STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	**234 CHESTNUT STREET , UNION, New Jersey, 07083**

(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
F0000	INITIAL COMMENTS Complaint #: NJ175447, NJ175908, NJ176059, NJ176962, NJ179586, NJ183048 Survey Date: 4/16/25 Census: 100 Sample: 23 + 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.	F0000		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0610	Resident # 260 no longer resides in the facility On 4/11/25, The Regional Director of Nursing in-serviced the[US FOIA (b)(6) [redacted]) on thorough investigation of Incident of unknown origin per the facility policy. The facility has determined that all resident residing in the facility are potentially at risk for the deficient practice. This can be identified by reviewing the medical records/incidents and accidents reports on 5/7/25, an Inservice education began by Regional Director of Nursing and the DON with the direct care staff addressing through investigation of all incidents and accident to include interview of witnesses, and to determine whether abuse occurred. The facility has also developed a system on Quality Assurance (QA) checklist for incident and accidents to thoroughly completing an investigation to ensure compliance. Education will be completed on 5/20/25 The DON /designee will audit and review all Incidents	05/30/2025

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

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

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F0610 SS = D	Continued from page 1 Complaint: #NJ183048 Based on interview, review of medical record, and other pertinent facility documentation, it was determined that the facility failed to thoroughly and accurately investigate an NJ Exec Order 26.4b1 This deficient practice was identified for 1 of 4 residents reviewed for accidents (Resident #260), and was evidenced by the following: The surveyor reviewed the closed medical record for Resident #260. A review of the Admission Record face sheet (an admission summary) indicated that Resident #260 had the diagnoses which included but were not limited to; NJ Exec Order 26.4b1 . A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26 reflected that Resident #260 had NJ Exec Order 26.4b1 , required NJ Exec Order 26.4b1 with activities of daily living (ADLs), and had NJ Exec Orde since admission to the facility. A review of the Incident Accident Report (IAR) dated 10/16/24 at 1:37 PM, indicated that while the nurse was performing rounds, Resident #260 was noted to have a scratch on their NJ Exec Order 26.4b1 . The site was cleansed with NJ Exec Order 26.4b1 , patted dry, and NJ Exec Order 26.4b1 was applied. The US FOIA (b)(6) and family members were notified of the NJ Exec Order 26.4b1 , and the investigation indicated that the NJ Ex Order 26.4b1 would follow up. The facility was unable to provide any NJ Ex Order 26.4b1 notes to the surveyor. A review of the Interdisciplinary Care Plan (ICP) meeting note dated NJ Exec Order 26. indicated that the team had discussed the NJ Exec O on the NJ Exec Order 26.4b1 that the resident NJ Exec Order 26.4 on NJ Exec Order 26. . The documentation reflected two NJ Exec Order 26.4b1 . A review of the individualized comprehensive care plan (ICCP) dated NJ Exec Order 26.4 reflected that the resident had a skin NJ Exec Order 26.4b1 .	F0610	Continued from page 1 investigations daily at clinical meetings Monday through Friday to ensure thorough investigation of the incident, interview witnesses and conclusion summary to include the root cause of the incident or if abuse occurred. This audit will be done utilizing a check list. Any findings from the audit will be addressed immediately and the results from the audit will be reviewed by the QAPI and Quality Assurance (QA) Committee monthly for one quarter. The QA committee will determine if further actions are needed and necessary adjustment to the corrective action.	

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F0610 SS = D	Continued from page 2 A review of the [redacted] witness statement dated [redacted], eight days prior to incident, indicated that the resident had a [redacted] observed on their [redacted]. That witness statement was included in the [redacted] investigation dated [redacted]. A review of the second witness statement obtained from the same [redacted] with a date of [redacted] and crossed out date of [redacted] indicated that the resident had a [redacted] observed on their '[redacted] The documentation reflected that both of the [redacted] statement dates were conflicting and contained different sites of [redacted] There were no other statements obtained from any nurses or other CNAs going back 72 hours on all shifts for the [redacted] A review of the IAR dated [redacted] at 2:09 PM, indicated that Resident #260 had a [redacted]. The report documented that Resident #260 [redacted] to tell the staff how it happened. A review of the Treatment Administration Record (TAR) dated [redacted] included a physician's order to [redacted] the '[redacted], and leave the area [redacted]. A review of the Interdisciplinary meeting note dated [redacted], indicated that the physician and that family member were notified that the resident [redacted] to their '[redacted]. A review of the ICCP updated on [redacted], reflected an intervention to monitor the [redacted] A review of the witness statement dated [redacted] written by the [redacted]), indicated that while she was assisting the resident with morning care, the resident was noted to have a [redacted].	F0610		

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F0610 SS = D	Continued from page 3 A review of the witness statement dated NJ Exec Order 26.4 one day prior to incident, documented by the US FOIA (b)(indicated that the resident had a NJ Exec Order 26.4b1. These statements had different NJ Exec Order 26.4b1 A review of the Progress Notes included a Health Status Note dated NJ Exec Order 26 at 2:24 PM, that the "Resident received in bed NJ Exec Order 26.4b1. About 10:00 AM Writer was called into resident's room and noticed resident has NJ Exec Order 26.4b1 . Resident NJ Exec Order 26. what was happening. NJ Exec Order 26.4b1 (US FOIA (b)(6) /family member notified. NJ Exec Order 26.4b1, remains NJ Exec Order There were no other statements obtained from nurses or CNAs on prior shifts going back 72 hours. On 4/11/25 at 11:49 AM, the surveyor interviewed the US FOIA (b)(6)), who stated she was responsible to conduct complete accurate investigations for incidents/accidents in the facility. the US FOIA (b)(stated that if a resident was found with a NJ Exec Order 26.4b1 , the primary nurse was responsible to assess the resident, initiate a treatment, call the physician, and notify the family. The US FOIA (b)(continued to explain that the primary nurse also obtained statements from the CNAs going back 72 hours prior to unwitnessed incident. The US FOIA (b)(stated that the facility did not obtain statements from the nurse that cared for the resident going back 72 hours. She stated, "we speak to them verbally, but do not get written statements from them." She stated that the resident would also be referred to the NJ Ex Order 26.4b1 team. At that time, the US FOIA (b)(reviewed the IAR dated NJ Exec Order 26.4 in the presence of the surveyor. The US FOIA (b)(reviewed the statements from the same US FOIA dated NJ Exec Order 2, and another dated NJ Exec Order 26, but then crossed out and changed to NJ Exec Order 26 The US FOIA (b)(stated that the resident did not have an incident on NJ Exec Order, and she thought that the US FOIA wrote the wrong date on the statement. The US FOIA (b)(stated that the NJ Exec O had occurred on NJ Exec Order 26. The US FOIA (b)(did not have an explanation as to why the witness statements had two different sites of NJ Exec O documented, and stated it was an error in documentation. The US FOIA (b)(also could not explain why the	F0610		

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F0610 SS = D	Continued from page 4 ICCP initiated NJ Exec Order 26.4, indicated that Resident #260 had a NJ Exec Order 26.4b1. The US FOIA (b)(stated again that must have been an error in documentation. The US FOIA (b)(continued to review the IAR dated NJ Exec Order 26, and stated that the nurse had documented that the resident sustained a NJ Exec Order 26.4 on their NJ Exec Order 26.4b and the interdisciplinary team (IDT) documented that the NJ Exec O had occurred on their NJ Exec Order 26.4b1. The US FOIA (b)(stated that there was a discrepancy in the documentation, and that the resident NJ Exec Order 26.4b1. The US FOIA (b)(then reviewed the witness statements from the NJ Exec Order 26.4b1 and agreed that there was also an error in documentation on the witness statement dated NJ Exec Order 26. The US FOIA (b)(explained that the statement written by the US FOIA indicated that while she was assisting the resident with morning care, the resident was noted to have a NJ Exec Order 26.4b1 on their ' NJ Exec Order 26.4b. The witness statement dated NJ Exec Order 26, one day prior to incident, the US FOIA documented that the resident had a NJ Exec Order 26.4b1. The US FOIA (b)(agreed that the US FOIA statement contradicted the US FOIA (b) statement that the resident had an NJ Exec Order 26.4b1. On 4/11/25 at 1:00 PM, the surveyor interviewed the US FOIA (b)(6)), who stated that witness statements from nurses and CNAs should have been obtained from both incidents going back 72 hours, and that these investigations dated NJ Exec Order 26.4b1 should have been checked for accuracy in documentation related to the NJ Exec of NJ Exec Or On 4/16/24 at 9:35 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that the NJ Exec Order 26.4b1 origin dated NJ Exec Order 26. actually happened on that date. The US FOIA (b)(stated that the witness statement dated NJ Exec Order 2 was an inaccurate date. The US FOIA (b)(also clarified that the NJ Exec Ord location was the ' NJ Exec Order 26. and that there was an error in documentation on the IDT note which indicated that the NJ Exec Order 26.4b1. The US FOIA (b)(also agreed that the witness statements from the NJ Exec Order 26.4 on NJ Exec Order 26. were NJ Exec Order 26.4 however the NJ Exec Ord was on the NJ Exec Order 26.4b1 which was documented by the nurse on the Progress Notes. The US FOIA (b)(6) documented inaccurately in the witness statement. A review of the facility's "Accidents and Incidents-Investigating and Reporting" policy dated	F0610		

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F0610 SS = D	Continued from page 5 10/2024, included the following data shall be included in the investigation: the date and time the incident took place; the condition of the injured person and nature of the injury; follow-up information; the name of witnesses and their accounts of the accident or incident... The policy did include the procedures for injuries of unknown origin or obtaining employee statements. A review of the facility's "Documentation in the Medical Record" policy dated 10/2023, included each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the residents' progress through complete, accurate and timely documentation... NJAC 8:39-4.1(a)5; 27.1(a)	F0610		
F0637 SS = B	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure that the completion of a significant change Minimum Data Set (MDS), an assessment tool, was completed in a timely manner. This deficient practice was identified for 1 of 23 residents reviewed for resident assessments (Resident # 40), and was evidenced by the following: On 4/9/25 at 10:00 AM, the surveyor observed Resident #40 lying in bed, NJ Exec Order 26.4 with the head of bed up. The surveyor was NJ Exec Order 26.4b1 the resident due to NJ Exec Order 26.4b1.	F0637	For Resident # 40 a significant change minimum Data Set (MDS) assessment was modified and corrected by the MDS coordinator on NJ Exec Order 2 On 4/15/25, an audit was conducted on all residents on Hospice program to ensure that a significant change assessment was completed , no issues found form the audit. All residents receiving hospice service are potentially at risk for the deficient practice on 5/7/25 The US FOIA (b)(6) was re-educated by the Regional MDS coordinator, regarding the need for a significant change in status in the MDS within the 14 days after a resident is enrolled in the hospice program sections of the MDS. The Regional MDS coordinator/ designee will audit each new resident admitted on hospice to ensure the required significant change assessment is done in the MDS. This audit will be completed utilizing QA auditing tool. The monitoring process will take place weekly for 4 weeks then monthly for 4 months and ongoing. Any findings from the audit will be addressed immediately and the results from the audit will be reviewed by the QAPI and Quality Assurance (QA) Committee monthly for one quarter. The QA committee will determine if further actions are needed and necessary adjustment to the corrective action.	05/30/2025

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F0637 SS = B	Continued from page 6 A review of the Admission Record face sheet (an admission summary) indicated that Resident #40 was admitted to the facility with the diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the physician order (PO) dated NJ Exec Order, reflected that Resident #40 was admitted to NJ Exec Order care. A review of the individualized comprehensive care plan (ICCP) indicated that the resident was receiving NJ Exec Order services. A review of the most recent quarterly MDS dated NJ Exec Order, reflected that Resident #40 had NJ Exec Order 26.4b1 [redacted] and required NJ Exec Order 26.4b1 [redacted] with activities of daily living (ADLs). There was NJ Exec Order 26.4b1 MDS to reflect that the resident had a change in status and was admitted to NJ Exec Order 26.4b1. On 4/15/25 10:49 AM, the surveyor interviewed the US FOIA (b)(6) [redacted] who stated when a resident was admitted to NJ Exec Order services, the US FOIA (b)(6) was responsible to complete a significant change in status MDS. On 4/15/25 at 11:24 AM, the surveyor interviewed the US FOIA (b)(6) [redacted]), who stated that a significant change MDS was required when the resident transitioned to NJ Exec Order services. The US FOIA (b)(6) confirmed that the resident's NJ Exec Order 26.4b1 MDS should have been completed within 14 days of their change in status. A review of the facility's "MDS 3.0 Completion" policy dated 10/2024, included a significant change in status-a comprehensive assessment (SCSA) was to be completed within 14 days of identification of a status change that meets the requirements. A SCSA is required when a resident enrolls in a hospice program or discontinues hospice services...	F0637		

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F0637 SS = B	Continued from page 7 NJAC 8:39-11.1	F0637		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Complaint # NJ175980 Based on observation, interview, and review of medical records, it was determined that the facility failed to provide necessary treatment services consistent with professional standards of clinical practice by not ensuring that a resident diagnosed with the [redacted] received care and services in a timely manner. This deficient practice was identified for 1 of 26 residents reviewed for quality of care (Resident #262), and was evidenced by the following: On 4/10/25 at 11:08 AM, the surveyor reviewed the closed medical record for Resident #262. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated a moderately [redacted].	F0684	Resident # 14 is no longer a resident in the facility. on on 4/15 A Audit was conducted by the DON for all residents with change of condition , no issues were found from the audit All Residents are determined to be potentially at risk for the deficient practice. This can be identified by reviewing the residents medical records. on 5/7/25, the Director of Nursing (DON) began an Inservice education program for staff nurses on the facility notification policy and the importance of promptly notifying the physician on the residents change in condition as well as the resident/resident representative and documenting the notification in the progress notes. Education will be completed on 5/20/25 The DON will do a random audit of 5 residents with a change in condition weekly for 12 weeks to ensure any change in a resident condition has been communicated to the physician /family promptly and documented in the progress notes. This audit will be completed utilizing QA auditing tool. Any findings from the audit will be addressed immediately and the results from the audit will be reviewed by the QAPI and Quality Assurance (QA) Committee monthly for one quarter. The QA committee will determine if further actions are needed and necessary adjustment to the corrective action.	05/30/2025

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F0684 SS = D	Continued from page 8 A review of the Progress Notes revealed a delay in treatment for 61 hours since the resident's initial complaint of a [NJ Exec] until the resident received treatment as follows: 1. On [NJ Exec Order 2] at 7:14 AM, a Physician Progress Note documented that the resident's [NJ Exec Order 26.4b1]. 2. On [NJ Exec Order 2] at 1:59 PM, a Health Status Note revealed that a [US FOIA (b)(6)]) reported to the [US FOIA (b)(6)]) that the "resident stated that [NJ Exec Order 26.4b1] call placed to [US FOIA (b)(6)] name redacted], message was left office awaiting a call back." 3. On [NJ Exec Order] at 1:59 PM, a Health Status Note documented that a "call placed to [US FOIA (b)(6)] regarding [NJ Ex Order 26.4b1], awaiting call back." 4. On [NJ Exec Order 26.4b] 8:16 AM, a Physician Progress Note revealed the resident's [NJ Exec] had [NJ Exec Order 26.4b1]) to the [NJ Exec Order 26.4b1] It did not include a plan of treatment for the resident's new diagnosis. 5. On [NJ Exec Order 26.4b] 2:32 PM, a Health Status Note documented that the resident complained of a [NJ Exec] to their [NJ Exec O] and awaiting a call back from the [US FOIA (b)(6)] A review of the Physician Order Sheet dated [NJ Exec Order], included a physician's order (PO) dated [NJ Exec Order 26] for [NJ Exec Order 26.4b1] give one tablet every eight hours for seven days [NJ Exec Order 26.4b1] related to [NJ Exec Order 26] A review of the corresponding Medication Administration Record (MAR) revealed the order was entered on [NJ Exec Order] at 3:25 PM, and the resident received their first dose of the [NJ Exec Order 26.4b1] at 10:00 PM. A further review of the [NJ Exec Order 26.4] MAR revealed that there was no evidence the resident was administered the [NJ Exec Order 26.4b1] at 10:00 PM.	F0684		

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F0684 SS = D	Continued from page 9 The nursing administration signatures for those dates and time were blank. A review of the individualized comprehensive care plan (ICCP) revealed that it was not updated to reflect the resident's new diagnosis of [NJ Exec Order 2] or placement on NJ Exec Order 26.4b1 . On 4/15/25 at 9:29 AM, the surveyor interviewed the US FOIA (b)(6)), who stated the facility's policy was to follow-up with calls to the physician within an hour, and if a call was not returned, then the staff told the US FOIA (b)(6) who called the physician on their private phone. The [US FOIA] continued that a full assessment by the nurse should have been done and documented in the Health Status Notes what the [NJ Ex O] looked like. The [US FOIA] stated it should have also been written on the 24-hour report that the resident had a new issue. A review of the facility provided "Physician Services" policy dated reviewed October 2024, included ...a medical evaluation of the resident and review of orders for care and treatment ...advice, treatment, and determination of appropriate level of care needed for each resident... A review of the facility provided "Documentation in the Medical Record" policy dated updated October 2023, included ...Principles of documentation include but not limited to documentation shall be accurate, relevant and complete containing sufficient details about the resident's care and /or responses to care...documentation shall be timely and in chronological order... A review of the facility provided "Medication Administration" policy dated revised September 2022, included ... sign the MAR after administered...report and document any adverse effects or refusals... NJAC 8:39-27.1(a); 29.2(d)	F0684		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F0760	On 4/10/25 Resident #40 the Physician was notified of the deficient practice. No further orders were given. The identified nurses with the deficient practice were in- serviced through a competency evaluation by the Director of nursing (DON) on the facility policy and	05/30/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET , UNION, New Jersey, 07083

(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
F0760 SS = E	Continued from page 10 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to ensure medication administration without significant error for a resident who received [redacted] on a [redacted] as ordered on multiple dates and times. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #40), and was evidenced by the following: On 4/9/25 at 10:00 AM, the surveyor observed Resident #40 lying in bed. The resident NJ Exec Order 26.4b1, and the resident's head of bed was up. The surveyor was NJ Exec Order 26.4b1 the resident due to [redacted] The surveyor reviewed the medical record for Resident #40. A review of the Admission Record face sheet (an admission summary) indicated that Resident #40 was admitted to the facility with the diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that Resident #40 had NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with activities of daily living (ADLs). A review of the resident's Medication Administration Record (MAR) for [redacted], included a physician's order (PO) dated [redacted], for NJ Exec Order 26.4b1 [redacted];	F0760	Continued from page 10 proper procedure of NJ Exec Order 26.4b1 according to the NJ Exec Order 26.4b1 Resident # 40 did not NJ Exec Order 26.4b1 outcome from the deficient practice All residents receiving insulin administration with sliding scale have the potential to be affected by the deficient practice therefore, on 4/10/25, the staff nurses were re-educated by the DON on insulin administration using the sliding scale. On 5/7/25, a reeducation program initiated by the DON for all nurses through a competency evaluation on the proper technique of insulin administration according to the sliding scale order and accurately documenting blood sugar results. This education will be added to the new hire process, annual competency evaluations and as needed. Education completion date is 5/20/25 The DON/Pharmacy consultant /designee will conduct Random medication administration audit on one nurse weekly on each shift for 4 weeks, then two nurses monthly for 3 months, then one monthly on-going to ensure compliance with facility guidelines. This audit will be completed utilizing QA auditing tool. Any findings from the audit will be addressed immediately and the results from the audit will be reviewed by the QAPI and Quality Assurance (QA) Committee monthly for one quarter. The QA committee will determine if further actions are needed and necessary adjustment to the corrective action.	

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F0760 SS = E	Continued from page 11 NJ Exec Order 26.4b1 call physician. NJ Exec Order 26.4b1 before meals related to diagnoses of NJ Exec The MAR reflected the following: On NJ Exec Order 26.4 7:30 AM, the NJ Ex results indicated that the resident had a NJ Ex of NJ Exec and the nurse did not administer NJ Exec Order 26.4b1. The nurse documented the code of 'NJ E which indicated "see nurses notes." The surveyor reviewed the Nursing Progress Notes, and there was no corresponding documentation as to why the resident did not receive NJ Exec Ord or if the physician was notified. On NJ Exec Order 26 4:30 PM, there was no NJ Ex documented and there was no documentation of NJ Exec Ord administration. On NJ Exec Ord at 4:30 PM, documentation on the MAR reflected that the resident's NJ Ex was NJ Exec According to the PO, the resident should have received 'NJ Exec Order 26.4 . The code documented on the MAR reflected a 'NJ E which meant 'NJ Exec Order 26.4b1 There was no documentation that NJ Exec Ord was administered and no documentation in the progress notes as to why NJ Exec Ord was not administered. On NJ Exec Orde at 4:30 PM, the documentation on the MAR reflected that the resident's NJ Ex was NJ Exec The PO indicated that the resident should have received 'NJ E NJ Exec Order 26.4b1 The code documented on the MAR reflected a 'NJ E which meant NJ Exec Order 26.4b1 " There was no documentation that NJ Exec Ord was administered and no documentation in the progress notes as to why NJ Exec Ord was not administered. On NJ Exec Ord at 7:30 AM, the NJ Ex was documented as NJ Exec The PO indicated that the resident should have received 'NJ E NJ Exec Order 26.4b1. The code documented on the MAR reflected a 'NJ E which meant 'NJ Exec Order 26.4b1 There was no documentation that NJ Exec Ord was administered and no documentation in the progress notes as to why NJ Exec Ord was not administered. On 4/10/25 at 10:31 AM, the surveyor interviewed the US FOIA (b)(6)), who explained that if	F0760		

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F0760 SS = E	Continued from page 12 the nurse checked the resident's NJ Exec Order 26.4b1, and the NJ Exec Order 26.4b1 was below the range of the physician's NJ Exec Order 26.4b1, the nurse documented in the MAR that the resident did not need NJ Exec Orde administration. The US FOIA explained to the surveyor that she had worked the 7:00 AM to 3:00 PM (7-3) shift on NJ Exec Orc. The US FOIA reviewed the documentation on the MAR in the presence of the surveyor and stated that on NJ Exec Orde the resident's NJ Exec Order 26.4b1, and that according to the PO, the resident should have been administered 'NJ E units of NJ Exec Orde The US FOIA stated that she had documented the code 'NJ E on the MAR which indicated that you had to see the nurses' notes as to why NJ Exec Orc was not received. The US FOIA and the surveyor reviewed the Nursing Progress Notes, and the US FOIA confirmed there was no documentation regarding why the resident did not receive the NJ Exec Orde The US FOIA did not have an explanation as to why she did not administer the NJ Exec Order 26.4b1. On 4/10/25 at 10:46 AM, the surveyor interviewed the US FOIA (b)(6)), who explained the process of NJ Exec Orc administration with a sliding scale. The US FOIA (b)(6) stated that the nurse took the resident's NJ Exe read result, and administer the NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that the nurse was expected to document in the MAR, a signature from the nurse, the NJ Ex and the amount of NJ Exec Orc the resident received. The US FOIA (b)(6) stated that if the resident did not receive the NJ Exec Orde the nurse was responsible to document in the progress notes the reason why the resident did not receive the NJ Exec Orde The US FOIA (b)(6) reviewed the MAR in the presence of the surveyor, and had no explanation as to why on NJ Exec Order 26.4b1, the resident did not received NJ Exec Orc when the NJ Exec Order 26.4b1 obtained required NJ Exec Orc administration. On 4/10/25 at 10:59 AM, the surveyor interviewed the US FOIA (b)(6) who both agreed that if the physician ordered the resident to be on NJ Exec Orc with a NJ Exec Order 26.4b1, and the resident's NJ Exec Order 26.4b1, the nurse was required to document in the progress notes why the NJ Exec Orc was not administered. The US FOIA (b)(6) both stated that they would review Resident #40's MAR, and would get back to the surveyor with additional information. On 4/11/25 at 10:14 AM, the surveyor interviewed the US FOIA (b)(6) who stated that on the NJ Exec Order 2 the US FOIA (b)(6) to print out paper	F0760		

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F0760 SS = E	Continued from page 13 MARs to be utilized on NJ Exec Order because the facility would not have access to the electronic medical record on that day. The US FOIA (b)(provided the surveyor with a written MAR dated NJ Exec Order which also contained discrepancies in NJ Exec Ord administration and documentation as followed: The MAR indicated that on NJ Exec Orde at 11:30 AM, the resident's NJ Exec Order 26.4b1. There was no documentation that the resident was administered 'NJ E NJ Exec Order 26.4b1 per the physician ordered NJ Exec Ord NJ Exec Order 26.4b1 4:30 PM, the MAR indicated that the resident's NJ Exec Order 26.4b1. There was no documentation that the resident was administered 'NJ E NJ Exec Order 26.4b1 per the physician ordered NJ Exec Ord On 4/11/25 at 11:26 AM, the surveyor interviewed the resident's US FOIA (b)(6)), who stated that everything should be documented. The US FOIA stated that the nurses should be documenting why NJ Exec Ord was not administered, and he should be notified if NJ Exec Ord was not given. the US FOIA stated the nurse should also document if the resident refused the NJ Exec Orde A review of Resident #40's Progress Notes reflected that there were NJ Exec Order 26.4b1 documented. The surveyor reviewed Resident #40's individualized comprehensive care plan (ICCP) which included a focus area dated NJ Exec Order 26.4b1 the resident's diagnoses of NJ Exec Interventions included the following: 'NJ Exec Order 26 medication as ordered by doctor. Monitor/document for side effects and effectiveness." A review of the facility's "High Risk Medications" policy dated 10/2024, included that the facility recognizes that some medications are associated with greater risk of adverse consequences and these medications can include anti-diabetics...the facility would obtain and document specific parameters for administration or withholding certain high-risk medications (e.g., insulin, anticoagulants, certain cardiac medications) as per physician's orders...	F0760		

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F0760 SS = E	Continued from page 14 A review of the facility's "Administration of insulin" policy dated 10/2024, included all insulin would be administered in accordance with physician orders... NJAC 8:39-29.2(d)	F0760		
F0880 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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	The identified [US FOIA] was immediately removed from the assignment and re-in serviced by the Infection Control Preventionist on the different types of Transmission Base Category, to include contact, Droplet and airborne isolation. The [US FOIA (b)(] was also re-educated through a competency on Handwashing, donning/Doffing PPE and the appropriate Personal Protective Equipment (PPE) for different categories of isolation with return demonstration per facility policy and procedure and the CDC guideline. Resident # 90 medical records were reviewed by the DON for the deficient practice; the resident did not have any [NJ Exec Order 26.4b1] from the deficient practice. All residents residing in the facility are potentially at risk for the deficient practice. This can be identified by reviewing the residents medical records. On 5/6/25 The Infection Control Preventionist began re-education program for all personnel on the facilitys policy on handwashing, donning/doffing PPE, Appropriate PPE for different categories of isolation IE (Contact, Droplet and Airborne isolation). Upon hiring at the facility, staff will receive education on Transmission Base Precaution, Donning and Doffing and competencies on handwashing per the facility policy and the CDC guidelines Infection Control Preventionist or designee will perform random audits of 10 staff members weekly on handwashing, donning/doffing PPE, and appropriate PPE for the different categories of transmission-based precautions i.e. (Contact, Droplet and Airborne isolation precautions) with return demonstration and competent test to ensure compliance for 3 months, then on-going as needed to ensure compliance with facility guidelines. Any findings from the audit will be addressed immediately and the results from the audit will be reviewed by the QAPI and Quality Assurance (QA) Committee monthly for one quarter. The QA committee will determine if further actions are needed and necessary adjustment to the corrective action.	05/30/2025

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F0880 SS = D	Continued from page 15 (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 observations, interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to use appropriate infection control practices to prevent the spread or reduce the risk of infection by ensuring proper use of personal protective equipment (PPE) for a resident on NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 1 resident reviewed for NJ Exec Order 26.4b1) (Resident #90), and was evidenced by the following: On 4/9/25 at 10:45 AM, during initial tour, the surveyor observed signage on Resident #90's door which indicated that the resident was on NJ Exec specifically, NJ Exec Order 26.4b1 ns. The signage specified that gloves and an NJ Exec Order 2 gown were to be applied prior to entering the resident's room. The surveyor observed two	F0880		

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F0880 SS = D	Continued from page 16 bins inside of the resident's door; one used for trash and the other used for laundry. The resident was lying in bed and was NJ Exec Order 26.4b1 secondary to NJ Exec Order 26.4b1. The surveyor reviewed the medical record for Resident #90. A review of the Admission Record face sheet (an admission summary) indicated that Resident #90 was admitted to the facility with the diagnoses which included but were not limited to; NJ Exec Order 26.4b1 . A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, reflected that Resident #90 was NJ Exec Order 26.4b1 with activities of daily living (ADLs) and had NJ Exec Order 26.4b1 . A review of the physician's order (PO) dated NJ Exec Order indicated that the resident was on NJ Exec Order 26.4b1 every shift for 14 days. A review of the individualized comprehensive care plan (ICCP) dated NJ Exec Ord, reflected Resident #90 had NJ Exec Order 26.4b1 . The interventions dated NJ Exec Order included NJ Exec Order 26.4b1 : wear gowns and masks when changing contaminated linens; place soiled linens in bags marked biohazard; bag linens and close bag tightly before taking to laundry, instruct family/visitors/caregivers to wear disposable gown and gloves during NJ Exec Order 26.4b1 with resident, and discard in appropriate receptacle and wash hands before leaving room and instruct visitors to wear disposable gloves and gown when in residents room and to wash hands before leaving room. On 4/10/25 at 12:57 PM, the surveyor observed a staff member sitting at the resident's bedside assisting the resident with their lunch meal. The staff member was observed wearing only a mask, no gloves or an NJ Exec Order 2 gown were worn. The surveyor observed the staff member touched the trash and linen bins inside the resident's room without gloves. The staff member was then observed performing hand hygiene with alcohol-based hand rub	F0880		

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F0880 SS = D	Continued from page 17 (ABHR) after leaving the resident's room. On 4/10/25 at 12:59 PM, the surveyor interviewed the staff member after she had exited the resident's room and she identified herself as a US FOIA (b)(6) The US FOIA admitted that she was not wearing an isolation gown or gloves while in Resident #90's room because she was NJ Exec Order 26.4b1 resident. The US FOIA stated that she did not have to wear a gown or gloves because she was not providing NJ Exec O resident care. The surveyor showed the US FOIA the signage that was posted on the resident's door that specified that an NJ Exec Order 2 gown and gloves had to be applied prior to entering to the room and before exiting the resident's room. The US FOIA admitted that she did not read the NJ Exec Order 2 signs before entering Resident #90's room. On 4/10/25 at 1:06 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the US FOIA should have donned (put on) a gown and gloves prior to going into the resident's room to assist the resident with their lunch meal. The US FOIA (b)(6) stated that the resident had NJ Exec Order 26.4b1, and she would re-educate the staff regarding NJ Exec and the importance of reading the signage outside of the resident's room and adhering to what the signage indicated. On 4/11/25 at 10:00 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that when a resident was on NJ Exec specific to NJ Exec Order 26.4b1, signs were posted on the resident's door that indicated that the resident was on NJ Exec Order 26.4b1 and specified what type of PPE was required. The US explained that NJ Exec Order 26.4b1 required staff, family, and visitors to don a gown and gloves before entering the resident's room and doff (remove) when exiting the room. The US stated that PPE was important to wear when a resident was of NJ Exec to prevent the NJ Exec Order 26.4b1. A review of the facility's policy "Isolation-Categories of Transmission-Based Precautions" policy dated 10/2024, included contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the residents' environment...staff and visitors would be required to wear gloves and disposable gown upon	F0880		

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F0880 SS = D	Continued from page 18 entering the room... NJAC 8:39-19.4(a); 27.1(a)	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2025

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S0000	Initial Comments No Information	S0000		
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint # NJ174825, NJ175447 Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for staffing for 5 of 35 days shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall	S0560	All residents medical records were reviewed for the deficient practice, no residents were affected by the deficient practice. Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. All residents have the potential to be at risk for deficient practice. The facility Administrator has put in place a bonus structure to help increase the levels of staffing according to census. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. In addition, the director of nursing or designee will meet daily with the staffing coordinator to ensure appropriate staffing. The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI Committee quarterly for 6 months or until compliance is met.	05/30/2025

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

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S0560	Continued from page 1 perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 7/7/24 to 7/13/24, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -7/7/24 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. 2. For the week of Complaint staffing from 9/8/24 to 9/14/24, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -9/8/24 had 12 CNAs for 120 residents on the day shift, required at least 15 CNAs. -9/10/24 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. 3. For the week of Complaint staffing from 1/26/25 to 2/1/25, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -1/26/25 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. 4. For the two weeks of staffing prior to survey from 3/23/25 to 4/5/25, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -3/23/25 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. On 4/16/25 at 9:19 AM, the surveyor interviewed the facility Staffing Coordinator (SC) regarding staffing guidelines. The SC was able to verbalize the regulations for Certified Nursing Assistant staffing to	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2025

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S0560	Continued from page 2 the surveyor. The surveyor asked the SC if she felt the regulations were being met, and the SC told the surveyor, "We meet the numbers, except for night shift." The SC stated the facility was not using agency staffing.	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315104	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 04/16/2025

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health. Health Facility Survey and Field Operations on 04/15/2025 and 04/16/2025. Cornell Hall Care and Rehab was found to be in NON-COMPLIANCE with the requirements for participation in Medicare/ Medicaid at 42 CFR 483,90 (a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA). Chapter 19 EXISTING Health Care Occupancy. The facility is a 1-story building that was built in the 60's. It is composed of Type II protected construction. The facility is divided into 6- smoke zones. The generator operates on natural gas and supplies power to approximately 40% of the facility. The building: 55,715 sq. ft. single story, wood truss roof, concrete slab floor and two (2) basements.	K0000		
K0211 SS = F	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. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 04/15/2025 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that A) doors in the means of egress swing in the direction of egress and B) where a pair of door leaves were required in a means of egress, each leaf of the pair was provided with a releasing device that does not depend	K0211	1. The Swing door in the courtyard was reversed. The door now swings in direction of the egress. Additionally, the maintenance director moved the signage to the correct door, which opens independently. Delayed egress is currently working. 2. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. 3. The door was fixed ti open in the direction of the egress The Administrator audited all doors with delayed egress with the Maintenance Director to ensure compliance. 4. The Maintenance Director will audit all doors in the facility, every month, for 6 months and bring the results to the 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315104	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 04/16/2025

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K0211 SS = F	Continued from page 1 on the release of one leaf before the other in accordance with NFPA 101:2012 Edition, Section 7.2.1.2.3.2, 7.2.1.4.2 and 7.2.1.5.11. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:59 AM revealed that the exit gate in the patio near the library did not swing in the direction of egress travel. When attempting to open the gate in the direction of egress, there was only a clear width of 16-inches. An observation at 12:07 PM revealed that the Kean unit exit contained a pair of door leaves. The door on the right was provided with a sign indicating that the door was equipped with a delayed egress locking arrangement. The delayed egress feature did not function when tested by the US FOI Additionally, release of the door on the right was dependent on release of the door on the left beforehand. In an interview at the time, the US FOI confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0211		
K0222 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 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	K0222	1. The exit door to the patio area near the library was affixed with a sign that says Push until alarm sounds door can be opened in 15 seconds The Delayed egress on the exit door in the dining room was fixed and tested and is currently working properly The Emergency lighting was installed in the employee lounge exit. The MD Removed the padlock on NJ Exec Order 26 4(low side. 2. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice.	05/30/2025

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K0222 SS = F	Continued from page 2 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. 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 STANDARD is NOT MET as evidenced by: Based on observations and interview on 04/15/2025 in the presence of the US FOIA (b)(6)), it was	K0222	Continued from page 2 3. The Administrator audited all doors with delayed egress, emergency lighting, and unit doors with the Maintenance Director to ensure compliance. 4. The Maintenance Director will audit all doors in the facility monthly for 6 months and bring the results to 2 quarterly Quality Assurance and Performance Improvement meetings.	

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K0222 SS = F	Continued from page 3 determined that the facility failed to ensure that doors in a required means of egress A) were not equipped with a latch or lock, and B) doors provided with delayed egress locking arrangements were installed and properly functioning in accordance with NFPA 101:2012 Edition, Sections 7.2.1.6.1 and 19.2.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:54 AM revealed that the exit door to the patio area near the library was equipped with a delayed egress locking arrangement. The door was not provided with a sign that read "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". An observation at 11:21 AM revealed that the NJ Exec Order 26.4 low-side fire/smoke barrier doors were equipped with an exit sign. However, a combination padlock affixed to the doors obstructed access to the designated exit, as identified in the evacuation plan located at the end of the hallway. An observation at 11:30 AM revealed that the designated exit door in the employee lounge was equipped with a delayed egress locking arrangement. The door was not provided with emergency lighting. An observation at 11:33 AM revealed that the main dining room exit door near the kitchen was equipped with a delayed egress locking arrangement. The delayed egress feature did not function when tested by the US FOI In interviews at the times, the US FO confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0222		
K0223 SS = F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices	K0223	All supplies and combustible items were removed from the kean unit low side . The swing door latch to laundry room was fixed and latches correctly now	05/30/2025

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K0223 SS = F	Continued from page 4 Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 04/15/2025 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that hazardous areas were separated from other spaces by smoke resisting partitions and doors in accordance with NFPA 101:2012 Edition, Section 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:50 PM revealed that the Kean unit low side contained 18 rooms that were being used for storage of combustible items. Ten of the 18 room doors were observed to be open with combustible items being stored inside. The doors to these rooms were not self-closing or automatic closing. Two of the 18 rooms were observed to have doors that were self-closing or automatic closing but were being blocked open by storage items. An observation at 1:22 PM revealed that the laundry room door from the corridor did not positive latch when tested by the US FOI An observation at 1:23 PM revealed that the swinging pair of exit doors from the laundry room did not positive latch when tested by the US FOI An observation at 1:27 PM revealed that the soiled	K0223	Continued from page 4 The soiled linen washing machine room door latch was fixed and latches correctly now 2. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. 3. The Administrator and Maintenance Director corrected the defficient practice and will check all swing doors and rooms with combustible items, annually to ensure compliance. 4. The Maintenance Director will audit all swing doors are latching, monthly for 6 months, and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	

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K0223 SS = F	Continued from page 5 linen washing machine room door did not positive latch when tested by the US FOI In interviews at the time, the US FO confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0223		
K0225 SS = F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 04/15/2025 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that stairways and smokeproof enclosures used as exits were in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3,19.2.2.4 and 7.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:21 PM revealed that the basement stairway enclosure door near the boiler room did not positive latch when tested by the US FOI In an observation at the time, the US FO confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0225	1.the Basement boiler room door latch was repaired. 2. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. 3. The Broken door latch was repaired and The Administrator and Maintenance Director will check all doors with latches annually to ensure compliance. 4. The Maintenance Director will audit all swing doors are latching monthly for 6 months and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025
K0281 SS = F	Illumination of Means of Egress	K0281	Proper emergency lighting was installed for the	05/30/2025

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K0281 SS = F	Continued from page 6 CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 04/15/2025 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that illumination of the means of egress was provided at exits, exit doors and exit discharges in accordance with NFPA 101:2012 Edition, Sections 7.8 and 19.2.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 04/15/2025 revealed that emergency lighting that was not continuously in operation or capable of automatic operation without manual intervention. The following areas contained emergency lighting that was controlled by a switch on the wall that when in the "OFF" position would not provide illumination in an emergency: Caldwell Unit exit access corridor near room 28, Kean Unit exit access corridors: High and Low side, Employee lounge exit access, Kitchen service hallway exit access and walk in fridge area exit access. An Observation at 11:25 AM revealed that the employee lounge exit discharge was provided with only a single bulb light fixture. An observation at 1:28 PM revealed that exit discharge from the kitchen walk-in fridge area was not provided with emergency lighting. An observation at 1:29 PM revealed that exit discharge area from the boiler room was not provided with emergency lighting.	K0281	Continued from page 6 following locations: Exit door outside room 28, Kean exit door, employee lounge exit, kitchen exit access, walk-in fridge room exit. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. The US FOIA (b)(6) was in-serviced to check all exit doors emergency lighting annually to ensure compliance. 4. The Maintenance Director will audit all exit emergency lighting monthly for 6 months and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	

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K0281 SS = F	Continued from page 7 Continuity of egress lighting can be accomplished by means such as use of duplicate light bulbs in a fixture or overlapping light patterns from neighboring fixtures. In interviews at the time, the [redacted] confirmed the observations. The facility's [redacted] was informed of the deficient practices at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0281		
K0291 SS = F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 04/15/2025 and 04/16/2025 in the presence of the [redacted]), it was determined that the facility failed to ensure that periodic functional testing of emergency lighting equipment was conducted in accordance with NFPA 101:2012 Edition sections 19.2.9.1 and 7.9.3. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 04/16/2025 revealed that documentation of periodic functional testing of battery powered emergency lighting could not found in the documentation that was provided for review. In an interview at the time, the [redacted] confirmed the findings and stated that periodic functional testing was not conducted on the battery powered emergency lighting. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit	K0291	The Maintenance Director performed the annual battery powered emergency lighting test. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. The [redacted] was in-serviced on NFPA 101 to ensure that he will perform battery powered emergency lighting tests annually and provide documentation to ensure compliance. The Maintenance Director will audit all exit emergency lighting test documentation monthly for 6 months and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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K0291 SS = F	Continued from page 8 conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0291		
K0345 SS = F	Fire Alarm System - Testing and Maintenance 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 STANDARD is NOT MET as evidenced by: Based on record review and interview on 04/16/2025 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that Inspection, Testing and Maintenance (ITM) of the fire alarm panel was in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 04/16/2025 revealed that the annual and semi-annual fire alarm report did not indicate that ITM of the electro-mechanical door releasing devices was conducted. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the observation. The RA stated that they spoke with the fire alarm vendor and was told that they would add electro-mechanical door releasing devices to the reports going forward. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0345	The inspection on the electro-mechanical door releasing devices was completed and the Vendor corrected his reporting and sent the report to the facility. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. The Administrator and Maintenance Director will ensure all testing documentation is provided by our vendors in a timely manner to ensure compliance. The Maintenance Director will audit testing documentation monthly for 6 months and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET , UNION, New Jersey, 07083

(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
K0345 SS = F	Continued from page 9 NFPA 70, 72	K0345		
K0351 SS = F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observations and interview on 04/15/2025 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that the fire sprinkler system was installed and maintained in accordance with NFPA 101:2012 Edition, Sections 19.3.5.1, 9.7 and NFPA 13:2010 Edition, Sections 6.2.7 -6.2.7.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:12 PM revealed that 2 of 7 concealed sprinkler heads in the rehab gym were not provided with a cover. In an interview at the time, the US FO confirmed the observations. The facility's US FOIA (b)(6) was informed of the	K0351	The Sprinkler Company came to install sprinkler covers in the rehab gym. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. The Administrator and Maintenance Director will ensure all sprinklers are equipped with covers to ensure compliance with NFPA13 The Maintenance Director will audit each units sprinkler cover per month for 6 months and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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K0351 SS = F	Continued from page 10 deficient practice at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 13	K0351		
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 04/16/2025 in the presence of the US FOIA (b)(6) was determined that the facility failed to ensure that Inspection, Testing and Maintenance (ITM) of the fire sprinkler system was in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed that documentation regarding the last 5-year internal obstruction investigation could not be found in the documentation that was provided for review.	K0353	The sprinkler company was called and came to do The 5 year internal Obstruction test The sprinkler company came to do the testing of the sprinklers that have been in service for 50 years No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. The US FOIA (b)(6) was in-serviced on regarding all the sprinkler testing for NFPA 25 and will schedule the tests to be done by the vendor in a timely manner and to provide documentation to ensure compliance. 4. The Maintenance Director will audit all yearly, 5 year and 50 year testing, monthly for 6 months, and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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K0353 SS = F	Continued from page 11 In an interview at the time, the US FOIA (b)(6) confirmed the finding. A record review revealed that the facility was constructed in 1969 (56 years ago). Documentation regarding the testing and or replacement of sprinklers that have been in service for 50 years could not found in the documentation that was provided for review. In an interview at the time, the [redacted] confirmed the finding and stated that testing was not conducted but they would get in contact with the fire sprinkler vendor to schedule it. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 13, 25	K0353		
K0363 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	K0363	The Latcheson the doors were fixed on the Livingston dayroom, Library, Kean dining room doors they now have the means to keep the door closed when a force of 5 ponds is applied No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. The US FOIA (b)(6) was in -serviced on the proper for procedures for all swinging doors and will ensure all swing doors in the facility latch properly by routine audits on each unit to ensure compliance. . The Maintenance Director will audit one units swing doors each month for 6 months and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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K0363 SS = F	Continued from page 12 of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 04/15/2025 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that doors in the corridor were capable of being closed and maintained closed against the force of 5 lb applied at the latch edge of the door in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.2 and 19.3.6.3.5. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:16 AM revealed that the NJ Exec Order 26.4 day room contained a pair of swinging doors to the corridor. The doors were not provided with a means to keep the door closed when a force of 5 lbs. was applied at the latch edge of the door. An observation at 11:25 AM revealed that the library contained a pair of swinging doors to the corridor. The doors were not provided with a means to keep the door closed when a force of 5 lbs. was applied at the latch edge of the door. An observation at 11:57 revealed that the Kean unit dining room contained a pair of swinging doors to the corridor. The doors were not provided with a means to keep the door closed when a force of 5 lbs. was applied at the latch edge of the door. In interviews at the time, the US FO confirmed the observations.	K0363		

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K0363 SS = F	Continued from page 13 The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0363		
K0372 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 STANDARD is NOT MET as evidenced by: Based on observations and interview on 04/15/2025 and 04/16/2025 in the presence of the US FOIA (b)(6) , it was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of fire/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 04/15/2025 at 10:18 AM revealed that the fire/smoke barrier wall on Caldwell Unit low side contained an unprotected 2-inch by 8-foot penetration directly above the fire/smoke barrier doors. Additionally, non-listed yellow spray foam was being used to seal current penetrations. In an interview at the time, the US FO confirmed the observations.	K0372	The penetration in the ceiling above Caldwell door was sealed. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. The US FOIA (b)(6) was in - serviced on NFPA 101 and to ensure that All smoke doors are checked and sealed to ensure compliance. The Maintenance Director will audit each units ceiling above the smoke doors for penetration monthly for 6 months and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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K0372 SS = F	Continued from page 14 The facility's Administrator was informed of the deficient practices at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0372		
K0761 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 STANDARD is NOT MET as evidenced by: Based on record review, observations and interview on 04/15/2025 and 04/16/2025 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that fire door assemblies were Inspected, Tested and Maintained (ITM) annually in accordance with NFPA 80 Standard for Fire Door and Other Opening Protectives. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 04/15/2025 revealed that the stairway enclosures to and from the basements were equipped with fire door assemblies. A record review on 04/16/2025 revealed that annual fire door assemblies ITM could not be found in the	K0761	All fire doors assemblies were inspected, tested in the building and documented. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. Facility-wide inspection was conducted to ensure compliance and the US FOIA (b)(6) was in -serviced to make sure that all testig and inspection are done in accordance with NFPA 80 The Maintenance Director will audit the inspection documentation monthly for 6 months and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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K0761 SS = F	Continued from page 15 documentation that was provided for review. In an interview at the time, the US FOI confirmed the observation and stated the annual fire door inspections in accordance with NFPA 80 were not conducted. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0761		
K0914 SS = F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review, observations and interviews on 04/15/2025 and 04/16/2025 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure non-hospital grade outlets in patient care rooms were tested annually in accordance with NFPA 99: 2012 Edition, Section 6.3.3, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0914	A Facility wide Electrical outlet testing was completed and documented on all non hospital grade outlets No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. Facility-wide testing was done and the Maintenace director was in serviced on NFPA 99 andtesting will be done quarterly to ensure compliance. The Maintenance Director will audit the inspection documentation every 3 months and bring results to 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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K0914 SS = F	Continued from page 16 Observations on 04/15/25 between 10:18 AM and 12:05 PM revealed the resident rooms were provided with non-hospital grade outlets. A record review on 04/16/2025 revealed there was no inspection and testing reports including: physical integrity, continuity, polarity and blade tension for non-hospital grade outlets in patient care rooms in the last 12 months. In an interview at the time, the [redacted] confirmed the observations and record review. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C. 8:39-31.2(e) NFPA 99	K0914		
K0921 SS = F Bldg. 01	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	K0921	1. Electrical equipment testing was conducted in the room 42 on the concentrator, the air mattress pump, and patient beds. 2. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. The Electrical equipment was tested and inspected and the [redacted] was in serviced on the policy and procedure to to be in compliance with NFPA 101 The Maintenace director wiill audit the electrical devices every 3 months for 6 months and bring the results to 2 quartely Quality Assurance Performance improvment meetings.	05/30/2025

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K0921 SS = F Bldg. 01	Continued from page 17 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. 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 STANDARD is NOT MET as evidenced by: Based on record review, observations and interviews on 04/16/2025 in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that Patient Care Related Electrical Equipment (PCREE) was inspected, tested and maintained (ITM) 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 residents and was evidenced by the following: An observation at 1:04 PM revealed that room 42 contained an oxygen concentrator with an inspection sticker dated 01-23-23. Additionally, inspection stickers for the electrically powered air mattress pump and 2 electrically powered patient beds could not be located. An observation at 1:20 PM revealed that 2 of 2 Automated External Defibrillators (AED's) in the corridor did not have an inspection sticker or tag. In an interview at the time, US FO confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K0921		

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E0000	Initial Comments This facility was found to be in NON-COMPLIANCE with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities	E0000		
E0015 SS = F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):]	E0015	1. a Policy and Procedure was implemented to ensure that safe temperatures will be maintained in the facility during a power outage by renting a commercial poratble air conditioning unit. If one isnt available, the facilities evacuation plan will be implemented. This was put into the Emergency Preparedness Plan. 2. No residents were affected by this deficient practice. All residents are at risk of being affected by this deficient practice. 3. Policy and Procedure implemented to ensure safe temperatures will be maintained in the facility during a power outage by renting a commercial air conditioning unit. If one isnt available, the facilities evacuation plan will be implemented. This was put into the Emergency Preparedness Plan.The Administrator and Maintenace director will review the Emergency Preparedness plan to ensure all that theres a alternate plan to maintain safe temtures 4. Maintenance Director will audit policy and procedure on a Quarterly basis for 6 months and bring the results to the 2 quarterly Quality Assurance and Performance Improvement meetings.	05/30/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	**234 CHESTNUT STREET , UNION, New Jersey, 07083**

(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
E0015 SS = F	Continued from page 1 Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is NOT MET as evidenced by: Based on record review and interview on 04/16/2025 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that the Emergency Preparedness Plan (EPP) contained policies and procedures regarding an alternate source of energy to maintain temperatures to protect patient health and safety. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 04/16/2025 revealed neither the facility's Heating, Ventilation and Cooling system (HVAC), nor resident room Packaged Terminal Air Conditioner (PTAC) units were connected to the emergency generator. In an interview at the time, the US FOI confirmed the record review and stated that in a power outage emergency, the HVAC system and PTAC units are not hooked up to the generator and will not operate. The EPP did not include a policy or procedure outlining either: A) an alternative energy source to ensure safe temperatures are maintained, or B) steps to be taken if	E0015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2025

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E0015 SS = F	Continued from page 2 safe temperatures could not be maintained. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 04/16/2025 at 2:00 PM. N.J.A.C. 8:39-31.2(e)	E0015		