STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE CRANFORD, NJ 07016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ178726 Census: 171 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Complaint #: NJ178726 Based on observation, interview, and review of other facility documentation, it was determined	F 812	The frying pan was re-sanitized per manufacturers guidelines. All residents could have been affected by this deficient practice.	12/6/24

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

Electronically Signed | 12/16/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE CRANFORD, NJ 07016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 1 that the facility failed to sanitize and ensure that the frying pan was cleaned to prevent microbial growth. This deficient practice was evidenced by the following: On 11/14/24 at 11:36 a.m. the surveyor, who was accompanied by the NJ Exec Order 26.4b1 [redacted], observed in the kitchen, Dietary Aide (DA #2) washed a frying pan, rinsed, and then dipped the frying pan in the sanitizer for less than 3 seconds and removed and placed the frying pan on the side of the sink to drain. During an interview with the U.S. FOIA (b)(6) [redacted] he stated that the sanitizing step should not be missed because it was the most important step, and it killed the bacteria and the germs. During an interview with DA #2 at 11:48 a.m., he stated that the frying pan should be sanitized for 20 seconds and that he did it for less than 20 seconds. DA #2 further stated it was important to disinfect the frying pan so that it does not have any germs, and that if there were germs, it was not good for serving food. During an interview with the [redacted] at 11:53 a.m., who also observed DS #2 washed the frying pan, he stated that the staff did not let the frying pan sit for the full 20 seconds. [redacted] stated that staff should have let the frying pan sat for a full 20 seconds and then pull the frying pan out to let it air dry. [redacted] further stated that it was important for staff to dip the frying pan in the sanitizer for 20 seconds to kill any bacteria or germs to prevent infecting residents.	F 812	Dietary staff were in-serviced by the IP on sanitizing pots and pans per manufacturer's guidelines, which for SMARTPOWER Sanitizer is for not less than one minute, in order to prevent microbial growth. Audits will be conducted by the FSD or designee daily for 4 weeks, then weekly for 2 months to ensure staff are sanitizing pots and pans per manufacturer's guidelines. Findings will be reviewed by the Administrator during monthly QAPI committee meeting x3 months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE CRANFORD, NJ 07016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 2 During an interview with Dietary supervisor (DS #1) at 12:08 p.m., he stated that staff should not have dipped the frying pan in the sanitizer taken it out immediately. DS #1 stated that staff should have held or placed the frying pan for at least 20 seconds in the sanitizer to make sure the frying pan was free of germ and bacteria. DS #1 further stated that the sanitizer killed the germs, and that germs could spread and cause sickness to the residents and employees who must consume the food. During an interview with the [redacted]., she stated that if the sanitizing process was not followed as directed by not sanitizing for the length of time, the item was still dirty, could attract pest, was unsanitary, and not fit for cooking in, which could result in people potentially getting sick. Review of undated policy titled "Cleaning Dishes - Manual Dishwashing" that dishes should be placed in the sanitizing sink and allow to stand according to the manufacturer's guidelines for sanitizer. Review of the Ecolab Smartpower Sanitizer Instruction revealed, "EPA-registered sanitizer for pre-cleaned use on hard, non-porous food prep surfaces and ware, kills food borne organisms as listed on product label." Review of the Ecolab Smartpower Sanitizer instructions revealed, "Apply SMARTPOWER Sanitizer at proper solution. Expose all surfaces of equipment, ware or utensils to the sanitizing solution for a period of not less than one minute. Air dry."	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE CRANFORD, NJ 07016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 3 NJAC 8:39 - 17.2 (g)	F 812		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315091 Y1	A. Building B. Wing Y2	12/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE CRANFORD, NJ 07016

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 12/06/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			