STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315106	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

(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 #s: NJ171411, NJ175879 Survey Dates: 09/15/2024 through 09/19/2024 Census: 86 Sample Size: 18 + 2 closed records A Recertification survey was conducted to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facility. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to provide a safe medical equipment (wheelchair with NJ Ex Order 26.4(b)(1)) which would provide NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 to NJ Ex Order 26.4(b)(1) of a resident. This deficient practice was observed for one (1) of eighteen (18) residents (Resident #23) reviewed for NJ Ex Order 26.4(b)(1). This deficient practice was evidenced by the	F 558	F558: Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) I. Element 1 Immediate Action NJ Ex Order 26.4 was immediately placed on Resident #23's wheelchair upon noting of the issue. Area cleaned and NJ Ex Order 26.4(b)(1) placed on NJ Ex Order 26.4(b)(1). II. Element 2 Identification of Others All Residents have potential to be affected	10/25/24

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

Electronically Signed | 10/10/2024

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
	315106	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

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F 558	Continued From page 1 following: On 9/15/24 at 11:38 AM, during initial tour, the surveyor observed Resident #23 who was seated in a [redacted] wheelchair in the dayroom. The surveyor further observed the [redacted] of the resident's [redacted] wheelchair had [redacted] On 9/16/24 at 9:35 AM, the surveyor observed Resident #23 in the day room. The resident was groomed and dressed and was seated in their [redacted] wheelchair which had [redacted] on the [redacted]. A review of Resident #23's Admission Record revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: [redacted] A review of Resident #23's Quarterly Minimum Data Set (MDS) an assessment tool revealed the resident had a Brief Interview for Mental Status score of [redacted] out of 15, which indicated that the resident had [redacted]. On 9/16/24 at 9:40 AM, the surveyor in the	F 558	by a missing armrest cushion. III. Element 3 Systematic Changes An in-service was held by the Director of Nursing regarding the importance of checking all cushions and equipment that is assigned to resident, that they are in place and working condition. If they need to be fixed to notify maintenance dept immediately. IV. Element 4 Quality Assurance Director of Nursing or Designee will monitor 10 randomly selected resident cushions are in place and in working condition. 3 times a week for 4 weeks, and then 1 time weekly for 2 months from 10/10/2024 until 1/10/25. All findings will be reported and discussed by the next QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315106	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

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F 558	Continued From page 2 presence of a U.S. FOIA (b) (6)) observed Resident #23 in their NJ Ex Order 26.4b1 wheelchair. The U.S. FO acknowledged that the resident was missing their NJ Ex Order 26.4b1 on the NJ Ex Order 26.4b of the wheelchair. The U.S. FO stated that there must be NJ Ex Order 26.4(b)(1) of the resident's wheelchair. The U.S. FO further stated that the NJ Ex Order 26.4(b)(1) needed to be fixed. On 9/16/24 at 9:45 AM, the surveyor interviewed the resident's U.S. FOIA (b) (6)) who acknowledged that the resident had no NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b) of their wheelchair. The U.S. FOIA stated that the resident should have an NJ Ex Order 26.4b1 on both armrests. The U.S. FOIA further stated that the NJ Ex Order 26.4(for the wheelchair was inside the resident's room. On 9/16/24 at 9:50 AM, the surveyor observed the U.S. FO retrieved the NJ Ex Order 26.4(b)(1) from the resident's room and was observed snapping the NJ Ex Order 26.4 on the resident's wheelchair NJ Ex Order 26.4(b)(1). The U.S. FO stated that she will contact the maintenance department to fix the resident's wheelchair. On 9/17/24 at 1:00 PM, the surveyor presented the above concerns to the facility administrative team which included the U.S. FOIA (b) (6)), U.S. FOIA (b) (6), U.S. FOIA (b) (6)). No further information was provided. A review of the facility policy, "Medical Equipment Management Plan" (Created 08/31/24) and was provided by the U.S. FOIA revealed the following: "3 Maintains equipment operational plans to help assure reliability."	F 558		

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	315106	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

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F 558	Continued From page 3 "4. Develops procedures that establish intervals for the testing and maintenance of the equipment." " 7. When problems are identified, actions are taken to resolve them." NJAC 8:39-27.1(a), 31.4(a),4.1(a)(12)	F 558		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 761	F761: Label/Store Drugs and Biologicals	10/25/24

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F 761	Continued From page 4 review, it was determined that the facility failed (a). remove and dispose a discontinued medication NJ Ex Order 26.4(b)(1)) from the active inventory, this was identified for one (1) of four (4) residents, (Resident #85) observed during medication administration and (b). properly label, store, and dispose medications in two (2) of four (4) medication carts inspected. This deficient practice was evidenced by the following: a). On 9/17/24 at 9:05 AM, during morning medication pass observation, the surveyor observed a Licensed Practical Nurse (LPN# 1) preparing medications for Resident #85. LPN #1 opened the medication cart and pulled out a bingo card (a bubble pack which contained one dose of medication commonly used in long term care facilities) which contained NJ Ex Order 26.4(b)(1) [redacted]. The surveyor observed LPN #1 checked the resident's electronic medication administration record. LPN #1 stated that the resident was on NJ Ex Order 26.4(b)(1). She then investigated the medication cart and found another bingo card for NJ Ex Order 26.4(b)(1) [redacted]. LPN#1 stated that the NJ Ex Order 26.4(b)(1) was for the evening dose. On 9/17/24 at 9:30 AM, during medication pass reconciliation the surveyor reviewed Resident #85's physician's orders (PO) which revealed that the resident's PO for NJ Ex Order 26.4(b)(1) were discontinued on NJ Ex Order 26.4 [redacted]. The surveyor reviewed the medication record for Resident #85. A review of the resident's Admission record	F 761	CFR(s): 483.45(g)(h)(1)(2) I. Element 1 Immediate Action The discontinued medication for Resident #85, NJ Ex Order 26.4(b) [redacted], NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) upon finding of the issue where immediately discarded and destroyed. II. Element 2 Identification of Others All residents have potential to be affected by discontinued medication, non-refrigerated PPD, non-refrigerated unopened insulin pen and expired eye drops. III. Element 3 Systematic Changes An in-service was held by the Director of Nursing to the entire nursing dept, regarding proper medication storage/destruction. The policy was reinstated, and staff was re-educated. IV. Element 4 Quality Assurance Director of Nursing or Designee will monitor all medication carts 3 times weekly for 4 weeks followed by weekly for 2 months 10/10/2024 until 1/10/25. All findings will be reported and discussed by the next QA meeting	

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F 761	Continued From page 5	F 761		

revealed the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1) [redacted].

A review of the Admission MDS dated NJ Ex Order 26.4(b)(1) reflected the resident had a Brief Interview for Mental Status score of NJ Ex [redacted] out of 15, indicating that the resident was NJ Ex Order 26.4(b)(1).

A review of the September 2024 Order Summary Report (OSR) revealed a PO dated NJ Ex Order 26.4 [redacted] for NJ Ex Order 26.4(b)(1), give 1 tablet by mouth two times a day for NJ Ex Order 26.4(b)(1) [redacted] The NJ Ex Order 26.4(b)(1) [redacted] OSR report also showed that the resident had the following discontinued PO's: NJ Ex Order 26.4(b)(1) give 1 tablet by mouth two times a day for NJ Ex Order 26.4(b)(1) [redacted] which had a discontinued date of NJ Ex Order 26 [redacted]

On 9/17/24 at 10:40 AM, the surveyor in the presence of LPN#1 reviewed Resident #85's medical records. LPN#2 acknowledged that the resident's NJ Ex Order 26.4(b)(1) was discontinued on NJ Ex Order 2 [redacted] and the medication should have been removed from the medication cart as soon as the medication was discontinued.

b). On 9/17/24 at 10:50 AM, the surveyor inspected the first-floor medication cart in the presence of LPN#2. The surveyor observed an

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	315106	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 6	F 761		

opened vial of NJ Ex Order 26.4(b)(1) that indicated an open date of 9/16/24 and was stored inside the medication cart. The surveyor also observed an unopened NJ Ex Order 26.4(b)(1) that was undated and stored inside the medication cart. The surveyor interviewed LPN#2 who acknowledged that the NJ Ex Order 26.4(b and the unopened NJ Ex Order 26.4(b)(1) should have been stored inside the medication refrigerator.

On 09/17/24 at 11:00 AM, the surveyor inspected the 2nd floor medication cart in the presence of LPN#3. The surveyor observed an opened NJ Ex Order 26.4(b)(1) that had an opened date of 8/16/24 and was expired.

At that time, the surveyor interviewed LPN#3 who stated that the NJ Ex Order 26.4(b)(1), once it's opened had a 28-day expiration date. LPN#3 acknowledged that the NJ Ex Order 26.4(b)(1) was expired and should have been removed from the medication cart.

A review of the Manufacturer's Specifications for the following medications revealed the following:

1. NJ Ex Order 26.4(b should be stored in the refrigerator.
2. Unopened NJ Ex Order 26.4(b)(1) should be stored in the refrigerator
3. NJ Ex Order 26.4(b)(1) once opened has an expiration date of 28-days.

On 9/17/24 at 1:00PM, the surveyor presented the above concerns to the facility administrative team which included the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and the U.S. FOIA (b) (6). There was no additional information provided.

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F 761	Continued From page 7 A review of the facility's policy titled "Medications Destruction" dated 3/31/24 and provided by the [redacted] included the following: "When non controlled medications are expired or discontinued, all medications in their original packaging are returned to the pharmacy for proper disposal." A review of the facility's policy titled "Medication Storage" dated 03/31/24 and provided by the [redacted] included the following: "5. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy." "6. Medications will be stored at the appropriate temperature in accordance with pharmacy and /or manufacturer's labeling." NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		10/25/24

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F 812	Continued From page 8 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 9/15/24 at 9:35 AM, the surveyor in the presence of the U.S. FOIA observed the following during the kitchen tour: 1. The inside of the ice machine was observed in two areas with a black colored substance. The U.S. FOIA stated the maintenance department oversees cleaning the ice machine and they were not aware of the black colored substance in the ice machine. On 9/15/24 at 12:34 PM, the surveyor conducted an interview with the U.S. FOIA (b) (6)), who stated the ice machine was cleaned monthly, normally the middle of the month. The U.S. FO was unable to state what the substance was or how long it had been there. On 9/17/24 at 9:45 AM, the U.S. FOIA (b) (6) provided the surveyor with a facility policy title, Cleaning Kitchen Equipment with a revised date	F 812	F812: Food Procurement, Store/Prepare/Serve- Sanitary CFR(s): 483.60(i)(1)(2) I. Element 1 Immediate Action The ice machine was immediately emptied and cleaned upon finding of the issue. II. Element 2 Identifications of Others All residents have potential to be affected by a non-sanitary ice machine. III. Element 3 Systematic Changes An in-service was held by administrator/designee regarding the importance of a sanitary ice machine and it will be checked daily. A new weekly checklist/ log was implemented to ensure the ice machine is checked 2x weekly and is clean at all times, besides the monthly full clean. IV. Element 4 Quality Assurance The Administrator or designee will monitor the ice machine 3 times weekly for 4 weeks followed by weekly for 2 months 10/10/2024 until 1/10/25. All findings will be reported and discussed by	

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F 812	Continued From page 9 of December 2023. Under the policy interpretation and implementation portion of the policy it states, "2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair ...11. Ice machines and ice storage containers will be drained, cleaned, and sanitized per manufacturer's instruction and facility policy." On 9/17/24 at 1:38 PM, the surveyor team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and U.S. FOIA (b) (6) and reviewed the above facility concerns. No additional information was provided. NJAC 8:39-17.2(g)	F 812	the next QA meeting.	

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
315106 Y1	A. Building B. Wing Y2	11/4/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

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 F0558	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	10/25/2024	LSC	10/25/2024	LSC	10/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315106	A. BUILDING **01** B. WING _____	**09/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	**1048 GROVE STREET** **ELIZABETH, NJ 07202**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/16/2024,09/17/2024 and 09/18/2024. Elizabeth Nursing &Rehab Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The building construction was stated to be 40s with no current major renovations or noted additions. It is a three-story building with the ground floor as floor #1. The construction is Type II (000) with a section of the attic constructed as a wood frame with a fully functional fire sprinkler system. The building has 6-smoke zones. The natural gas generator inside the facility does approximately 40% of the building as per the U.S. FOIA (b) (6). The heating system has a loop-pipe hot water system and AC units in the walls and windows of the facility.	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING	K 293		10/25/24

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

Electronically Signed | 10/10/2024

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
	315106	A. BUILDING **01** B. WING _____	**09/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	**1048 GROVE STREET** **ELIZABETH, NJ 07202**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 1 Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/16/2024, in the presence of the U.S. FOIA (b) (6) [redacted], the facility failed to provide exit signs showing the direction of travel, in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 1 of 15 exit signs observed and was evidenced by the following: On at 8:28 AM, the surveyor in the presence of the U.S. FOIA (b) (6) and observed that the long exit/egress corridor leading to the laundry exit was not provided with an exit sign and until you walked three quarters of the way from elevator #1, it was not obvious where the exit was located. The finding was verified by the U.S. FO [redacted] at the time of the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 09/18/2024 at 4:28PM. NJAC 8:39-31.2(e)	K 293	K293: Exit Signage CFR(s): NFPA 101 I. Element 1 Immediate Action A new Exit Sign was hard wired and was installed immediately. II. Element 2 Identification of Others All residents and staff have the potential to be affected by a missing Exit Sign showing the direction of travel to the nearest exit. III. Element 3 Systemic Changes The Administrator in-serviced the U.S. FOIA (b) (6) the importance of ensuring appropriate Exit Signs and all safety signs. IV. Element 4 Quality Assurance The Administrator or Designee will monitor 2 x weekly for 8 weeks from 10/2/2024 until 12/2/2024 and then 2x monthly for 6 months, will check and ensure that all the exit and directional signs are displayed in accordance with continuous illumination. All findings will be reported at the next quarterly quality assurance meeting PS: see attachment icon for photo proof.	

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K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/18/2024 in the presence of the [redacted], it was determined that the facility failed to ensure that hazardous areas were protected with doors that had self-closing devices in accordance with NFPA 101: 2012 Edition,	K 321	K321: Hazardous Areas - Enclosure CFR(s): NFPA 101 I. Element 1 Immediate Action A vendor was called and installed a self-closing device on the clean laundry	10/25/24

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K 321	Continued From page 3 Sections 19.3.2, 19.3.5.9 and 8.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:18 PM in the laundry area, revealed the doors to the Clean laundry room and the commercial dryer room had no self-closing devices. In an interview at the time, the U.S. FO confirmed the findings. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 4:28 PM. NJAC 8:39-31.2(e)	K 321	room door and commercial dryer room door. II. Element 2 Identification of Others All residents and staff have the potential to be affected by hazardous areas not being protected by a door with a self closing device. III. Element 3 Systematic Changes The Administrator in-serviced the U.S. FOIA (b) (6) regarding the importance of safety and ensuring appropriate self-closing devices/doors in all hazardous areas. IV. Element 4 Quality Assurance The Administrator or Designee (administrator assistant) will monitor that doors in hazardous areas are self-closing and indicate that its fire rated for 2 x weekly for 8 weeks from 10/2/2024 until 12/2/2024 and then 3x monthly for 6 months. All findings will be reported at the next quarterly quality assurance meeting. PS: see attachment icon for photo proof.	
K 351 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	K 351		10/25/24

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K 351	Continued From page 4 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 REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/17/2024 in the presence of U.S. FOIA (b) (6) [redacted]), it was determined the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations 09/17/2024 at Right exit stairwell, revealed there were no fire sprinklers coverage under the First floor and Second floor accessible landing. In an interview at the time, the U.S. FO confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the findings at the Life Safety Code survey exit on 09/18/2024 at 4:28 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	K351: Sprinkler System - Installation CFR(s): NFPA 101 I. Element 1 Immediate Action A vendor was called in to install 2 new sprinkler heads scheduled for 10/16/2024 in the right exit stairwell. 1 under the first floor & 2 on the second floor accessible landing. II. Element 2 Identification of Others All residents and staff have the potential to be affected by missing sprinkle head coverage. III. Element 3 Systematic Changes The administrator in-serviced the U.S. FOIA (b) (6) regarding the importance of ensuring appropriate sprinkler coverage. IV. Element 4 Quality Assurance The Administrator or Designee will continue to monitor that all areas have appropriate sprinkler coverage. All findings will reported at the next quarterly	

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K 351	Continued From page 5	K 351	quality assurance meeting. PS: see attachment icon for photo proof.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/16/2024 and 09/17/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to maintain the automatic fire sprinkler system and ensuring the ceiling level was smoke resisting in accordance with NFPA 101:2012 Edition, Section 9.7.5,9.7.7, 9.7.8 and NFPA 25: 2011 Edition, Section 5.2.1.1.1(2). This deficient practice had the potential to affect all residents and was evidenced by the following:	K 353	K353: Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 I. Element 1 Immediate Action A vendor was called and installed a 3 escutcheon plates. 1st on sprinkler near first floor elevator, 2nd in room number 104 and 3rd the social workers office. The ceiling tile was put in place in the conference room. II. Element 2	10/25/24

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K 353	Continued From page 6 An observation on 09/16/2024 at 9:45 AM in the closet next to room #111, revealed an opening in the ceiling. In an interview at the time, the U.S. FO confirmed the observation. Observations on 09/19/2024 in the presence of U.S. FOI revealed the following: 1. At 11:03AM First floor sprinkler next to elevator #2 had no escutcheon plate. 2. At 11:06AM in Room #104 1of 2 sprinklers had no escutcheon plate. 3. At 11:35AM in the conference room closet ceiling tile was not in place. 4. At 11:46AM in the social service office sprinkler had no escutcheon plate. In an interview at the time, the U.S. FO confirmed the findings. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 09/18/2024 at 4:28 PM. N.J.A.C. 8:39-31.2(e) NFPA 13. 25	K 353	Identification of Others All residents and staff have potential to be affected by missing escutcheon plates and non properly placed ceiling tile. III. Element 3 Systematic Changes The Administrator in serviced the U.S. FOIA (b) (6) regarding the importance of escutcheon plates and about missing ceiling tiles. IV. Element 4 Quality Assurance The Administrator or Designee will monitor that all escutcheon plates and ceiling tiles are in place x1 weekly for 4 weeks, and 2x biweekly for 8 weeks. All findings will be reported at the next quarterly quality assurance meeting. PS: see attachment icon for photo proof.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.	K 355		10/25/24

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K 355	Continued From page 7 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/17/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that fire extinguishers were not blocked or obstructed in any way that would delay staff from accessing the fire extinguisher in the event of an emergency in accordance with NFPA 101:2012 Edition. Section19.3.5.12,9.7.4 and NFPA 10, Standard for Portable Fire Extinguishers. This deficient practice had the potential to affect all resident and was by the following: Observation at 1:02PM in the facility's kitchen, revealed Portable K and A B C Fire Extinguishers were blocked with kitchen plate storage rack. During an interview at the time of the observation, the U.S. FO[redacted] and the US FOIA (b)(6) [redacted] acknowledged and confirmed the observation. The facility's U.S. FOIA (b) (6) [redacted] was informed of the deficient practice during the Life Safety Code exit conference on 09/18/2024 at 4:28PM. NJAC 8:39-31.2 (e)	K 355	K355: Portable Fire Extinguishers CFR(s): NFPA 101 I. Element 1 Immediate Action The kitchen plate storage rack was immediately moved to not block the fire extinguisher. II. Element 2 Identification of Others All residents and staff have the potential to be affected by a blocked fire extinguisher. III. Element 3 Systematic Changes The Administrator in serviced all staff upon the importance of not blocking fire extinguishers, emergency outlets and fire doors. IV. Element 4 Quality Assurance The Administrator or Designee will monitor 3 times weekly for 4 weeks followed by weekly for 2 months from 10/10/24 until 1/10/25 upon the compliance of not blocking fire extinguishers. All findings will be reported at the next quarterly quality assurance meeting. PS: see attachment icon for photo proof.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements	K 921		10/25/24

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K 921	Continued From page 8 The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review on 09/16/2024,09/17/2024 and 09/18/2024, in the presence of the U.S. FOIA (b) (6) it was determined that the facility failed to provide an electrical policy for all patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and detailed log of all required tests, test results, safety labels and	K 921	K921: Electrical Equipment - Testing and Maintenance I. Element 1 Immediate Action Maintenance Director inspected room # NJ Ex O fan, room # NJ Ex O feeding pump & radio, room # NJ Ex O 5 liter oxygen concentrator, room # NJ Ex O feeding pump, 54 electric beds on the first floor and 47	

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K 921	Continued From page 9 repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 09/17/2024 between 8:15 AM and 3:30 PM in second floor resident rooms, revealed the following: 1. Room #[NJ Ex C] had an electric standing fan without inspection sticker. 2. Room #[NJ Ex C] had feeding pump and a radio without inspection stickers. 3. 47 of 47resident's electric beds on the second floor had no inspection stickers. In an interview at the time, the [U.S. FO] confirmed the observation. Observations on 09/18/2024 between 8:55AM and 3:45PM in first floor resident rooms, revealed the following: 1. Room #[NJ Ex C] had 5liter oxygen concentrator without inspection sticker. 2. Room #[NJ Ex C] had a feeding pump without inspection sticker. 3. 54 of 54 resident's electric beds on the first floor had no inspection stickers. 4. No policies and protocols on PCREE were provided to the surveyor. In an interview at the time, the [U.S. FO] confirmed the observation and acknowledged there were no documentation on PCREE.	K 921	electric beds on second floor. PCREE Policy was created (medical equipment safety plan/program) ,reviewed and updated by the administrator and the maintenance director. II. Element 2 Identification of Others all residents and staff have the potential to be affected by non-inspected electrical equipment. III. Element 3 Systematic Changes The Administrator in serviced the U.S. FOIA (b) (6) upon the importance of inspecting electrical equipment and maintaining a log of all inspections. Additional in service was held to all departments about the importance of reporting to maintenance not properly working equipment. IV. Element 4 Quality Assurance The maintenance director will randomly select 10 room to make sure all electrical equipment is inspected 3 times a week for 4 weeks followed by weekly for 2 months from 10/10/24 until 1/10/25. All findings will be reported at the next quarterly quality assurance meeting. PS: see attachment icon for photo proof.	

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K 921	Continued From page 10 The facility's U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code survey exit conference at 4:28 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K 921		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier.	K 923		10/25/24

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ELIZABETH NURSING AND REHAB	**1048 GROVE STREET** **ELIZABETH, NJ 07202**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 11 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/17/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that Empty portable oxygen cylinder tanks were separated from Full portable oxygen cylinder tanks in accordance NFPA 101:2012 Edition. Section 19.3.2.4,8.7 and NFPA 99. This deficient practice had the potential to affect all residents and was evidenced by the following: Observation at 11:43AM in the facility's oxygen storage closet, revealed 4 of 15 Empty portable oxygen cylinder tanks in a storage rack with sign indicating Full Tanks. In an interview at the time, the U.S. FO [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 09/18/2024 at 4:28PM. N.J.A.C 8:39-31.2(e). NFPA 99.	K 923	K923: Gas Equipment - Cylinder and Container Storage I. Element 1 Immediate Action Maintenance Director immediately separated the full of empty oxygen cylinder tank and created clear signage for empty and full tanks. Full and empty are stored in two separate places with clear signs. II. Element 2 Identification of Others All residents and staff have the potential to be affected by non-separated full/empty oxygen cylinder tanks. III. Element 3 Systematic Changes The Administrator in serviced the U.S. FOIA (b) (6) and nursing staff regarding the importance of separating full of empty oxygen cylinder tanks. IV. Element 4 Quality Assurance The maintenance director with the administrator will inspect all oxygen cylinder tank storage are separated 3 times a week for 4 weeks followed by weekly for 2 months from 10/10/24 until 1/10/25. All findings will be reported at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315106	A. BUILDING **01** B. WING _____	**09/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	**1048 GROVE STREET** **ELIZABETH, NJ 07202**

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K 923	Continued From page 12	K 923	next quarterly quality assurance meeting PS: see attachment icon for photo proof.	

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
315106 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/4/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING AND REHAB	1048 GROVE STREET ELIZABETH, NJ 07202

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	10/25/2024	LSC K0321	10/25/2024	LSC K0351	10/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	10/25/2024	LSC K0355	10/25/2024	LSC K0921	10/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	10/25/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
9/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO