STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315374	A. BUILDING _____ B. WING _____	01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	810 NEWMAN SPRINGS RD LINCROFT, NJ 07738

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS STANDARD SURVEY: 01/08/2024 CENSUS: 27 SAMPLE SIZE: 12 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 812 SS=E	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	F 812		2/16/24

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

Electronically Signed | 01/24/2024

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

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F 812	Continued From page 1 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 documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of foodborne illnesses, and b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross-contamination. This deficient practice was observed and evidenced by the following: On 01/03/24 from 09:22 AM until 10:06 AM, the surveyor toured the kitchen in the presence of the US FOIA (b) (6)) and observed the following: 1. In the walk-in refrigerator, there was a stack of yellow square cheese wrapped in clear plastic with no open or use by dates and no label. The US FOIA (b) acknowledged there was no label and stated that there should have been a label marked with the open date and the good through date. There was one opened plastic bag of shredded cheddar cheese wrapped in clear plastic wrap with no open or use by dates and no label. There was one white plastic container containing meat, with no label and no use by dates. The container was partially covered by clear plastic wrap and the meat was visible and exposed to air. The US FOIA (b) identified the meat as lamb chops and acknowledged that the container was not covered correctly and that it should have had a lid and a label with a use by date. The US FOIA (b) stated that it was important, for the prevention of	F 812	1.There were no residents identified. I.(a). In the walk-in refrigerator, there was a stack of yellow square cheese wrapped in clear plastic with no open or use by dates and no label. This cheese was thrown out. (b). There was an opened plastic bag of shredded cheddar cheese wrapped in clear plastic wrap with no open or use by dates and no label. The bag of cheese was also thrown out. (c). There was one white plastic container containing meat, with no label and no use by date. The container was partially covered by clear plastic wrap and the meat was visible and exposed to air. The meat was thrown out. (d).In a half pan on the bottom shelf of a metal rack, there was one bag of defrosted chicken that the US FOIA (b) stated were chicken tenders, with no label or dates. The US FOIA (b) states that the chicken was pulled that morning and used the following day for dinner. II. In the walk-in freezer, there was one opened package of frozen tortillas wrapped in clear plastic, marked by the manufacturer, "date use by June 2, 2023". The tortillas were thrown out. III. In the spice area, there was one 22 ounce jar of siracha seasoning, one 14 oz jar of Aleppo style pepper, one 16 oz jar of Ancho chile pepper, one 5 oz jar of dill weed, one 6 oz jar of rosemary leaves, all undated and no open dates. All of the	

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F 812	Continued From page 2 bacterial growth and foodborne illness, for food to have not been held longer than a specified time, and proceeded to throw the lamb chops in the trash. In a half pan on the bottom shelf of a metal rack there was one bag of defrosted chicken that the [redacted] stated were chicken tenders, with no label or dates. The [redacted] stated it was pulled last night and that it should have had a label. 2. In the walk-in freezer, there was one opened package of frozen tortillas wrapped in clear plastic, marked by manufacturer, "date use by June 2, 2023." The [redacted] stated that they were expired and disposed of them into the trash. 3. In the spice area, there was one 22 ounce (oz) jar of sriracha seasoning, one 14 oz jar of Aleppo style pepper, one 16 oz jar of Ancho chile pepper, one 5 oz jar of dill weed, and one 6 oz jar of rosemary leaves, all undated and no open dates. The [redacted] acknowledged the spices were undated and stated, "I have no idea how old they are, I just got here." The [redacted] threw the spices into the garbage. 4. On a metal table was the Robot Coup which the [redacted] stated was used then cleaned. The [redacted] removed the lid and inside of the cannister was clear liquid and white food debris. The [redacted] removed the food debris with her finger and acknowledged that the Robot Coup should not have been wet nested and stated that it could have passed bacteria. The slicer, which the [redacted] stated was clean, was resting in the same area. There was dried white debris on the slicer pan which the [redacted] scraped with her finger and then used a wet cloth to wipe the area. There was white and brown debris on the slicer base which the [redacted] wiped with her finger and stated, "Men	F 812	above spices were thrown out. IV.(a). On a metal table the Robot Coup which the [redacted] stated was used then cleaned. The [redacted] removed the lid and inside of the cannister was clear liquid and white food debris. The Robot Coup was removed from service and properly cleaned. (b).The slicer, which the [redacted] stated was clean, was resting in the same area. There was dried white debris on the slicer pan. There was white and brown debris on the slicer base. The slicer was taken apart and cleaned thoroughly. V.Under the prep table on the bottom rack was one white cutting board with brown smudges, one yellow cutting board with gouges and brown smudges, and one white cutting board with gouges and brown smudges. The white cutting board with smudges only has been cleaned. The yellow and white cutting boards with gouges have been thrown out. VI. In a 1/6 size pan in the reach in refrigerator, there were four clear plastic bags of herbs. None of the bags had a label nor any open by or use by dates. The four bags of herbs were thrown out. VII. In the dry storage room, there were three opened bags of pasta knotted closed and two opened bags of pasta wrapped in clear plastic wrap with no opened or used by date. The three bags of pasta were thrown out. VIII. In the ice cream freezer, there were 20 unmarked individual covered cups of scooped ice cream with no label or use by dates. The 20 cups of ice cream were thrown out.	

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F 812	Continued From page 3 don't clean well." 5. Under the prep table on the bottom rack was one white cutting board with brown smudges, one yellow cutting board with gouges and brown smudges, and one white cutting board with gouges and brown smudges. The [redacted] acknowledged that the cutting boards should not have had smudges and gouges and stated that bacteria could have gotten into the grooves. 6. In a 1/6 size pan in the reach in refrigerator, there were four clear plastic bags of herbs. The [redacted] identified: one bag of rosemary with green and brown leaves; one bag of cilantro; one bag of thyme; and one bag of sage. None of the bags had a label nor any open or use by dates. The [redacted] acknowledged that the herbs were not labeled nor dated and stated that they should have been. The [redacted] threw all the bags of herbs away. 7. In the dry storage room, there were three opened bags of pasta knotted closed and two opened bags of pasta wrapped in clear plastic wrap with no opened or use by dates. The [redacted] acknowledged the pasta was not stored correctly and stated that they should have been marked with an open and use by date. The [redacted] stated that it was important to store the pasta correctly, so bugs did not get in and to ensure food was not served past expiry. 8. In the ice cream freezer, there were 20 unmarked individual covered cups of scooped ice cream with no label or use by dates. The [redacted] acknowledged the cups should have had a label with the use by date.	F 812	2. All the residents had the potential to be affected from a sanitation and safety perspective. 3.All food items will be properly covered, stored, and labeled to indicate the received, opened, and used by date. All kitchen staff will be in-serviced on the proper storage and labeling of food by the Food Service Director. All food service staff will be in-serviced by the Food Service Director on the proper cleaning of equipment and assessing damaged equipment for infection control issues. This in-servicing will occur upon hire, and then quarterly thereafter unless it is needed sooner, based on results of the audits. An audit tool will be used inspect all areas of the kitchen for safety and sanitation. 4.The Food Service Director will complete weekly inspections using the audit tool for two months and then monthly. The Food Service Director will submit the reports to the Administrator weekly for review. As an additional measure, the Dietician will provide the Administrator with a weekly inspection report to ensure compliance. Inspection Reports will be reviewed by the QA Committee quarterly to ensure compliance and remediation.	

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F 812	Continued From page 4 On 01/05/24 at 12:12 PM, the US FOIA (b)(6) [redacted] met with the surveyors in the conference room, and was made aware of the kitchen concerns. A review of the facility policy, "Storage of Food and Supplies," reviewed 12/7/2020, revealed, Method/How To/Procedure: Most, but not all, products contain an expiration date. The words "sell-by", "best-by", "enjoy-by", or "use-by" should precede the date ...Discard food past the "use-by", "sell-by", or "enjoy-by" date. Cover, label and date unused portions and open packages. Complete all sections on a Unidine Universal Date Label or use an approved labeling system. Date and rotate items. Discard food past the use-by or expiration date. Refrigerated Storage Life of Food: Use manufacturer's expiration date for products before opened. If there is no expiration date on the package, add the time listed here to the date the food received. Add the time in the "opened" column to the date when the food is prepared or opened. Label when product is "opened." A review of the facility document, "7.4 Food Protection, Facility/Equipment," created 10/1/2022, revealed no information on equipment cleaning.	F 812		
F 880 SS=D	NJAC 8:39-17.2(g) 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	F 880		2/8/24

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F 880	Continued From page 5	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 6 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to maintain proper infection control practices for donning (putting on) the appropriate Personal Protective Equipment (PPE) prior to entering an NJ Exec Order 26.4b1 room to prevent the transmission of NJ Exec Order 26.4b1 for 2 of 13 residents (Resident #1 and Resident #16) NJ Exec Order 26.4b1 This deficient practice was evidenced by the following: 1. During an interview with the surveyor on 01/04/24 at 9:33 AM, the US FOIA (b)(6) stated the facility was currently in a	F 880	1.Resident #1 had the NJ Exec Order 26.4b1 and the sign indicating what PPE should be worn replaced on the resident's door. Resident #1 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Exec Order 26.4b1 Resident #16 was NJ Ex Order 26.4b1 by the deficient practice and NJ Ex Order 26.4b1 NJ Exec Order 26.4b1 . 2.All residents had the potential to be affected from an infection control and safety stand point. 3. On 1/05/24,both the Regional Housekeeping Director and the Infectious Disease Physician were instructed on the proper use of PPE when entering the	

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F 880	Continued From page 7 NJ Exec Order 26.4b1, but that all residents were fully NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 as well. On 01/04/24 at 10:36 AM, the surveyor observed the US FOIA (b)(6) standing outside of Resident #1's room. Outside the resident's room, there was a three-tiered PPE supply bin next to the door which contained N95 masks, gowns, gloves, and face shields, but there wasn't any signage on the door to indicate what PPE was required to enter the resident's room. The US FOIA (b donned a N95 mask, gown, and gloves and entered the resident's room. The US FOIA (b did not don any eye protection prior to entering the resident's room. At 10:42 AM, the US FOIA (b opened the door to Resident #1's room and was observed wearing a N95 mask, gown, and gloves inside the resident's room. The US FOIA (b doffed (removed) his PPE, disposed of the PPE in the resident's room, and performed hand hygiene with alcohol-based hand rub (ABHR) before exiting the resident's room. During an interview with the surveyor on 01/04/24 at 10:44 AM, the US FOIA (b stated Resident #1 was on NJ Exec Order 26.4b1 and that the PPE required to enter the resident's room included a N95 mask, gown, and gloves. The US FOIA (b further stated that there is normally a sign on the resident's door to indicate what PPE was required for the NJ Exec Order 26.4b1. When asked about eye protection, the US FOIA (b stated eye protection is also required in the NJ Exec Order 26.4b1 rooms. He then pulled out eyeglasses from his pants pocket and stated he wore eyeglasses in the resident's room. When asked if the US FOIA (b wore a face shield or goggles inside the resident's room, the	F 880	room of a resident who has been identified as being on droplet precautions. The IP did the in-servicing and will continue to do this in-servicing quarterly for all current employees and consultant/contracted staff. Additional education was provided on the importance of reading signage with instruction on the type of PPE to be used prior to entering a resident's room. The IP will continue to educate all staff, including physicians, and other contracted employees on basic infection prevention and control, use of PPE, isolation, signage, and hand washing. This in-servicing is done upon hire and then quarterly thereafter or as needed if required sooner. 4. The IP will conduct monthly audits to ensure compliance among staff and contractors with regard to infection control. The outcome of these audits will be reviewed at the QA meetings which are held quarterly. Any areas on non-compliance will be reported to the QA committee for remediation.	

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F 880	Continued From page 8	F 880		

US FOIA (b) stated he should have worn a face shield or goggles in the NJ Exec Order 26.4b1 room.

According to the Admission Record, Resident #1 had diagnosis of NJ Exec Order 26.4b1.

Review of resident's Order Summary Report, as of NJ Exec Order 26.4b, included a physician's order, dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 results x NJ Exec Order 26."

Review of the resident's Care Plan, revised NJ Exec Order 26.4b, included a focus of, "NJ Exec Order 26.4b1 Based Precautions - Fitted N95 mask, gown, face shield or goggles, and gloves to be worn Q Shift [every shift]," with an intervention that, "Staff will wear PPE to enter my room and perform hand hygiene."

Review of the resident's Progress Notes included a Nurse's Note, dated NJ Exec Order 26.4b at 12:04 PM, that revealed, "NJ Exec Order 26.4b1." Further review of the Progress Notes included a Nurse's Note, dated NJ Exec Order 26.4b at 2:41 PM, that revealed, NJ Exec Order 26.4b1

During an interview with the surveyor on 01/04/23 at 10:49 AM, the US FO stated that when a resident was placed on NJ Exec Order 26.4b1, signs were posted on the resident's door to notify staff and visitors to "Please see a nurse before entering this room," and, "NJ Exec Order 26.4b1 Based Precautions in Place, Anyone entering the room must wear: Gown, Mask: N95, Goggles/Face Shield, Gloves," and a PPE supply bin is placed outside the resident's room. The US FO further stated that residents diagnosed with NJ Exec Order 26.4b1 were

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F 880	Continued From page 9	F 880		

placed on NJ Exec Order 26.4b1 and the PPE required to enter that resident's room was a N95 mask, gown, gloves, and a face shield or goggles. At that time, the surveyor notified the US FOIA (b)(6) of the missing signage for Resident #1's room and that the US FOIA (b)(6) did not wear eye protection while in Resident #1's room. The US FOIA (b)(6) stated that the staff should have notified her that the signage was missing and that the US FOIA (b)(6) should have worn NJ Exec Order 26.4b1 PPE in Resident #1's room.

2. On 01/05/24 at 10:56 AM, the surveyor observed the US FOIA (b)(6) standing outside of Resident #16's room. Outside the resident's room, there was a three-tiered PPE supply bin next to the door which contained N95 masks, gowns, gloves, and face shields, and there was signage on the door that included, "NJ Exec Order 26.4b1 Based Precautions in Place, Anyone entering the room must wear: Gown, Mask: N95, Goggles/Face Shield, Gloves." The US FOIA (b)(6) donned a gown, gloves, and N95 mask and entered the resident's room. The US FOIA (b)(6) was wearing eyeglasses but did not don eye protection, such as a face shield or goggles prior to entering Resident #16's room.

At 10:58 AM, the US FOIA (b)(6) exited Resident #16's room and performed hand hygiene with ABHR. The surveyor interviewed the US FOIA (b)(6) at that time. The US FOIA (b)(6) stated that Resident #16 was on NJ Exec Order 26.4b1 and that the required PPE for that room included a N95 mask, gloves, and gown. The US FOIA (b)(6) further stated that the resident's door had signage which indicated the PPE required for the room, but that he doesn't look at that sign since he already knows what PPE to wear. The US FOIA (b)(6) then acknowledged the sign included

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F 880	Continued From page 10	F 880		

that staff must wear eye protection, such as a face shield or goggles, prior to entering the resident's room. The US FOIA (b)(6) further stated that it was important to wear the correct PPE for residents NJ Exec Order 26.4b1 in order to prevent the spread of NJ Exec Order 26.4b1

According to the Admission Record, Resident #16 was admitted with a diagnosis of NJ Exec Order 26 .

Review of the resident's Order Summary Report, as of NJ Exec Order 26.4b, included a physician's order, dated NJ Exec Order 26.4, for, "NJ Exec Order 26.4b1 Based Precautions - Fitted N95 mask, gown, face shield or goggles, and gloves to be worn Q Shift."

Review of the resident's Care Plan, revised NJ Exec Order 26.4b, included a focus of, "NJ Exec Order 26.4b1 Based Precautions for NJ Exec Order 26.4b1," and an intervention of, "PPE and signage at room."

Review of the Progress Notes included a Nurse's Note, dated NJ Exec Order 26.4b at 9:32 AM, which revealed, "Resident c/o [complained of] NJ Exec Order 26.4b1 . NJ Exec Order 2 . ID [physician] informed ... placed on NJ Exec Order 26.4b1 Based Precautions."

On 01/05/24 at 11:04 AM, the surveyor notified the US FO of the surveyor's observation of the US FO . The US FO stated the US FOIA (b)(6) should have worn goggles or a face shield prior to entering Resident #16's room.

Review of the facility's Outbreak Response Plan, reviewed 10/2023, included, "Staff will be educated on exposure risks, symptoms, and prevention of the Emerging Infectious Disease

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315374	A. BUILDING _____ B. WING _____	01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	810 NEWMAN SPRINGS RD LINCROFT, NJ 07738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11	F 880		

(EID). Special emphasis will be on reviewing basic infection prevention and control, use of PPE, isolation, and other prevention strategies such as hand washing."

Review of the facility's Application of Transmission-Based Precautions policy, revised 10/09/23, included, "Droplet Precautions: Intended to prevent transmission of pathogens spreading through close respiratory or membrane contact with respiratory secretions. Staff caring for residents with Droplet Precautions should wear a face mask for close contact with the resident. Consider adding goggles or a face shield to protect eyes from exposure to respiratory droplets, especially when caring for residents with a significant cough or respiratory secretions." Further review of the policy included, "Communication about Transmission-Based Precautions ... Room entry signage indicating what type of Transmission-Based Precautions and appropriate PPE to be used."

Review of the Centers for Disease Control and Prevention (CDC) guidelines titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 05/08/23, included, "HCP [Health Care Professionals] who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face)."

NJAC 8:39-19.4(a); 27.1(a)

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62207	A. BUILDING: _____ B. WING _____	01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by:	S1405		1/31/24

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

Electronically Signed | 01/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62207	A. BUILDING: _____ B. WING _____	01/08/2024

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S1405	Continued From page 1 Based on staff interview and record review it was determined that the facility failed to provide physical examinations for 1 of 5 newly hired employees as evidenced by the following: The surveyor reviewed 5 employee records as follows: 1.) Registered Nurse (RN#1) hired [NJ Exec Order 26.4]. 2.) Registered Nurse (RN#2) hired [NJ Exec Order 26.4]. 3.) Licensed Practical Nurse (LPN) hired [NJ Exec Order 26.4]. 4.) Certified Nursing Assistant (CNA#1) hired [NJ Exec Order 26.4]. 5.) Nursing Assistant hired [NJ Exec Order 26]. On 01/08/24 at 09:33 AM, the surveyor reviewed RN #1's employee file which indicated that the employee was hired [NJ Exec Order 26.4]. There was no documentation that a physical was performed by a physician within two weeks of hire or that a mini-physical was performed by an RN upon hire. The surveyor reviewed the facility form titled "Employee Health Questionnaire (EHQ)" dated [NJ Exec Order 26.4], that was completed by RN #1. There was a signature area that was to be signed by an RN, however the signature area was blank. The surveyor reviewed the facilities form titled, "Physical Examination," for RN#1 which had the employee's name, vital signs (VS), height, and weight documented on the top of the form. The rest of the form was blank and did not contain a physician's signature that indicated that the physical was completed. On 01/08/24 at 09:47 AM, the surveyor interviewed the Registered Nurse Infection Preventionist (RN/IP) who stated that a mini	S1405	1. There were no residents identified. 2. All residents had the potential to be affected from a safety and infection control perspective. The DON signed the mini-physical for RN #1 upon her return from [US FOIA (b)(6)] on 1/10/2024. The Medical Director conducted a physical on 1/25/2024 for RN #1. 3. The Human Resources person and the DON will cross check all new employee files monthly utilizing a check list audit tool to ensure completion and accuracy. From now on, this will be done every month to assure accuracy and completion of employee records. 4. The Human Resources person will prepare a report for the QA committee based on findings from these monthly meetings. These findings will be reported quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 2 physical was to be completed by an RN on hire. She explained that the mini physical was an EHQ that the RN completed which also included VS. She reviewed RN #1's EHQ with the surveyor and stated that she did not know why an RN did not sign the mini physical. She stated that a second physical from the doctor was to be completed within [redacted] days from the hire date. She stated that a Physical was completed to assure that the employee was fit to work. The RN/IP stated that the DON was responsible to assure that the mini physical was completed and signed by the RN and that the physical from the MD was completed. On 01/08/24 at 09:56 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated that she was not sure why RN #1's mini physical was not completed by the RN, or why an RN did not sign the EHQ. She confirmed that mini physical that was to be completed by the RN was not completed because there was no signature from the RN on the form. She explained that employee physicals were to be completed by the MD [redacted] days after hire. On 01/08/24 at 10:11 AM, the surveyor telephone interviewed the Director of Nursing (DON) who stated mini physicals should have been done by the RN prior to work or upon hire to assure that the employee was fit to work, and then [redacted] days after hire the physician completed a full physical. She stated that she must have been distracted and forgot to sign the EHQ upon the employee's hire. A review of the facility's undated policy titled, "Employee Health Requirements" indicated that employees must be in good physical health and	S1405		

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S1405	Continued From page 3 free from contagious disease to begin employment. Each prospective employee must complete a pre-employment medical examination by their primary care physician to attest that he/she is free from communicable disease and has no physical or mental disabilities that would prevent the prospective employee from performing the essential functions of their job with or without accommodations.	S1405		

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
315374 Y1	A. Building B. Wing Y2	2/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	810 NEWMAN SPRINGS RD LINCROFT, NJ 07738

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	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	02/16/2024	LSC	02/08/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/8/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62207 Y1	A. Building B. Wing Y2	2/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	810 NEWMAN SPRINGS RD LINCROFT, NJ 07738

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S1405	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-19.5(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/31/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/8/2024	☐ 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
	315374	A. BUILDING **01** B. WING _____	**01/08/2024**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/04/2024 De La Salle Hall 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. De La Salle Hall is a single story Type II Protected building that was built in January 1997. The facility is divided into 3 smoke zones. The facility has a 208 KW natural gas Emergency Generator that supplies emergency power to the entire building.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING 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 review of facility provided documentation on 01/04/2024 in the presence of facility management, it was determined that the facility failed to: 1) provide two (2) illuminated exit signs to clearly identify the exit access path to reach an exit discharge	K 293	1.There were no residents identified. 2. All residents had the potential to be affected from a safety perspective. 3.Illuminated exit signs have been installed on the three doors located in the facility courtyard outside to indicate a way	2/14/24

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

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

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K 293	Continued From page 1 door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in	K 293	to enter the facility. The three illuminated exit signs were installed on 2/14/2024 as the signs were ordered weeks ago but were not available due to a supply chain issue. 4.The Maintenance Director will be responsible for compliance. The three illuminated exit signs will be inspected monthly with the other illuminated exit signs throughout the building to ensure that they are in good working order. Results of these will be kept in a log which will be reviewed by the QA Committee quarterly to ensure completion.	

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K 293	Continued From page 2 an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 01/04/2024 during the survey entrance at approximately 9:01 AM, a request was made to the Administrator and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with one (1) enclosed (surrounded by the building) outside courtyard that Resident, Staff and Visitors could use. Starting at 10:15 AM, in the presence of the DOM a tour of the building was conducted. During the building tour at approximately 12:10 PM PM, an inspection in the outside enclosed center courtyard was performed. The surveyor observed three (3) doors leading out of the enclosed center courtyard with no evidence of two (2) illuminated exit signs to clearly identify the exit access route to reach an exit. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency during the Life Safety Code survey exit on 01/04/2024 at approximately 1:40 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c)	K 293		

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K 293	Continued From page 3 NFPA Life Safety Code 101 2012 -7.7	K 293		
K 351 SS=D	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 REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/04/2024, in the presence of facility management it was determined that: The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following,	K 351	1.There were no residents identified. 2.All residents had the potential to affected from a fire safety perspective. 3.(a).The Maintenance Director replaced the escuheon cap in the clean linen closet located in the hallway. (b).The Maintenance Director replaced the escuheon cap in the emergency supply closet located in the front of the building. (c).The Maintenance Director replaced the escheon cap in the LPA closet inside the closet with the electric panel. The 1-1/2 by	1/31/24

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DE LA SALLE HALL	**810 NEWMAN SPRINGS RD** **LINCROFT, NJ 07738**

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K 351	Continued From page 4 On 01/04/2024 during the survey entrance at approximately 9:01 AM, a request was made to the Administrator and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked how many Resident sleeping rooms are in the facility. The DOM told the surveyor that there are 27 Resident sleeping rooms. A review of the facility provided lay-out identified the facility is a single-story building. Starting at 10:15 AM, in the presence of the DOM a tour of the building was conducted. During the building tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: 1) At approximately 11:47 AM, an inspection inside the Clean Line closet the surveyor observed the fire sprinkler had no escuheon cap, leaving an approximately 1/2 inch gap around the sprinkler. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 2) At approximately 12:01 PM, an inspection inside the Emergency Supply closet the surveyor observed the fire sprinkler had no escuheon cap, leaving an approximately 1/2 inch gap around the sprinkler. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the	K 351	8 inch hole in the ceiling with several wires running from the electrical panel upward through the wall board ceiling was filled with fire sealant caulk to close the hole. (d). A 12 x 12 metal plate was installed over the hole in the tub room closet with screws and fire sealant caulk. 4. A monthly audit will be conducted by the Director of Maintenance to ensure that all escuheon caps are in place. If any outside contractors perform work in the ceiling, the Maintenance Director will ensure that any open voids created are filled with fire sealant caulk. The esucheon caps's audit and maintenance logs will be reviewed by the QA Committee quarterly to maintain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315374	A. BUILDING **01** B. WING _____	**01/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	**810 NEWMAN SPRINGS RD** **LINCROFT, NJ 07738**

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K 351	Continued From page 5 area and not activate the fire sprinkler system. 3) At approximately 12:08 PM, an inspection inside a closet that had electrical panel "LPA" inside the surveyor observed the fire sprinkler escuheon cap was hanging down and not tight to the wall board ceiling, leaving an approximately 1-1/4 inch gap in the ceiling. The surveyor also observed above the "LPA" electrical panel an approximately 1-1/2" by 8" hole in the ceiling with several wires running from the electrical panel upward through the wall board ceiling. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 4) At approximately 12:18 PM, an inspection inside the Tub rooms closet was performed. The surveyor observed inside the closet that an approximately 10 inch by 10 inch wall board ceiling around the fire sprinkler head had been removed. With the approximately 10" by 10" opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the closet and not activate the fire sprinkler system. The DOM confirmed the findings at the time of observations. The Administrator was informed of the deficiency during the Life Safety Code survey exit on 01/04/2024 at approximately 1:40 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie	K 372		1/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315374	A. BUILDING **01** B. WING _____	**01/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	**810 NEWMAN SPRINGS RD** **LINCROFT, NJ 07738**

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K 372	Continued From page 6 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 01/04/2024, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for one (1) of three (3) smoke barrier walls inspected as evidenced by the following: On 01/04/2024 during the survey entrance at approximately 9:01 AM, a request was made to the Administrator and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with three (3) smoke barrier walls. Starting at 10:15 AM, in the presence of the facility's DOM an inspection above the corridor ceiling tiles of three (3) smoke barrier walls was	K 372	1.There were no residents identified. 2.All residents had the potential of being affected from a fire safety stand point. 3. At approximately 10:56 AM, the surveyor observed the above the ceiling tiles adjacent to the corridor double smoke doors (next to the Pantry) that the smoke barrier wall had an approximately 1-1/4 inch penetration with 8 wires running through the wall. The penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The Maintenance Director used fire sealant caulk to fill in around the 8 wires running through the wall. 4. Maintenance Director will be responsible for inspecting any work performed by outside contractors. He will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315374	A. BUILDING **01** B. WING _____	**01/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	**810 NEWMAN SPRINGS RD** **LINCROFT, NJ 07738**

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K 372	Continued From page 7 performed. At approximately 10:56 AM, the surveyor observed the above the ceiling tiles adjacent to the corridor double smoke doors (next to the Pantry) that the smoke barrier wall had an approximately 1-1/4 inch penetration with 8 wires running through the wall. The penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The smoke barrier wall failed to maintain the 1/2 hour fire rated construction as required by code. The facility DOM confirmed the finding at the times of observations. The Administrator was informed of the deficiency during the Life Safety Code survey exit on 01/04/2024 at approximately 1:40 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372	bring an audit report of said work for review and potential remediation to the QA Committee which meets quarterly.	

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
315374 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA SALLE HALL	810 NEWMAN SPRINGS RD LINCROFT, NJ 07738

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	02/14/2024	LSC K0351	01/31/2024	LSC K0372	01/31/2024
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	
1/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO