was determined that the facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, accurately for 1 of 28 residents reviewed (Resident # 132).	F 641	1. Resident #132 was [redacted] this deficient practice. The assessment was immediately re-coded to reflect the correct discharge location. 2. All discharged residents have the potential to be affected by this deficient	8/29/24

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

Electronically Signed | 08/29/2024

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 The deficient practice was evidenced by the following: The surveyor reviewed Resident # 132's records. The resident was discharged from the facility and according to the NJ ex order 26.4b1 [redacted], an assessment tool used to facilitate the management of care, dated [redacted] the resident was assessed as being discharged to the hospital. A review of Resident # 132's progress notes dated [redacted] revealed the resident was NJ ex order 26.4b1 [redacted]. On 8/8/24 at 12:50 PM, the surveyor interviewed the US FOIA (b)(6), who stated that the MDS dated [redacted] should have indicated NJ ex order 26.4b1 [redacted] and that it was an error that it indicated NJ ex order 26.4b1. During an interview on 8/8/24 at 1:30 PM, the surveyor brought the above concerns to the attention of the US FOIA (B) (6) and US FOIA (B) (6). NJAC 8:39-11.2(e)1	F 641	practice. Discharged residents were audited to ensure there were no inaccuracies in coding. 3. Regional MDS Coordinator educated MDS coordinators on accuracy of assessments and proper discharge coding on the MDS. 4. The Director of Nursing/Designee will conduct an audit of 3 discharged residents weekly x 4 weeks and monthly x 2 months to ensure discharged location is properly coded on the MDS. The results of the audits will be presented at the monthy QAPI.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		8/29/24

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F 755	Continued From page 2 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Complaint #NJ00174420 Based on interviews, and record reviews, it was determined that the facility failed to provide pharmaceutical services by ensuring the resident did not receive a medication not ordered by the physician. The medication, NJ ex order 26.4b1 [redacted] Resident #395 without a valid physician order. The deficient practice was identified for one (1) of	F 755	1. Resident #395 was NJ Ex Order 26.4b1 this deficient practice. The resident, physician and responsible party were notified at the time of the NJ ex order 26.4b1, with NJ ex order 26.4b1 [redacted] There was NJ ex order 26.4b1 to the resident. The US FOIA (b)([redacted] was educated, and a medication pass observation was conducted at the time of the incident. 2. All residents have the potential to be affected by this deficient practice. 3. Facility educator educated nurses on medication administration, and the 5	

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F 755	Continued From page 3 28 residents, (Resident #395) reviewed for medication management. The deficient practice was evidenced by the following: Resident #395 was not in the facility; the surveyor conducted interviews and investigated the closed records. A review of the electronic health records (EHR) revealed the resident with a diagnosis of but not [redacted] According to the order summary in the EHR revealed orders for: [redacted] The admission minimum data set (MDS), an assessment tool, dated [redacted] revealed a brief interview mental status (BIMS) score of [redacted] out of 15 indicating [redacted]. A review of the care plan revealed care plan for [redacted] According to the nurse's progress notes, a [redacted]) on [redacted] stated, "Followed up for the report by the other [redacted] of [redacted] @ 17:18 PM. Resident's [redacted]	F 755	rights of medication administration. 4. The Director of Nursing/Designee will conduct a medication pass audit of 3 nurses per week x 4 weeks and then monthy x 2 months to ensure accuracy of medication administration. The results will be presented at the monthly QAPI meeting.	

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F 755		F 755		

Continued From page 4

NJ ex order 26.4b1 .
NJ ex order 26.4b1 ."

A review of the progress notes from NJ ex order 26 through NJ ex order 26 revealed resident had NJ ex order 26.4b1

The surveyor reviewed documentation titled, "Employee Medication Error dated NJ ex order 26, which revealed on NJ ex order 26 an agency LPN #1 nurse NJ ex order 26.4b1 . The resident's NJ Exec Order 26 US FOIA (B) (6) and medical doctor were notified. The US FOIA (b)(6) ordered to NJ ex order 26.4b1 and the resident NJ ex order 26.4b1 . The nurse who admitted to giving the NJ ex order 26.4b1 resident was educated and medication pass was completed on NJ ex order 26.

On 8/7/24 at 11:00 AM, the surveyor interviewed the US FOIA (B) (6) in the NJ Exec Order Unit, LPN #2, who has been working in the facility for NJ Exec . The US FOIA stated, "The patient was NJ Exec Order 26.4b I don't recall having NJ Exec Order 26.4b1 from the resident, he/she would be NJ Exec Order 26 I was told that the patient was given the wrong medication. The process is to contact the doctor when there is a medication error, make the US FOIA (B) (6) aware, and follow doctor's orders. Inform emergency contact if patient NJ Exec Order 26.4b1 . The US FOIA (B) stated that she went into the wrong room thinking it was another room. The patient was NJ ex order 26.4b1 NJ ex order 26.4b1

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F 755	Continued From page 5 On 8/7/24 at 11:53 AM, the surveyor interviewed the US FOIA (b) who started working in the facility since last NJ ex order 26.4b1 The US FOIA (b) stated, NJ ex order 26.4b [redacted] that the LPN #1 went to the room and NJ ex order 26.4b1 [redacted] I think the nurse realized the wrong medication was given when she signed it on the medication administration record (MAR) and realized it was the NJ ex order 26.4b1. She's a very good nurse. Upon coming here, the agency nurse usually gets an orientation packet. They must be med pass and we have a schedule for the med pass. The nurse did not have any previous infractions." The surveyor requested for the LPN's #1 medication pass and medication administration education on policies. On 8/7/24 at 12:30 PM, the US FOIA (B) provided the medication pass observation for LPN #1 which was completed before this NJ ex order 26.4b1 with no issues. On 8/7/24 at 1:30 PM, in the presence of the survey team, the surveyor discussed the concern of NJ ex order 26.4b1 to the wrong resident, to the administration: US FOIA (B) (6) [redacted], and US FOIA (B) (6) [redacted] No additional documentations were provided. On 8/8/24 at 9:26 AM, the US FOIA (B) provided the most current facility policy and procedure titled, "Medication Administration" and reviewed on 7/1/24. The policy stated, "Ensure that the rights of medication administration are followed: right resident; right drug; right dosage; right route; and right time."	F 755		

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F 755	Continued From page 6 NJAC 8:39-29.2(b), (d); 29.3(a)6	F 755		
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 maintain kitchen equipment in a clean and sanitary manner as evidenced by the following: On 08/01/24 at 10:29 AM in the presence of the US FOIA (b)(6)) and the US FOIA (b)(6) the surveyor observed the following: 1. Inspection of the Microwave unit revealed the interior to have multi-colored splattered food debris stuck to the interior upper wall. 2. During inspection of the oven the surveyor	F 812	1. No residents were affected by this deficient practice. The multicolored splattered food debris stuck to the microwave unit's interior wall was removed and cleaned upon notification. The 3 cast iron grill plates were removed from the oven and cleaned immediately upon notification. 2. All residents have the potential to be affected by this deficient practice. All other areas in the kitchen were inspected to ensure they were clean and free of debris.	8/29/24

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F 812	Continued From page 7 observed 3 cast iron grill plates that were visibly used, dirty with solidified grease in the oven. The [redacted] stated they had been used the night before. On 08/05/24 at 10:15 AM, the surveyor interviewed the [redacted]. who stated that the cooking equipment should have been removed from the oven and cleaned after use. It needs to be cleaned and maintained in a sanitary way to prevent food borne illness and contamination. The microwave should be thoroughly cleaned daily in the evening. The [redacted] acknowledged that the above items should have been cleaned. On 08/05/24 10:30 AM, the surveyor interviewed the [redacted]. who stated that the cooking equipment should have been cleaned and maintained in a sanitary way to prevent food borne illness and contamination according to regulations. It did not meet supervisory expectations, facility policy or regulations. A review of the facilities General Kitchen Cleaning Policy, dated revision February 2024, revealed ... Policy: The staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. A review of the facilities Food Borne Illness Policy, dated revision 1/2024, revealed ... Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Definitions: "Contamination" means the unintended presence of potentially harmful substances including, but not limited to	F 812	3. Administrator re-educated dietary staff on proper cleaning of all kitchen equipment. 4. The Food Service Director/Designee will conduct an audit of the microwave and oven to ensure they are clean, free of debris and that there is no eqipment left inside of oven that requires cleaning. The audit will be completed weekly x4 then monthly x2 months. The results of the audit will be presented at the monthly QAPI meeting.	

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F 812	Continued From page 8 microorganisms, chemicals, or physical objects. Policy Explanation and Compliance Guidelines: 1) Food safety practices shall be followed throughout the facility's entire food handling process. Elements of the process include the following: c.) Preparation of food, including thawing, cooking, cooling, holding, and reheating. 6) All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. a) Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment. NJAC 8:39-17.2(g)	F 812		
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80);	F 836		8/29/24

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F 836	Continued From page 9 nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility documentation, it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and apply for a change in name to include Doing Business As in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish	F 836	1. No residents were affected by this deficient practice. The facility has submitted an application for the Name Change of the 'Doing Business As' name of the facility to CN & Healthcare Facility Licensure Program, NJ Department of Health, Office of Certificate of Need and Healthcare Facility Licensure, 171 Jersey St, Building 5, First Floor, Trenton NJ 08611-2425, in accordance with Federal and State regulations. This was submitted on 8/28/2024. 2. All residents have the potential to be affected by this deficient practice. 3. The Regional Administrator educated the US FOIA (b)(6) on ensuring the proper licensing credentials are in place for the facility. 4. The Administrator/Designee will conduct an audit of all licensing credentials for the facility weekly x 4 weeks and monthly x2months to ensure that the proper and updated licensing	

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F 836	Continued From page 10 and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76..... (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location. (2) All other changes in enrollment must be reported within 90 days." A review of the facility Admission agreement revealed under the facility name section as "Complete Care at Barn Hill Center." A review of the Census Report revealed the name of the facility as "Complete Care at Barn Hill Center." The Business cards provided to the surveyors upon entrance reflected the facility name as "Complete Care at Barn Hill."	F 836	credentials are in place. The results will be presented at the monthly QAPI meetings.	

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F 836	Continued From page 11 During an interview with the surveyor on 8/6/24 at 11:04 AM, an interview with US FOIA (b)(6) [redacted] stated that the Facility is called Complete Care at Barn Hill and this is according to signage outside of the facility, it is also documented on the facility's policies and procedures and printed clinical documentation. The surveyor indicated that the above noted documents do not match the documentation according to CMS Novitas, dated October 2026, whcih revealed "Legal Business Name (LBN): COMPLETE CARE AT BARN HILL LLC Doing Business As Name: BARN HILL CARE AND REHAB CENTER." The surveyor asked if the facility had filed a 855 B form and the US FOIA (b)(6) [redacted] explained that they have not done the 855B form and that they would need to do one to change the DBA name to Complete Care at Barn Hill. The US FOIA (b)(6) [redacted] was only able to provide the surveyor with a LSC-9 application for a long term care facility license which revealed DBA "Barn Hill Care and Rehab Center." A review of the facility license that was issued by the New Jersey Department of Health Division of Certificate of Need and Licensing with an issue date of April 1, 2024, and an expiration date of March 31, 2025 revealed under name licensed to operate Barn Hill Care and Rehab Center and not Complete Care at Barn Hill. NJAC 8:39-5.1 (a)	F 836		

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BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member	S 560	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. Additional per diem, part time, and full time were scheduled to meet minimum staff to resident ratios. Licenses/certifications were verified by the staffing manager/Human Resources for current licensed/certified staff. DON/Designee to in-service Staffing Coordinator on appropriate staffing levels. The facility has advertised open jobs through online recruiting platforms as well as traditional recruiting firms. The facility also has an agreement in place with NJ Ex Orde [redacted] to train candidates to be certified as CNAs. The facility has conducted job fairs and has contracts with nursing staffing agencies. 4. The Scheduling manager or designee will audit weekly x4 weeks and monthly x2 months to ensure staffing levels are within the mandated ratios. All identified concerns will be corrected immediately. The resiults of the audits will be reviewed in the monhly QAPI meetings.	8/29/24

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

Electronically Signed | 08/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061903	A. BUILDING: _____ B. WING _____	C 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1	S 560		

shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and

(3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties

b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.

c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.

(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.

(3) All computations shall be based on the midnight census for the day in which the shift begins.

d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing hometo increase staffing levels, at any time, beyond the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061903	A. BUILDING: _____ B. WING _____	C 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks of staffing prior to the 8/13/24 Standard Recertification Survey from 7/14/24 to 7/27/24, revealed this deficient practice was evidenced by the following: The facility was deficient in CNA staffing for residents on 12 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -07/14/24 had 14.5 CNAs for 139 residents on the day shift, required at least 17 CNAs. -07/15/24 had 14 CNAs for 135 residents on the day shift, required at least 17 CNAs. -07/18/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -07/19/24 had 11 CNAs for 132 residents on the day shift, required at least 17 CNAs. -07/20/24 had 13.5 CNAs for 142 residents on the day shift, required at least 18 CNAs. -07/21/24 had 11 CNAs for 142 residents on the day shift, required at least 18 CNAs. -07/22/24 had 12.5 CNAs for 142 residents on the day shift, required at least 18 CNAs. -07/23/24 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs. -07/23/24 had 9 total staff for 141 residents on the overnight shift, required at least 10 total staff. -07/24/24 had 12 CNAs for 141 residents on the day shift, required at least 18 CNAs. -07/25/24 had 12 CNAs for 141 residents on the day shift, required at least 18 CNAs. -07/26/24 had 11 CNAs for 141 residents on the day shift, required at least 18 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061903	A. BUILDING: _____ B. WING _____	C 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 -07/27/24 had 12.5 CNAs for 143 residents on the day shift, required at least 18 CNAs. On 8/6/24 at 9:59 AM, the surveyor interviewed the facility's staffing coordinator who stated that she was aware of the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. The staffing coordinator further stated that the Administrator and Director of Nursing (DON) were aware of the daily staffing and whether minimum staffing ratios were met. On 8/8/24 at 1:23 PM, the survey team discussed staffing concerns with the Administrator and DON.	S 560		

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
315137 Y1	A. Building B. Wing Y2	9/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0755	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/29/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/13/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061903 Y1	A. Building B. Wing Y2	9/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/29/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315137 Y1	A. Building B. Wing Y2	9/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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 F0755	Correction	ID Prefix F0812	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	08/29/2024	LSC	08/29/2024	LSC	08/29/2024
ID Prefix F0836	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(a)-(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/29/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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?
8/13/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. BUILDING **01** B. WING _____	**08/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	**249 HIGH STREET** **NEWTON, NJ 07860**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/12/2024 and 8/13/2024, and Barn Hill Care and Rehabilitation Center 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 is a 1- story building that was built in 70's, It is composed of Type III unprotected construction. The facility is divided into 8-smoke zones. The facility has one 400 KW Diesel Emergency Generator that supplies 100% of the buildings electrical power in the event of electric power loss to the building. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door holds open devices, exterior door releases, emergency facility lighting, and life safety components utilized for preservation of life. The facility has 154 certified beds. At the time of the survey the census was 139.	K 000		
K 321 SS=F	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	K 321		8/29/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. BUILDING **01** B. WING _____	**08/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	**249 HIGH STREET** **NEWTON, NJ 07860**

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K 321	Continued From page 1 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, documentation review, and interview on 08/12/2024 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice had the potential to affect all	K 321	1. A door locking device was installed, door labeled, and self closing hinges installed. This was completed on 8/16/2024. Photos sent. 2. All residents have the potential to be affected by this deficient practice. 3. The Regional Maintenance Director educated the US FOIA (b)(6) on ensuring doors in the facility can resist the passage of smoke by closing and latching	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. BUILDING **01** B. WING _____	**08/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 2 135 residents and was evidenced by the following: An observation at 11:20 AM in the basement with US FOI and US FOI, revealed a room over 50 square feet in size being used as a storage for combustible storage had the door locking hardware removed, no label and self-closing device not installed. The room contained boxes, chairs, tables and 3 mannequins. In an interview at that time, the US FOI stated that "the room was a classroom now being used as storage". Both the US FOI and US FOI confirmed the observation. The facility's US FOIA (b)(6) and the US FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 08/13/2024.	K 321	appropriately. 4. Maintenance Director/Designee will conduct weekly audits x4weeks and then monthly x2 months to ensure the door is closing and latching properly. The QAPI committee will review the audits at the monthly QAPI meetings to ensure compliance.	
K 341 SS=F	NJAC 8:39-31.2(e) Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission	K 341		8/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. BUILDING **01** B. WING _____	**08/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 341	Continued From page 3 paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/12/2024 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 main dining enclosed courtyards in accordance with NFPA 101: 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72: 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. This deficient practice had the potential to affect all 135 residents and was evidenced by the following: An observation at 8:45 AM in the presence of the US FOIA (b)(6), revealed there was no fire alarm system horn/strobe installed in the main dining enclosed courtyard. In an interview at the time, the SDM, MD and FA confirmed the observation. The facility's US FOIA (b)(6) [redacted] ere notified of the deficient practice at Life Safety Code survey exit conference on 08/13/2024. N.J.A.C. 8:39-31.2(a) NFPA 72	K 341	1. A fire alarm notification (strobe/horn) system was installed in the enclosed courtyard by the main dining room. This was completed on 8/26/2024. No resident was affected by this deficient practice. 2. All residents have the potential to affected by this deficient practice. 3. The US FOIA (b)(6) was educated on ensuring that there is sufficient alarm notification system in place in the enclosed courtyard. 4. Maintenance Director/Designee will conduct weekly audits x 4weeks and monthly x2 months to ensure that fire alarm notification (Strobe) system in the enclosed courtyard is in working condition. Audits will be reviewed at the monthly QAPI meetings to ensure compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance	K 345		8/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. BUILDING **01** B. WING _____	**08/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	**249 HIGH STREET** **NEWTON, NJ 07860**

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K 345	Continued From page 4 CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 8/12/2024 and 8/13/2024 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that smoke detection sensitivity testing of the smoke detectors were completed in accordance with NFPA 72 National Fire Alarm and Signaling Code [2010 Edition] Section 14.4.5.3.2. This deficient practice had the potential to affect all 135 residents and was evidenced by the following: 1. Observations on 08/12/24 from 9:10 AM to 3:45 PM, revealed smoke detectors were in the corridors, the resident rooms, and other concealed areas throughout the building. 2. A review of the facility's "Inspection and Testing Reports," dated 07/10/24, provided by the US FOIA on 8/13/2024, revealed the report had no reference to a smoke detection sensitivity test. In an interview at the time of the observations, the US FOIA confirmed the smoke sensitivity testing was not completed on the smoke detectors.	K 345	1. A fire alarm sensitivity test was conducted. This was completed on 8/16/2024. No residents were affected as a result of this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was educated on the need to have the sensitivity test done when due and the record of testing always available for inspection. 4. Maintenance Director/Designee will conduct weekly audits x4 weeks and then monthly x 2 months to ensure that the sensitivity testing is conducted when due and records of the testing maintained. Audits will be reviewed at the monthly QAPI meetings to ensure compliance.	

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BARN HILL CARE AND REHAB CENTER	**249 HIGH STREET** **NEWTON, NJ 07860**

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K 345	Continued From page 5 The facility's US FOIA (b)(6) ere notified of the deficient practice at Life Safety Code survey exit conference at 3:25 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review, and interview on 08/12/2024 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to maintain the fire sprinkler system and ensuring the ceiling level was smoke	K 353	1. The 4 sprinkler heads that had lint build up were cleaned. Completed on 8/13/2024. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was educated on ensuring that all sprinkler heads in the	9/14/24

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K 353	Continued From page 6 resisting in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7,9.7.8, NFPA 25: 2011 Edition, Section 5.2.1.1.1(2). This deficient practice had the potential to affect all 135 residents and was evidenced by the following: An observation in the presence of the US FOIA (b)(6) revealed the following: 1. At 9:15 AM in the laundry room, 4 of 4 sprinkler heads were covered with lint. 2. At 9:20 AM in Sparta Rehab Gym, 1 of 6 sprinkler head escutcheon plate was not in place. 3. At 9:25 AM in the Newtonian staff bathroom, 1 of 1 sprinkler head escutcheon plate was not in place. 4. Documentation review at 1:30 PM, revealed no records indicating the facility's private fire hydrant annual inspection and testing had been conducted. In an interview at the time, the US FOIA (b)(6) confirmed the findings. The facility's US FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 08/13/2024. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	laundry room remain free of lint and debris. 4. The maintenance director/designee will conduct weekly audits x4 weeks and then monthly x2months to ensure sprinkler heads remain free of lint and debris. Audits will be reviewed at the monthly QAPI meetings to ensure compliance. 1. The missing escutcheon plate in the Sparta Gym was installed. Completed on 8/13/2024. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was educated on ensuring that all sprinkler heads have escutcheon plates in place. 4. The maintenance director/designee will conduct weekly audits x4 weeks and then monthly x 2 months to ensure that there are escutcheon plates in place for all sprinkler heads. Results of the audits will be presented at the monthly QAPI meetings to ensure compliance. 1. The missing escutcheon plate in the Newtonian staff bathroom was installed. Completed on 8/13/2024. 2. All residents have the potential to be affected by this deficient practice. 3.The US FOIA (b)(6) was educated on ensuring that all sprinkler heads have escutcheon plates in place. 4. The maintenance director/designee will conduct an audit weekly x 4weeks and then monthly x 2months. Results of the audit will be presented at the monthly	

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K 353	Continued From page 7	K 353	QAPI. 1. The fire inspection vendor for the facility, NJ Ex Order 26.4b1 Company, will conduct annual inspections of the fire hydrant located on the premises. Next inspection will be completed by 9/13/2024. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was educated on the need to ensure that the annual inspection of the fire hydrant is done and documented. 4. The maintenance director/designee will conduct weekly audits x4 weeks and the monthly x 2 months ensure the fire hydrant inspection is done and documented. Results of the audits will be reviewed at the monthly QAPI meeetings.	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames.	K 362		8/29/24

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K 362	Continued From page 8 If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, and interview on 8/12/2024 in the presence of US FOIA (b)(6) [redacted]), it was determined facility failed to ensure that corridor walls were constructed to resist the passage of smoke in accordance with the requirement of NFPA 101: 2012 Edition, Section 19.3.6.2 and 19.3.2.7. This deficient practice had the potential to affect all 135 residents and was evidenced by the following: 1. An observation at 8:15 AM with the US FOIA (b)(6) [redacted] revealed a hole in the wall above the corridor door in the ceiling between room #122 and room #30. 2. An observation at 11:17 AM with the US FOIA (B) (6) and US FOIA [redacted] revealed a hole in the wall above the corridor door in the ceiling between Executive Nurse office and Executive Director office. In an interview at the time, the US FOIA (B) (6) and US FOIA confirmed the observation. The facility's US FOIA (b)(6) [redacted] ere notified of the deficient practice at Life Safety Code survey exit conference on 08/13/2024. N.J.A.C. 8:39-31.2(e)	K 362	1. The hole in the wall above the corridor door in the ceiling between room 122 and room 30 and the hole in the wall above the corridor door in the ceiling between the US FOIA (B) (6) [redacted] offices were sealed with fire retardant caulking. This was completed on 8/12/2024. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] was in serviced on ensuring that there were no holes in the walls throughout the facility. 4. The maintenance director/designee will conduct weekly audits x 4 weeks and then monthly for 2 months to ensure that there are no holes in any wall in the facility. Results of the audits will be presented at the monthly QAPI meetings.	

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K 363 SS=F	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 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.	K 363		8/29/24

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K 363	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/12/2024 in the presence of the [US FOIA (B) (6)] and [US FOIA (B) (6)] it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101:2012 Edition, Section 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect all 135 residents was evidenced by the following: Observations from 9:10 AM to 3:30 PM in the presence of [US FOIA] and [US FOIA], revealed the following: 1. At 9:59 AM, resident room door #59 was rubbing on the frame and not latching when tested by the [US FOIA]. 2. At 10:06 AM, resident room door #51 was not latching to its frame when tested by the [US FOIA] 3. At 10:12 AM, the Franklin Hall corridor door was not closing properly to resist smoke when tested by the [US FOIA] 4. At 11:15 AM, resident room door #45 was stuck at the bottom when tested by the [US FOIA]. 5. At 11:19 AM, the Blair Hall utility closet door was not latching to its frame when tested by the [US FOIA] 6. At 10:22 AM, resident room door #29 had a gap on top when it was tested by the [US FOIA]. 7. At 1:25 PM, the corridor door next to kitchen office had a gap on top when it was tested by the	K 363	1. Room# 59, Room# 51, Room #45 the Franklin hall corridor door have been fixed. These were completed on 8/28/2024. The Blair Hall utility closet door, room#29, the corridor door next to kitchen, the corridor door next to kitchen/dining, and the Sparta Hall set doors will be completed by 9/30/2024. Our door vendor, [NJ Ex Order 26.4b1] are working on correcting the deficient doors. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance has been in serviced on ensuring that all doors in the facility can resist and prevent the passage of smoke in accordance with NFPA requirements and regulations. 4. Maintenance Director/Designee will conduct weekly x 4 weeks and then monthly x2 months to ensure all doors can resist the passage of smoke in accordance with NFPA requirements. Audit results will be oresented and reviewed at the monthly QAPI meetings.	

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K 363	Continued From page 11 US FOIA. 8. At 1:27 PM, the corridor door next to kitchen/dining had a gap on top when it was tested by the US FOIA. 9. At 1:31 PM, the Sparta Hall set doors by the lounge had gap between when tested by the US FOIA In an interview at the time, the US FOIA and US FOIA confirmed the observations. The facility's US FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 08/13/2024. N.J.A.C. 8:39-31.2(e)	K 363		
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 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/12/2024 in the presence of the US FOIA (b)(6) it was determined that the facility failed to	K 521	1. The ventilation system was repaired and all affected rooms were inspected and found to be working properly on 8/23/2024.	8/29/24

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K 521	Continued From page 12 ensure resident bathroom ventilation systems for 17 of 17 units were functionally maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: Observations in the presence of the US FOIA (B) (6) and US FOIA, revealed that the ventilation in the following resident room bathrooms were not functioning: Room #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17. The surveyor requested that the US FOIA, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue were not held in place by any suction. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. In an interview at the time, the US FOIA confirmed that the exhaust vents in the above resident room bathrooms were not functioning when tested. The facility's US FOIA (B) (6) and the US FOIA (B) (6) were notified of the deficient practice at Life Safety Code survey exit conference on 08/13/2024. NJAC 8:39-31.2(e). NFPA 90 A.	K 521	2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was in serviced by regional maintenance director on ensuring that the ventilation system always works properly in all resident rooms and all areas of the facility. 4. The maintenance director/designee will conduct weekly audits x4 weeks and then monthly x 2 months of the ventilation system to ensure that the vents always work properly. Results of the audits will be presented at the monthly QAPI meetings.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K 761		8/29/24

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K 761	Continued From page 13 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 8/13/2024 in the presence of the US FOIA (B) (6) and the US FOIA (B) (6), it was determined that the facility failed to ensure that annual Inspection, Testing and Maintenance (ITM) of the fire door assemblies were conducted in accordance with NFPA 101:2012 Edition, Sections 19.7.8, 8.3.3.1 and NFPA 80 Standard for Fire Doors and Other Opening Protectives, Sections 5.2. This deficient practice had the potential to affect all 135 residents and was evidenced by the following: A document review at 10:20 AM, revealed that the fire door assemblies were not inspected and tested annually in accordance with NFPA 80 Standard for Fire Doors. In an interview at the time, the US FOIA confirmed the fire doors were inspected annually but could not provide any inspection log documentation listing the required inspection detailed results.	K 761	1. All the fire door assemblies were inspected, and the inspection detail results documented. This was completed on 8/16/2024. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was in serviced on ensuring that all fire doors are inspected annually, and the inspection detail results properly documented. 4. The maintenance director/designee will conduct weekly audits x 4 weeks and then monthly x2 months of all fire door assemblies and accompanying detailed inspection documentation. Results of the audits will be presented and reviewed at the monthly QAPI meetings.	

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K 761	Continued From page 14 The US FOIA (B) (6) and the US FOIA (B) (6) were notified of the deficient practice at Life Safety Code survey exit conference at 3:25 PM. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 80	K 761		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.	K 921		8/29/24

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BARN HILL CARE AND REHAB CENTER	**249 HIGH STREET** **NEWTON, NJ 07860**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 15 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 8/12/2024 and 8/13/2024 in the presence of the US FOIA (B) (6) and the US FOIA (B) (6) it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, and 10.5.8. This deficient practice had the potential to affect all 135 residents and was evidenced by the following: Observations from 9:10 AM to 3:30 PM, revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers identifying an inspection throughout the facility. In an interview at the time, the US FOIA stated he checked all PCREE equipment but could not provide a policy and procedure for testing of the equipment or evidence of annual testing and maintenance program for PCREE. The US FOIA (B) (6) and US FOIA (B) (6) were informed of the deficient practice at the Life Safety Code exit conference on 8/13/2024. NJAC 8:39-31.2(e). NFPA 99.	K 921	1. All fixed and portable patient care related electrical equipments were inspected and tested and labeled as such. A policy regarding the annual inspection and maintenance of patient care related equipment was created. This was completed on 8/28/2024. 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was educated on ensuring that all fixed and portable patient care related equipment is inspected annually and labeled. 4. The maintenance director/designee will conduct weekly audits x 4 weeks and then monthly x 2 months to ensure complaince with the policy. The audit results will be presented and reviewd at the monthly QAPI meetings.	

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
315137 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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 K0321	08/29/2024	LSC K0341	08/29/2024	LSC K0345	08/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	09/14/2024	LSC K0362	08/29/2024	LSC K0363	08/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	08/29/2024	LSC K0761	08/29/2024	LSC K0921	08/29/2024
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	
8/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO